

LEIDOS

January 1, 2020

BC PPO HSA Plan
(non-California resident)
Benefit Booklet

Dear Plan Member:

This Benefit Booklet ("*benefit booklet*") provides a complete explanation of your benefits, limitations and other plan provisions which apply to you.

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

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

Please read this Benefit Booklet ("*benefit booklet*") carefully so that you understand all the benefits your *plan* offers. Keep this Benefit Booklet handy in case you have any questions about your coverage.

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

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

COMPLAINT NOTICE

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

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

Claims Administered by:

ANTHEM BLUE CROSS

on behalf of

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

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TYPES OF PROVIDERS

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

Participating Providers. There are two kinds of *participating providers* in this *plan*:

- **PPO Providers** are providers who participate in a Blue Cross and/or Blue Shield Plan. PPO Providers have agreed to a rate they will accept as reimbursement for covered services that is generally lower than the rate charged by Traditional Providers. *Participating providers* have agreed to a rate they will accept as reimbursement for covered services.
- **Traditional Providers** are providers who might not participate in a Blue Cross and/or Blue Shield Plan, but have agreed to a rate they will accept as reimbursement for covered services for PPO members.

The level of benefits paid under this *plan* is determined as follows:

- If your *plan* identification card (ID card) shows a PPO suitcase logo and:
 - You go to a PPO Provider, you will get the higher level of benefits of this *plan*.
 - You go to a Traditional Provider because there are no PPO Providers in your area, you will get the higher level of benefits of this *plan*.
- If your ID card does NOT have a PPO suitcase logo, you must go to a Traditional Provider to get the higher level of benefits of this *plan*.

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

How to Access Primary and Specialty Care Services

Your health plan covers care provided by primary care *physicians* and specialty care providers. To see a primary care *physician*, simply visit any *participating provider physician* who is a general or family practitioner, internist or pediatrician. Your health plan also covers care provided by any *participating provider* specialty care provider you choose (certain providers' services are covered only upon referral of an M.D.

(medical doctor) or D.O. (doctor of osteopathy), see “Physician,” below). Referrals are never needed to visit any *participating provider* specialty care provider including a behavioral health care provider.

- To make an appointment call your *physician’s* office:
- Tell them you are a PPO Plan *member*.
- Have your Member ID card handy. They may ask you for your group number, member I.D. number, or office visit coinsurance.
- Tell them the reason for your visit.

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

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

Please call the toll-free BlueCard Provider Access number on your ID card to find a *participating provider* in your area. A directory of PPO Providers is available upon request.

Certain categories of providers defined in this *benefit booklet* as *participating providers* may not be available in the Blue Cross and/or Blue Shield Plan in the service area where you receive services. See “Co-Insurance” in the SUMMARY OF BENEFITS section and “Maximum Allowed Amount” in the YOUR MEDICAL BENEFITS section for additional information on how health care services you obtain from such providers are covered.

Non-Participating Providers. *Non-participating providers* are providers which have not agreed to participate in a Blue Cross and/or Blue Shield Plan. They have not agreed to the reimbursement rates and other provisions.

The *claims administrator* has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. *Members* seeking services from *non-participating providers* could be balance billed by the *non-participating provider* for those services that are determined to be not payable as a result of these review processes and meets the criteria set forth in any applicable state regulations adopted pursuant to state law. A claim may also be determined to be not payable due to a provider's failure to submit medical records with the claims that are under review in these processes.

Physicians. "Physician" means more than an M.D. Certain other practitioners are included in this term as it is used throughout the *plan*. This doesn't mean they can provide every service that a medical doctor could; it just means that the *plan* will cover expenses you incur from them when they're practicing within their specialty the same as would be covered if the care were provided by a medical doctor.

Other Health Care Providers. *Other health care providers* are neither *physicians* nor *hospitals*. See the definition of "Other Health Care Providers" in the DEFINITIONS section for a complete list of those providers. *Other health care providers* are not *participating providers*.

Reproductive Health Care Services. Some *hospitals* and other providers do not provide one or more of the following services that may be covered under your *plan* and that you or your 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 *physician* or clinic, or call the Member Services telephone number listed on your ID card to ensure that you can obtain the health care services that you need.

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

- **Transplant Facilities.** Transplant facilities have been organized to provide services for the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. Subject to any applicable co-payments, co-insurance or deductibles, *CME* and *BDCSC* have agreed to a rate they will accept as payment in full for covered services.
- **Bariatric Facilities.** Hospital facilities have been organized to provide services for bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss programs.

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

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

- Before you leave home, call the Member Services number on your ID card for coverage details. **You have coverage for services and supplies furnished in connection only with *urgent care* or an *emergency* when travelling outside the United States.**
- Always carry your current ID card.
- In an emergency, seek medical treatment immediately.
- **The Blue Cross Blue Shield Global Core Service Center is available 24 hours a day, seven days a week toll-free at (800) 810-BLUE (2583) or by calling collect at (804) 673-1177.** An assistance coordinator, along with a medical professional, will arrange a *physician* appointment or hospitalization, if needed.

Payment Information

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

Claim Filing

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

Additional Information About Blue Cross Blue Shield Global Core Claims.

- You are responsible, at your expense, for obtaining an English-language translation of foreign country provider claims and medical records.

- Exchange rates are determined as follows:
 - For inpatient *hospital* care, the rate is based on the date of admission.
 - For outpatient and professional services, the rate is based on the date the service is provided.

Claim Forms

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

www.bcbsglobalcore.com

The address for submitting claims is on the form.

SUMMARY OF BENEFITS

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

THE BENEFITS OF THIS PLAN ARE PROVIDED ONLY FOR SERVICES WHICH ARE CONSIDERED TO BE MEDICALLY NECESSARY. THE FACT THAT A PHYSICIAN PRESCRIBES OR ORDERS THE SERVICE DOES NOT, IN ITSELF, MAKE IT MEDICALLY NECESSARY OR MEAN THAT THE SERVICE IS COVERED UNDER THIS PLAN.

CONSULT THIS BENEFIT BOOKLET OR TELEPHONE THE NUMBER SHOWN ON YOUR ID CARD IF YOU HAVE ANY QUESTIONS REGARDING WHETHER SERVICES ARE COVERED.

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

This summary provides a brief outline of your benefits. You need to refer to the entire *benefit booklet* for complete information about the benefits, conditions, limitations and exclusions of your *plan*.

Second Opinions. If you have a question about your condition or about a plan of treatment which your *physician* has recommended, you may receive a second medical opinion from another *physician*. This second opinion visit will be provided according to the benefits, limitations, and exclusions of this *plan*. If you wish to receive a second medical opinion, remember that greater benefits are provided when you choose a *participating provider*. You may also ask your *physician* to refer you to a *participating provider* to receive a second opinion.

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

Telehealth. This *plan* provides benefits for covered services that are appropriately provided through telehealth, subject to the terms and conditions of the *plan*. 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. “Telehealth” is the means of providing health care services using information and communication technologies in the consultation, diagnosis, treatment, education, care management and self-management of a patient’s physical and mental health care when the patient is located at a distance from the health care provider. Telehealth does not include consultations between the patient and the health care provider, or between health care providers, by telephone, facsimile machine, electronic mail or *chat therapy*.

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

The benefits of this *plan* may be subject to subrogation and reimbursement services administered by the Benefit Recovery Group, through a direct arrangement with the *plan administrator*.

IMPORTANT: For the full benefits of this *plan* to be payable, each time you are admitted to a *hospital, residential treatment center, skilled nursing facility* or transplant facility, receive services from a *home health agency, hospice unit or home infusion therapy provider*, the appropriate utilization reviews must be performed. When pre-service review is not performed as required, the benefits to which a *member* would be otherwise entitled **may be subject to a 20% reduction.** (See UTILIZATION REVIEW PROGRAM for information on how to obtain certification.)

MEDICAL BENEFITS

DEDUCTIBLES

Calendar Year Deductibles

- Member Deductibles:
 - *Participating providers and other health care providers* **\$4,000**
 - *Non-participating providers* **\$8,000**
- Family Deductible:
 - *Participating providers and other health care providers* **\$8,000***
 - *Non-participating providers* **\$16,000***

* If the *subscriber* and one or more *members* of the employee's family are enrolled under this *plan*, the members of the enrolled family must satisfy the Family Deductible. For any given family member, the Deductible is met after the entire Family Deductible is met. The Family Deductible can be met by any combination of amounts from any family member.

Note: Covered charges applied toward the *participating provider* and *other health care provider* Calendar Year Deductibles do not apply toward the *non-participating provider* Calendar Year Deductibles, and covered charges applied toward the *non-participating provider* Calendar Year Deductibles do not apply toward the *participating provider* and *other health care provider* Calendar Year Deductibles.

Exceptions: In certain circumstances, the Calendar Year Deductibles may not apply, as described below:

- The Calendar Year Deductible will not apply to benefits for Preventive Care Services provided by a *participating provider*.
- The Calendar Year Deductible will not apply to covered charges for prenatal care services provided by a *participating provider* who is not a specialist.

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

CO-INSURANCE

Co-Insurance.* After you have met your Calendar Year Deductible, you will be responsible for the following percentages of the *maximum allowed amount*:

- *Participating Providers*.....50%
- *Other Health Care Providers*50%
- *Non-Participating Providers*.....50%

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

***Exceptions:**

- There will be no co-insurance for any covered services provided by a *participating provider* under the Preventive Care benefit.
- You will not be required to pay co-insurance for prenatal care services provided by a *participating provider* who is not a specialist.

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

Out-of-Pocket Amount*. After you have made the following total out-of-pocket payments for covered services or supplies during a *calendar year*, you will no longer be required to pay co-insurance for the remainder of that *year*, but you remain responsible for costs in excess of the *maximum allowed amount*.

The applicable Out-of-Pocket Amounts depends on who is covered under the *plan* at the time service is rendered. If you, the *subscriber*, are the only person enrolled in this *plan*, only the amounts under “Subscriber-Only Out-of-Pocket Amounts” apply to you. If you, the *subscriber*, and any other *family member(s)* are enrolled in this *plan*, only the amounts shown under “Subscriber and Family Member Out-of-Pocket Amounts” will apply to you and your *family member(s)*.

Subscriber-Only Out-of-Pocket Amounts. The following Out-of-Pocket Amounts will apply if you are the *subscriber* enrolled in this *plan* and do not have any *family members* also enrolled under this *plan*:

Per *member*

- *Participating providers and other health care providers*.....**\$6,750**
- *Non-participating providers*.....**\$13,000**

Subscriber and Family Members Out-of-Pocket Amounts. The following Out-of-Pocket Amounts will apply if you are the *subscriber* enrolled in this *plan* and your eligible *family members* are also covered under this *plan*:

Per *member*:

- *Participating provider and other health care provider*.....**\$8,150**
- *Non-participating provider***\$27,000**

Per *family*

- *Participating providers and other health care providers*.....**\$13,500****
- *Non-participating providers*.....**\$27,000****

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

Note: Covered charges applied toward the *participating provider* and *other health care provider* Out-of-Pocket Amount do not apply toward the *non-participating provider* Out-of-Pocket Amount, and covered charges applied toward the *non-participating provider* Out-of-Pocket Amount do not apply toward the *participating provider* and *other health care provider* Out-of-Pocket Amount.

Any expense applied to any deductible and any co-insurance for prescription drugs (provided under your drug plan) will apply toward the satisfaction of the Out-of-Pocket Amount.

***Exception:**

- Expense which is applied toward Medical Management Program Penalty, which is incurred for non-covered services or supplies, or which is in excess of the amount of the *maximum allowed amount*, will not be applied toward your Out-of-Pocket Amount, and is always your responsibility.

Medical Management Program Penalties. The *maximum allowed amount* may be **reduced by 20%** for the following:

- Covered *hospital, residential treatment center, skilled nursing facility* or transplant facility expenses when pre-service review is not obtained as required for admission. See UTILIZATION REVIEW PROGRAM.
- Covered home health care services, home infusion therapy services or hospice care when pre-service review is not obtained as required for treatment. See UTILIZATION REVIEW PROGRAM.

MEDICAL BENEFIT MAXIMUMS

The *plan* will pay benefits, for the following services and supplies, up to the maximum amounts, or for the maximum number of dollar amounts, days and visits shown below:

Skilled Nursing Facility

- For covered *skilled nursing facility* care..... **60 days***
per confinement

* Outpatient visits to *skilled nursing facility* will be counted against the maximum limit for home health care services.

Home Health Care

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

* Includes outpatient visits to *skilled nursing facility* care and private duty nursing services.

Infertility Services

- For all covered services and supplies
except, artificial insemination..... **\$5,000**
during your lifetime

Physical Therapy, Physical Medicine, Occupational Therapy, Speech Therapy and Chiropractic Services

- For covered outpatient services
except, chiropractic services **60**
visits per *calendar year*

Transplant Travel Expense

- For hotel accommodations **\$50**
per day for each person,
for up to \$100 per day maximum
- For all authorized travel expense
in connection with a specified transplant..... **\$10,000**
per transplant

Lifetime Maximum

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

MEDICAL DEDUCTIBLE

Calendar Year Deductible. Under this *plan* there is a Calendar Year Deductible that must be satisfied in each *calendar year* before the *plan* begins to pay medical benefits.

Subscriber. If only the *subscriber* is covered under this *plan*, each year such *subscriber* will be responsible for satisfying the Member Deductible before benefits for medical are paid.

Dependents. If the *subscriber* and one or more *members* of the employee's family are enrolled under this *plan*, the members of the enrolled family must satisfy the Family Deductible. For any given family member, the Deductible is met after the entire Family Deductible is met. The Family Deductible can be met by any combination of amounts from any family member. Once the Family Deductible is satisfied, no further Calendar Year Deductible expense will be required for any enrolled member of that family.

Note: Covered charges applied toward the *participating provider* and *other health care provider* Calendar Year Deductibles do not apply toward the *non-participating provider* Calendar Year Deductibles, and covered charges applied toward the *non-participating provider* Calendar Year Deductibles do not apply toward the *participating provider* and *other health care provider* Calendar Year Deductibles.

Participating Providers, CMEs and Other Health Care Providers.

Only covered charges up to the *maximum allowed amount* for the services of *participating providers*, *CMEs* and *other health care providers* will be applied to the *participating provider* and *other health care provider* Calendar Year Deductibles. When these deductibles are met, the *plan* will pay benefits only for the services of *participating providers*, *CMEs* and *other health care providers*. The *plan* will not pay any benefits for *non-participating providers* unless the separate *non-participating provider* Calendar Year Deductibles (as applicable) are met.

Non-Participating Providers. Only covered charges up to the *maximum allowed amount* for the services of *non-participating providers* will be applied to the *non-participating provider* Calendar Year Deductibles. The *plan* will pay benefits for the services of *non-participating providers* only when the applicable *non-participating provider* deductibles are met.

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

MEDICAL OUT-OF-POCKET AMOUNTS

Satisfaction of the Out-of-Pocket Amount. If, after you have met your Calendar Year Deductibles, you pay co-insurance equal to your Out-of-Pocket Amount per *member* during a *calendar year*, you will no longer be required to make co-insurance for any covered services and supplies during the remainder of that *year*, except as specifically stated below under Charges Which Do Not Apply Toward the Out-of-Pocket Amount.

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

Covered charges applied to your Calendar Year Deductible will be applied to both the *participating provider* and *other health care provider* Out-of-Pocket Amount and the *non-participating provider* Out-of-Pocket Amount no matter where such charges are incurred.

Please Note: Your *plan* includes “Subscriber-Only Out-of-Pocket Amounts” that will apply if you are the *subscriber* enrolled in this *plan* and do not have any *family members* also covered under this *plan*. Your *plan* also includes “Subscriber and Family Members Out-of-Pocket Amounts” which will apply if you are the *subscriber* enrolled in this *plan* and your eligible *family members* are also covered under this *plan*.

How Out-of-Pocket Amounts are Affected by the Addition or Removal of Family Members. The Out-of-Pocket Amounts will be applied according to the Out-of-Pocket Amounts in effect at the time service is rendered. If the *subscriber* is currently enrolled as the sole *member* in this *plan* and, subsequently, a *family member* is added to the *plan* during the *calendar year*, the “Subscriber and Family Members Out-of-Pocket Amounts” will apply on the date coverage for your *family member(s)* begins. Any Out-of-Pocket Amounts the *subscriber* met while enrolled as the sole *member* in this *plan* will be applied towards the *subscriber's* Per Member Out-of-Pocket Amounts and the Per Family Out-of-Pocket Amounts listed above in the SUMMARY OF BENEFITS under the “Subscriber and Family Members Out-of-Pocket Amounts”.

In addition, if the *subscriber* is currently enrolled with *family members* and, subsequently, all *family members* are removed from the *plan* during the *calendar year*, any Out-of-Pocket Amounts the *subscriber* met while

enrolled with *family members* will be applied towards the “Subscriber-Only Out-of-Pocket Amounts”. The *subscriber* will not be credited for any “Subscriber and Family Members Out-of-Pocket Amounts” he/she met that exceeds the “Subscriber-Only Out-of-Pocket Amounts”.

Participating Providers, CMEs, BDCSCs and Other Health Care Providers. Only covered charges up to the *maximum allowed amount* for the services of a *participating provider, CME, BDCSC or other health care provider* will be applied to the *participating provider and other health care provider* Out-of-Pocket Amount.

After this Out-of-Pocket Amount has been satisfied during a *benefit year*, you will no longer be required to make any co-insurance for the covered services provided by a *participating provider, CME, BDCSC or other health care provider* for the remainder of that *year*.

Non-Participating Providers. Only covered charges up to the *maximum allowed amount* for the services of a *non-participating provider* will be applied to the *non-participating provider* Out-of-Pocket Amount. After this Out-of-Pocket Amount has been satisfied during a *benefit year*, you will no longer be required to make any co-insurance for the covered services provided by a *non-participating provider* for the remainder of that *year*.

Family Maximum Out-of-Pocket Amount*. When the *subscriber* and one or more members of the subscriber’s family are insured under this *plan*, if members of an insured family satisfy the Family Out-of-Pocket Amount during a *calendar year*, no further Out-of-Pocket Amount will be required for any insured member of that family for expenses incurred during that *year*.

Note: Covered charges applied toward the *participating provider and other health care provider* Out-of-Pocket Amount do not apply toward the *non-participating provider* Out-of-Pocket Amount, and covered charges applied toward the *non-participating provider* Out-of-Pocket Amount do not apply toward the *participating provider and other health care provider* Out-of-Pocket Amount.

Any expense applied to any deductible and any co-insurance for prescription drugs (provided under your drug plan) will apply toward the satisfaction of the Out-of-Pocket Amount.

Charges Which Do Not Apply Toward the Out-of-Pocket Amount. Charges for services or supplies not covered under this plan, charges which are applied toward Medical Management Program Penalty and charges which exceed the *maximum allowed* will not be applied toward satisfaction of an Out-of-Pocket Amount.

Prior Plan Out-of-Pocket Amounts. If you were covered under the *prior plan*, any amount applied during the same *calendar year* toward your out-of-pocket amount under the *prior plan* will be applied toward your Out-of-Pocket Amount under this *plan*.

YOUR MEDICAL BENEFITS

MAXIMUM ALLOWED AMOUNT

General

This section describes the term “*maximum allowed amount*” as used in this *benefit booklet*, and what the term means to you when obtaining covered services under this plan. The *maximum allowed amount* is the total reimbursement payable under your plan for covered services you receive from *participating* and *non-participating providers*. It is the *plan’s* payment towards the services billed by your provider combined with any Deductible or Co-Insurance owed by you. In some cases, you may be required to pay the entire *maximum allowed amount*. For instance, if you have not met your Deductible under this plan, then you could be responsible for paying the entire *maximum allowed amount* for covered services. In addition, if these services are received from a *non-participating provider*, you may be billed by the provider for the difference between their charges and the *maximum allowed amount*. In many situations, this difference could be significant.

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

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

- The *member* receives services from a *participating* surgeon. The charge is \$2,000. The *maximum allowed amount* under the plan for the surgery is \$1,000. The *member’s* co-insurance responsibility when a *participating* surgeon is used is 30% of \$1,000, or \$300. This is what the *member* pays. The *plan* pays 70% of \$1,000, or \$700. The *participating* surgeon accepts the total of \$1,000 as reimbursement for the surgery regardless of the charges.

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

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

When you receive covered services, the *claims administrator* will, to the extent applicable, apply claim processing rules to the claim submitted.

The *claims administrator* uses these rules to evaluate the claim information and determine the accuracy and appropriateness of the procedure and diagnosis codes included in the submitted claim. Applying these rules may affect the *maximum allowed amount* if the *claims administrator* determines that the procedure and/or diagnosis codes used were inconsistent with procedure coding rules and/or reimbursement policies. For example, if your provider submits a claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed, the *maximum allowed amount* will be based on the single procedure code.

Provider Network Status

The *maximum allowed amount* may vary depending upon whether the provider is a *participating provider*, a *non-participating provider* or *other health care provider*.

Participating Providers. For covered services performed by a *participating provider* the *maximum allowed amount* for this *plan* will be the rate the *participating provider* has agreed with the *claims administrator* to accept as reimbursement for the covered services. Because *participating providers* have agreed to accept the *maximum allowed amount* as payment in full for those covered services, they should not send you a bill or collect for amounts above the *maximum allowed amount*. However, you may receive a bill or be asked to pay all or a portion of the *maximum allowed amount* to the extent you have not met your Deductible or have co-insurance. Please call the Member Services telephone number on your ID card for help in finding a *participating provider* or visit www.anthem.com/ca.

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

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

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

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

Non-Participating Providers and Other Health Care Providers.*

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

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

For covered services rendered outside the Anthem Blue Cross service area by *non-participating providers*, claims may be priced using the local Blue Cross Blue Shield plan's *non-participating provider* fee schedule / rate or the pricing arrangements required by applicable state or federal law. In certain situations, the *maximum allowed amount* for out of area claims may be based on billed charges, the pricing used if the healthcare services had been obtained within the Anthem Blue Cross service area, or a special negotiated price.

Unlike *participating providers*, *non-participating providers* and *other health care providers* may send you a bill and collect for the amount of the *non-participating provider's* or *other health care provider's* charge that exceeds the *maximum allowed amount* under this *plan*. You may be responsible for paying the difference between the *maximum allowed amount* and the amount the *non-participating provider* or *other health care provider* charges. This amount can be significant. Choosing a *participating provider* will likely result in lower out of pocket costs to you.

Please call the Member Services number on your ID card for help in finding a *participating provider* or visit the website www.anthem.com/ca. Member Services is also available to assist you in determining this *plan's maximum allowed amount* for a particular *covered service* from a *non-participating provider* or *other health care provider*.

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

***Exceptions:**

- **Clinical Trials.** The *maximum allowed amount* for services and supplies provided in connection with Clinical Trials will be the lesser of the billed charge or the amount that ordinarily applies when services are provided by a *participating provider*.
- **If Medicare is the primary payor, the *maximum allowed amount* does not include any charge:**
 1. By a *hospital*, in excess of the approved amount as determined by Medicare; or
 2. By a *physician* who is a *participating provider* who accepts Medicare assignment, in excess of the approved amount as determined by Medicare; or
 3. By a *physician* who is a *non-participating provider* or *other health care provider* who accepts Medicare assignment, in excess of the lesser of *maximum allowed amount* stated above, or the approved amount as determined by Medicare; or
 4. By a *physician* or *other health care provider* who does not accept Medicare assignment, in excess of the lesser of the *maximum allowed amount* stated above, or the limiting charge as determined by Medicare.

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

WARNING! The *Maximum Allowed Amount* may be reduced by 20% for the following:

1. Covered *hospital, residential treatment center, skilled nursing facility* or transplant facility expenses when pre-service review is not obtained as required for admission. See UTILIZATION REVIEW PROGRAM.
2. Covered home health care services, home infusion therapy services or hospice care when pre-service review is not obtained as required for treatment. See UTILIZATION REVIEW PROGRAM.

MEMBER COST SHARE

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

The *plan* will not provide any reimbursement for non-covered services. You may be responsible for the total amount billed by your provider for non-covered services, regardless of whether such services are performed by a *participating provider* or *non-participating provider*. Non-covered services include services specifically excluded from coverage by the terms of your plan and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, Medical Benefit Maximums or day/visit limits.

In some instances you may only be asked to pay the lower *participating provider* cost share percentage when you use a *non-participating provider*. For example, if you go to a *participating* hospital or facility and receive covered services from a *non-participating provider* such as a radiologist, anesthesiologist or pathologist providing services at the hospital or facility, you will pay the *participating provider* cost share percentage of the *maximum allowed amount* for those covered services. However, you also may be liable for the difference between the *maximum allowed amount* and the *non-participating provider's* charge.

AUTHORIZED REFERRALS

In some circumstances the *claims administrator* may authorize *participating provider* cost share amounts (Deductibles or Co-Insurance) to apply to a claim for a covered service you receive from a *non-participating provider*. In such circumstance, you or your *physician* must contact the *claims administrator* in advance of obtaining the covered service. It is your responsibility to ensure that the *claims administrator* has been contacted. If the *claims administrator* authorizes a *participating provider* cost share amount to apply to a covered service received from a *non-participating provider*, you also may still be liable for the difference between the *maximum allowed amount* and the *non-participating provider's* charge. Please call the Member Services telephone number

on your ID card for *authorized referral* information or to request authorization.

CO-INSURANCE AND MEDICAL BENEFIT MAXIMUMS

After you satisfy your Medical Deductible, your co-insurance will be subtracted and benefits will be paid up to the *maximum allowed amount*, not to exceed any applicable Medical Benefit Maximum. The Co-Insurance and Medical Benefit Maximums are set forth in the SUMMARY OF BENEFITS.

CO-INSURANCE

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

The *plan* will apply the applicable co-insurance percentage to the *maximum allowed amount* remaining after any deductible has been met. This will determine the dollar amount of your co-insurance.

MEDICAL BENEFIT MAXIMUMS

The *plan* does not make benefit payments for any *member* in excess of any of the Medical Benefit Maximums.

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

CREDITING PRIOR PLAN COVERAGE

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

If the *plan administrator* moves from one of the *claims administrator's* plans to another, (for example, changes its coverage from HMO to PPO), and you were covered by the other product immediately before enrolling in this product with no break in coverage, then you may get credit for any accrued Calendar Year Deductible and Out of Pocket Amounts, if applicable and approved by the *claims administrator*. Any maximums, when applicable, will be carried over and charged against the Medical Benefit Maximums under this *plan*.

If the *plan administrator* offers more than one of the *claims administrator's* products, and you change from one product to another with no break in coverage, you will get credit for any accrued Calendar Year Deductible and, if applicable, Out of Pocket Amounts and any maximums will be carried over and charged against Medical Benefit Maximums under this *plan*.

If the *plan administrator* offers coverage through other products or carriers in addition to the *claims administrator's*, and you change products or carriers to enroll in this product with no break in coverage, you will get credit for any accrued Calendar Year Deductible, Out of Pocket Amount, and any Medical Benefit Maximums under this *plan*.

This Section Does Not Apply To You If:

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

CONDITIONS OF COVERAGE

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

1. You must incur this expense while you are covered under this *plan*. Expense is incurred on the date you receive the service or supply for which the charge is made.
2. The expense must be for a medical service or supply furnished to you as a result of illness or injury or pregnancy, unless a specific exception is made.
3. The expense must be for a medical service or supply included in MEDICAL CARE THAT IS COVERED. Additional limits on covered charges are included under specific benefits and in the SUMMARY OF BENEFITS.
4. The expense must not be for a medical service or supply listed in MEDICAL CARE THAT IS NOT COVERED. If the service or supply is partially excluded, then only that portion which is not excluded will be covered under this plan.
5. The expense must not exceed any of the maximum benefits or limitations of this *plan*.

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

MEDICAL CARE THAT IS COVERED

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

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

Hospital

1. Inpatient services and supplies, provided by a *hospital*. The *maximum allowed amount* will not include charges in excess of the *hospital's* prevailing two-bed room rate unless your *physician* orders, and the *claims administrator* authorizes, a private room as *medically necessary*.
2. Services in *special care units*.
3. Outpatient services and supplies provided by a *hospital*, including outpatient surgery.

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

Hospital Pre-Admission Testing. Outpatient *hospital* services for pre-admission testing if the tests are:

1. Made within five days prior to the date inpatient care begins;
2. Made in the same *hospital* where the inpatient care is scheduled;
3. Ordered by the same *physician* who ordered the inpatient care; and

4. The same as would have been made as an inpatient, or admission is not appropriate or *medically necessary*.

Skilled Nursing Facility. Inpatient services and supplies provided by a *skilled nursing facility*, for up to 60 days per confinement. The amount by which your room charge exceeds the prevailing two-bed room rate of the *skilled nursing facility* is not considered covered under this plan.

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

Note: Outpatient visits to a *skilled nursing facility* will be counted against the 100 visit limit applicable to benefits for services provided by a *home health agency*.

If covered charges are applied toward the Calendar Year Deductible and payment is not provided, those days will be included in the 60 days for that *year*.

Private Duty Nursing. Services of a licensed nurse (R.N., L.P.N. or L.V.N.) for nursing services. The *plan's* maximum payment for private duty nursing and home health care services is limited to a combined total of 100 visits per *calendar year*. "Private duty" means a session of four or more hours that continuous nursing care is furnished to you alone.

The combined maximum for home health care and private duty nursing services will be 100 visits during a *calendar year*. In addition, the maximum for home health care services will be further reduced by any skilled nursing care paid to you or on your behalf under any other health plan sponsored by the *plan administrator*.

If covered charges are applied toward the Calendar Year Deductible and payment is not provided, those visits will be included in the 100 visits for that *year*.

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

1. Services of a registered nurse or licensed vocational nurse under the supervision of a registered nurse or a *physician*.
2. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy, or respiratory therapy.
3. Services of a medical social service worker.
4. Services of a health aide who is employed by (or who contracts with) a *home health agency*. Services must be ordered and supervised by a registered nurse employed by the *home health agency* as

professional coordinator. These services are covered only if you are also receiving the services listed in 1 or 2 above. Other organizations may give services only when approved by the *claims administrator*, and their duties must be assigned and supervised by a professional nurse on the staff of the *home health agency* or other provider as approved by the *claims administrator*.

5. *Medically necessary* supplies provided by the *home health agency*.

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 CONDITIONS OR SUBSTANCE ABUSE section below.

The combined maximum for home health care and private duty nursing services will be 100 visits during a *calendar year*. In addition, the maximum for home health care services will be further reduced by any outpatient skilled nursing care paid to you or on your behalf under any other health plan sponsored by the *plan administrator*. A visit of four hours or less by a home health aide shall be considered as one home health visit.

If covered charges are applied toward the Calendar Year Deductible and payment is not provided, those visits will be included in the 100 visits for that *year*.

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

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

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

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

1. Interdisciplinary team care with the development and maintenance of an appropriate plan of care.
2. Short-term inpatient *hospital* care when required in periods of crisis

or as respite care. Coverage of inpatient respite care is provided on an occasional basis and is limited to a maximum of five consecutive days per admission.

3. Skilled nursing services provided by or under the supervision of a registered nurse. Certified home health aide services and homemaker services provided under the supervision of a registered nurse.
4. Social services and counseling services provided by a qualified social worker.
5. Dietary and nutritional guidance. Nutritional support such as intravenous feeding or hyperalimentation.
6. Physical therapy, occupational therapy, speech therapy, and respiratory therapy provided by a licensed therapist.
7. Volunteer services provided by trained *hospice* volunteers under the direction of a *hospice* staff member.
8. Pharmaceuticals, medical equipment, and supplies necessary for the management of your condition. Oxygen and related respiratory therapy supplies.
9. Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the *member's* death. Bereavement services are available to the patient and those individuals who are closely linked to the patient, including the immediate family, the primary or designated care giver and individuals with significant personal ties, for one year after the *member's* death.
10. Palliative care (care which controls pain and relieves symptoms, but does not cure) which is appropriate for the illness.

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

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

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

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

1. Medication, ancillary medical supplies and supply delivery, (not to exceed a 14-day supply); however, medication which is delivered but not administered is not covered;
2. Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications;
3. *Hospital* and home clinical visits related to the administration of infusion therapy, including skilled nursing services including those provided for: (a) patient or alternative caregiver training; and (b) visits to monitor the therapy;
4. Rental and purchase charges for durable medical equipment; maintenance and repair charges for such equipment;
5. Laboratory services to monitor the patient's response to therapy regimen.
6. Total Parenteral Nutrition (TPN), Enteral Nutrition Therapy, antibiotic therapy, pain management, chemotherapy, and may also include injections (intra-muscular, subcutaneous, or continuous subcutaneous).

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

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

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

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

1. Exams for minor illnesses and injuries.
2. Preventive services and vaccinations.
3. Health condition monitoring and testing.

Online Visits. When available in your area, covered services will include consultations using the internet via webcam, voice or *chat therapy*. Online visits are covered under *plan* benefits for office visits to *physicians*.

Non-covered services include, but are not limited to, the following:

- Reporting normal lab or other test results.
- Office visit appointment requests or changes.
- Billing, insurance coverage, or payment questions.
- Requests for referrals to other *physicians* or healthcare practitioners.
- Benefit precertification.
- Consultations between *physicians*.
- Consultations provided by telephone, electronic mail, or facsimile machines.

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

For *mental health conditions* or substance abuse online visits, please see “MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE” benefit for a description of this coverage.

Professional Services

1. Services of a *physician*.
2. Services of an anesthetist (M.D. or C.R.N.A.).

Reconstructive Surgery. Reconstructive surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or creating a normal appearance. This includes *medically necessary* dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. “Cleft palate” means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

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

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

professionals. Ambulance services are covered when one or more of the following criteria are met:

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

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

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

Coverage includes *medically necessary* treatment of an illness or injury by medical professionals from an ambulance service, even if you are not transported to a *hospital*. Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your *family members* or *physician* are not a covered service.

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

- A *physician's* office or clinic;

- A morgue or funeral home.

If provided through the 911 emergency response system*, ambulance services are covered if you reasonably believed that a medical *emergency* existed even if you are not transported to a *hospital*.

Important information about air ambulance coverage. Coverage is only provided for air ambulance services when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a *hospital* than the ground ambulance can provide, this *plan* will cover the air ambulance. Air ambulance will also be covered if you are in a location that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a *hospital* that is not an acute care *hospital* (such as a skilled nursing facility or a rehabilitation facility), or if you are taken to a *physician's* office or to your home.

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

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

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

Advanced Imaging Procedures. Imaging procedures, including, but not limited to, Magnetic Resonance Imaging (MRI), Computerized Tomography (CT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography and nuclear cardiac imaging are subject to pre-service review to determine medical necessity. You may call the toll-free Member Services telephone number on your

identification card to find out if an imaging procedure requires pre-service review. See UTILIZATION REVIEW PROGRAM for details.

Radiation Therapy

Chemotherapy

Hemodialysis Treatment

Prosthetic Devices

1. Breast prostheses following a mastectomy.
2. *Prosthetic devices* to restore a method of speaking when required as a result of a covered *medically necessary* laryngectomy.
3. Wigs for alopecia resulting from chemotherapy or radiation therapy.
4. The *plan* will pay for other *medically necessary prosthetic devices*, including:
 - a. Surgical implants;
 - b. Artificial limbs or eyes;
 - c. The first pair of contact lenses or eye glasses when required as a result of a covered *medically necessary* eye surgery;
 - d. Therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications; and
 - e. Benefits are available for certain types of orthotics (braces, boots, splints). Covered services include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

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

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

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

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

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

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

Dental Care

1. **Admissions for Dental Care.** Listed inpatient *hospital* services for up to three days during a *hospital stay*, when such *stay* is required for dental treatment and has been ordered by a *physician* (M.D.) and a dentist (D.D.S. or D.M.D.). The *claims administrator* will make the final determination as to whether the dental treatment could have been safely rendered in another setting due to the nature of the procedure or your medical condition. *Hospital stays* for the purpose of administering general anesthesia are not considered necessary and are not covered except as specified in #2, below.
2. **General Anesthesia.** General anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a *hospital* or *ambulatory surgical center*. This applies only if (a) the *member* is less than seven years old, (b) the *member* is developmentally disabled, or (c) the *member's* health is compromised and general anesthesia is *medically necessary*. Charges for the dental procedure itself, including professional fees of a dentist, are not covered.
3. **Dental Injury.** Services of a *physician* (M.D.) or dentist (D.D.S. or D.M.D.) solely to treat an *accidental injury* to natural teeth. Coverage shall be limited to only such services that are *medically necessary* to repair the damage done by the *accidental injury* and/or

restore function lost as a direct result of the *accidental injury*. Damage to natural teeth due to chewing or biting is not *accidental injury* unless the chewing or biting results from a medical or mental condition.

4. **Cleft Palate.** *Medically necessary* dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. "Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.
5. **Orthognathic surgery.** Orthognathic surgery for a physical abnormality that prevents normal function of the upper or lower jaw and is *medically necessary* to attain functional capacity of the affected part.

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

Pregnancy and Maternity Care

1. All medical benefits for a *member* when provided for pregnancy or maternity care, including the following services:
 - a. Prenatal postnatal and postpartum care;
 - b. Ambulatory care services (including ultrasounds, fetal non-stress tests, *physician* office visits, and other *medically necessary* maternity services performed outside of a *hospital*);
 - c. Involuntary complications of pregnancy;
 - d. Diagnosis of genetic disorders in cases of high-risk pregnancy; and
 - e. Inpatient *hospital* care including labor and delivery.

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

2. Medical *hospital* benefits for routine nursery care of a newborn *child*, if the *child's* natural mother is a *member* and provided the *child* is enrolled under this *plan*. Routine nursery care of a newborn child includes screening of a newborn for genetic diseases, congenital conditions, and other health conditions provided through a program established by law or regulation.
3. Certain services are covered under the "Preventive Care Services" benefit. Please see that provision for further details.

Infertility Services. The following services and supplies furnished in connection with the diagnosis and treatment of *infertility*, when under the direct care and treatment of a *physician*:

1. Examinations.
2. Diagnostic tests and work-ups.
3. Medications administered in a *physician's* office.
4. Reconstructive surgery, except for sterilization reversal.
5. Artificial insemination.
5. Supplies and appliances.

The services and supplies furnished in connection with infertility procedures, including, but not limited to:

1. In vitro fertilization (IVF),
2. Zygote intra-fallopian transfer (ZIFT),
3. Gamete intra-fallopian transfer (GIFT), and
4. Cryopreserved embryo transfers.

The benefit payments for infertility procedures and prescription drugs will not exceed **\$5,000** for all covered expense incurred during your lifetime. This maximum will not apply to artificial insemination. Treatment for *infertility* will not include sterilization reversal or any other services for *infertility* not specifically stated above.

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

1. The recipient; or
2. The donor.

Benefits for an organ donor are as follows:

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

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

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

To maximize your benefits, you should call the Transplant Department as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation or work-up for a transplant. The *claims administrator* will help you maximize your benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, *Centers of Medical Excellence (CME)* or *Blue Distinction Centers for Specialty Care (BDCSC)* rules, or exclusions apply. Call the Member Services phone number on the back of your ID card and ask for the transplant coordinator.

You or your *physician* must call the Transplant Department for pre-service review prior to the transplant, whether it is performed in an inpatient or outpatient setting. Prior authorization is required before the

claims administrator will provide benefits for a transplant. Your *physician* must certify, and the *claims administrator* must agree, that the transplant is *medically necessary*. Your *physician* should send a written request for prior authorization to the *claims administrator* as soon as possible to start this process. Not getting prior authorization will result in a denial of benefits.

Please note that your *physician* may ask for approval for HLA (human leukocyte antigen) testing, donor searches, or collection and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges will be covered as routine diagnostic tests. The collection and storage request will be reviewed for medical necessity and may be approved. However, such an approval for HLA testing, donor search, or collection and storage is NOT an approval for the later transplant. A separate medical necessity decision will be needed for the transplant itself.

Specified Transplants

You must obtain the *claims administrator's* prior authorization for all services including, but not limited to, preoperative tests and postoperative care related to the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. Call the toll-free telephone number for pre-service review on your ID card if your *physician* recommends a specified transplant for your medical care.

Transplant Travel Expense

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

- Ground transportation to and from the transplant facility.
- Coach airfare to and from the transplant facility.
- Lodging, limited to one room, double occupancy, not to exceed **\$50** per day for each person, for up to \$100 per day maximum.
- Other reasonable expenses. Tobacco, alcohol, drug expenses, and meals are excluded.

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

No co-insurance will be required for transplant travel expenses authorized in advance by the *claims administrator*. The *plan* will provide benefits for lodging and ground transportation, up to the current limits set forth in the Internal Revenue Code.

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

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

Bariatric Surgery. Services and supplies in connection with *medically necessary* surgery for weight loss, only for morbid obesity. See UTILIZATION REVIEW PROGRAM for details.

You must obtain pre-service review for all bariatric surgical procedures.

Transgender Services. Services and supplies provided in connection with gender transition when you have been diagnosed with gender identity disorder or gender dysphoria by a *physician*. This coverage is provided according to the terms and conditions of the *plan* that apply to all other covered medical conditions, including medical necessity requirements, utilization management, and exclusions for cosmetic services. Coverage includes, but is not limited to, *medically necessary* services related to gender transition such as transgender surgery, hormone therapy, psychotherapy, and vocal training.

Coverage is provided for specific services according to *plan* benefits that apply to that type of service generally, if the *plan* includes coverage for the service in question. If a specific coverage is not included, the service will not be covered. For example, transgender surgery would be covered on the same basis as any other covered, *medically necessary* surgery; hormone therapy would be covered under the *plan's prescription drug* benefits (if such benefits are included).

Services that are excluded on the basis that they are cosmetic include, but are not limited to, liposuction, facial bone reconstruction, voice modification surgery, breast implants, and hair removal. Transgender services are subject to prior authorization in order for coverage to be provided. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

Mental Health Conditions or Substance Abuse. Covered services shown below for the *medically necessary* treatment of *mental health conditions* or substance abuse.

1. Inpatient *hospital* services and services from a *residential treatment center* as stated in the "Hospital" provision of this section, for inpatient services and supplies.
2. *Partial hospitalization programs*, including intensive outpatient programs and visits to a *day treatment center*. *Partial hospitalization programs* are covered as stated in the "Hospital" provision of this section, for outpatient services and supplies.
3. *Physician* visits during a covered inpatient *stay*.
4. *Physician* visits (including online visits) and *intensive in-home behavioral health programs* for outpatient psychotherapy or psychological testing or outpatient rehabilitative care for the treatment of *mental health conditions* or substance abuse. This includes nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa.

Treatment for substance abuse does not include smoking cessation programs, nor treatment for nicotine dependency or tobacco use.

Preventive Care Services. Preventive care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA) and applicable state law. This means for *preventive care services*, the *calendar year* deductible will not apply to these services or supplies when they are provided by a *participating provider*. No co-insurance will apply to these services or supplies when they are provided by a *participating provider*.

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

1. A *physician's* services for routine physical examinations.
2. Immunizations prescribed by the examining *physician*.
3. Radiology and laboratory services and tests ordered by the examining *physician* in connection with a routine physical examination, excluding any such tests related to an illness or injury. Those radiology and laboratory services and tests related to an illness or injury will be covered as any other medical service

available under the terms and conditions of the provision “Diagnostic Services”.

4. Health screenings as ordered by the examining *physician* for the following: breast cancer, including BRCA testing if appropriate (in conjunction with genetic counseling and evaluation), cervical cancer, including human papillomavirus (HPV), prostate cancer, colorectal cancer, and other medically accepted cancer screening tests, blood lead levels, high blood pressure, type 2 diabetes mellitus, cholesterol, obesity, and screening for iron deficiency anemia in pregnant women.
5. Human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.
6. Counseling and risk factor reduction intervention services for sexually transmitted infections, human immunodeficiency virus (HIV), contraception, tobacco use, and tobacco use-related diseases.
7. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
 - a. All FDA-approved contraceptive *drugs*, devices and other products for women, including over-the-counter items, if prescribed by a *physician*. This includes contraceptive *drugs*, injectable contraceptives, patches and devices such as diaphragms, intra uterine devices (IUDs) and implants, as well as voluntary sterilization procedures, contraceptive education and counseling. It also includes follow-up services related to the *drugs*, devices, products and procedures, including but not limited to management of side effects, counseling for continued adherence, and device insertion and removal.

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

In order to be covered as preventive care, contraceptive prescription drugs must be *generic* oral contraceptives. *Brand name drugs* will be covered as *preventive care services* when *medically necessary* according to your attending *physician*.

- b. Breast feeding support, supplies, and counseling. One breast pump will be covered per pregnancy under this benefit.

- c. Gestational diabetes screening.
 - d. Preventive prenatal care.
8. Preventive services for certain high-risk populations as determined by your *physician*, based on clinical expertise.

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

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

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

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

1. Diagnostic mammogram examinations in connection with the treatment of a diagnosed illness or injury. Routine mammograms will be covered initially under the Preventive Care Services benefit.
2. Breast cancer (BRCA) testing, if appropriate, in conjunction with genetic counseling and evaluation. When done as a *preventive care service*, BRCA testing will be covered under the Preventive Care Services benefit.
3. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.
4. Reconstructive surgery of both breasts performed to restore and achieve symmetry following a *medically necessary* mastectomy.
5. Breast prostheses following a mastectomy (see “Prosthetic Devices”).

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

Clinical Trials. Coverage is provided for routine patient costs you receive as a participant in an approved clinical trial. The services must

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

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

An “approved clinical trial” is a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or another life-threatening disease or condition, from which death is likely unless the disease or condition is treated. Coverage is limited to the following clinical trials:

1. Federally funded trials approved or funded by one or more of the following:
 - a. The National Institutes of Health,
 - b. The Centers for Disease Control and Prevention,
 - c. The Agency for Health Care Research and Quality,
 - d. The Centers for Medicare and Medicaid Services,
 - e. A cooperative group or center of any of the four entities listed above or the Department of Defense or the Department of Veterans Affairs,
 - f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants, or
 - g. Any of the following departments if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines (1) to be comparable to the system of peer review of investigations and studies used by the National Institutes of Health, and (2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
 - i. The Department of Veterans Affairs,
 - ii. The Department of Defense, or
 - iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration.

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

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

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

1. The investigational item, device, or service itself.
2. Any item or service provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.
3. Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
4. Any item, device, or service that is paid for, by the sponsor of the trial or is customarily provided by the sponsor free of charge for any enrollee in the trial.

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

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

1. Physical therapy and physical medicine provided on an outpatient basis for the treatment of illness or injury including the therapeutic use of heat, cold, exercise, electricity, ultra violet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care which are customarily provided by chiropractors, physical therapists and osteopaths. It does not include massage therapy services at spas or health clubs.) Visits for physical therapy and physical medicine will require pre-service review after the first 24 visits. No benefits are payable if pre-service review is not obtained for visits after the 24th visit. (See UTILIZATION REVIEW PROGRAM.)
2. Occupational therapy provided on an outpatient basis when the ability to perform daily life tasks has been lost or reduced by, or has not been developed due to, illness or injury including programs which are designed to rehabilitate mentally, physically or emotionally handicapped persons. Occupational therapy programs are designed

to maximize or improve a patient's upper extremity function, perceptual motor skills and ability to function in daily living activities.

3. Outpatient speech therapy following injury or organic disease.

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

Up to 60 visits in a *year* for all covered physical therapy, physical medicine, occupational therapy and speech therapy are payable.

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

For speech therapy, pre-service review must be obtained prior to receiving services. Please refer to utilization review program for information on how to obtain the proper reviews.

Injectable Drugs and Implants for Birth Control. Injectable drugs and implants for birth control administered in a *physician's* office if *medically necessary*.

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

Sterilization Services. Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered.

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

Acupuncture. The services of a *physician* for acupuncture treatment to treat a disease, illness or injury, including a patient history visit, physical examination, treatment planning and treatment evaluation, electroacupuncture, cupping and moxibustion.

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

Vision Therapy. Eye exercises and orthoptics which are customarily provided by optometrists and ophthalmologists to correct or improve visual dysfunctions.

Vision therapies are subject to pre-service review to determine medical necessity. See UTILIZATION REVIEW PROGRAM for details.

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

1. The following equipment and supplies:
 - a. Blood glucose monitors, including monitors designed to assist the visually impaired, and blood glucose testing strips.
 - b. Insulin pumps.
 - c. Pen delivery systems for insulin administration (non-disposable).
 - d. Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin.
 - e. Podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes-related complications.

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

2. Diabetes education program which:
 - a. Is designed to teach a *member* who is a patient and covered members of the patient's family about the disease process and the daily management of diabetic therapy;
 - b. Includes self-management training, education, and medical nutrition therapy to enable the *member* to properly use the equipment, supplies, and medications necessary to manage the disease; and
 - c. Is supervised by a *physician*.

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

3. The following items are covered as medical supplies:
 - a. Insulin syringes, disposable pen delivery systems for insulin administration. Charges for insulin and other prescriptive medications are not covered.
 - b. Testing strips, lancets, and alcohol swabs.
4. Screenings for gestational diabetes are covered under your Preventive Care Services benefit. Please see that provision for further details.

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

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

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

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

- Prescribed by a *physician* or nurse practitioner for the treatment of PKU, and
- Consistent with the recommendations and best practices of qualified *physicians* with expertise in the treatment and care of PKU, and
- Used in place of normal food products, such as grocery store foods, used by the general population.

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

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

Designated Pharmacy Provider. The *claims administrator* may establish one or more *designated pharmacy provider* programs which provide specific pharmacy services (including shipment of *prescription drugs*) to *members*. A *participating provider* is not necessarily a *designated pharmacy provider*. To be a *designated pharmacy provider*, the *participating provider* must have signed a *designated pharmacy*

provider agreement with the *plan*. You or your *physician* can contact Member Services to learn which *pharmacy* or *pharmacies* are part of a *designated pharmacy provider* program.

For *prescription drugs* that are shipped to you or your *physician* and administered in your *physician's* office, you and your *physician* are required to order from a *designated pharmacy provider*. A patient care coordinator will work with you and your *physician* to obtain precertification and to assist shipment to your *physician's* office.

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

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

You can get the list of the *prescription drugs* covered under this section by calling Member Services at the phone number on the back of your ID card or check the *claims administrator's* website at www.anthem.com.

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

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

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

Prior Authorization. Certain *specialty pharmacy drugs* require written prior authorization of benefits in order for you to receive them. Prior authorization criteria will be based on medical policy and the pharmacy and therapeutics process. You may need to try a drug other than the one originally prescribed if it's determined that it should be clinically effective for you. However, if it's determined through prior authorization that the drug originally prescribed is *medically necessary* and is cost effective, you will be provided the *drug* originally requested. If, when you first become a *member*, you are already being treated for a medical condition by a *drug* that has been appropriately prescribed and is considered safe and effective for your medical condition, the *claims administrator* will not require you to try a drug other than the one you are currently taking.

In order for you to get a *specialty pharmacy drug* that requires prior authorization, your *physician* must make a request to the *claims administrator* for you to get it. The request may be made by either telephone or facsimile. At the time the request is initiated, specific clinical information will be requested from your *physician* based on medical policy and/or clinical guidelines, based specifically on your diagnosis and/or the *physician's* statement in the request or clinical rationale for the *specialty pharmacy drug*.

If the request is not for urgently needed drugs, after the *claims administrator* gets the request from your *physician*:

- Based on your medical condition, as *medically necessary*, the *claims administrator* will review it and decide if they will approve benefits within 5-business days. The *claims administrator* will tell you and your *physician* what has been decided in writing - by fax to your doctor, and by mail, to you.
- If more information is needed to make a decision, the *claims administrator* will tell your *physician* in writing within 5-business days after they get the request what information is missing and why a decision cannot be made. If, for reasons beyond the *claims administrator's* control, they cannot tell your *physician* what information is missing within 5-business days, the *claims administrator* will tell your *physician* that there is a problem as soon as they know that they cannot respond within 5-business days. In any event, the *claims administrator* will tell you and your *physician* that there is a problem by telephone, and in writing by facsimile, to your *physician*, and in writing to you by mail.
- As soon as the *claims administrator* can, based on your medical condition, as *medically necessary*, within 5-business days after they have all the information they need to decide if they will approve benefits, the *claims administrator* will tell you and your *physician*

what has been decided in writing - by fax to your *physician* and by mail to you.

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

If a request for prior authorization of a *specialty pharmacy drug* is denied, you or your prescribing *physician* may appeal the decision by calling the number on the back of your ID card.

MEDICAL CARE THAT IS NOT COVERED

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

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

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

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

Experimental or Investigative. Any *experimental* or *investigative* procedure or medication. But, if you are denied benefits because it is determined that the requested treatment is *experimental* or *investigative*, you may request that the denial be reviewed.

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

Incarceration. For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

Uninsured. Services received before your *effective date* or after your coverage ends, except as specifically stated under EXTENSION OF BENEFITS.

Non-Licensed Providers. Treatment or services rendered by non-licensed health care providers and treatment or services for which the

provider of services is not required to be licensed. This includes treatment or services from a non-licensed provider under the supervision of a licensed *physician*, except as specifically provided or arranged by the *claims administrator*.

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

Services Received from Providers on a Federal or State Exclusion List. Any service, *drug*, *drug* regimen, treatment, or supply furnished, ordered or prescribed by a provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies. This exclusion does not apply to an *emergency medical condition*.

Excess Amounts. Any amounts in excess of *maximum allowed amounts* or any Medical Benefit Maximum.

Work-Related. Any injury, condition or disease arising out of employment for which benefits or payments are covered by any worker's compensation law or similar law. If the *plan* provides benefits for such injuries, conditions or diseases the *claims administrator* shall be entitled to establish a lien or other recovery under section 4903 of the California Labor Code or any other applicable law.

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

Medicare. For which benefits are payable under Medicare Parts A and/or B, or would have been payable if you had applied for Parts A and/or B, except as listed in this booklet or as required by federal law, as described in the section titled "BENEFITS FOR MEDICARE ELIGIBLE MEMBERS: Coordinating Benefits With Medicare". If you do not enroll in Medicare Part B, benefits will be calculated as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.

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

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

- Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
- Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
- Enhancements to standard equipment and devices that is not *medically necessary*.
- Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is *medically necessary* in your situation.
- Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered under the “Durable Medical Equipment” provision of MEDICAL CARE THAT IS COVERED.

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

Voluntary Payment. Services for which you are not legally obligated to pay. Services for which you are not charged. Services for which no charge is made in the absence of insurance coverage, except services received at a non-governmental charitable research *hospital*. Such a *hospital* must meet the following guidelines:

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

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

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a *hospital stay* primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Mental Health Conditions or Substance Abuse. Academic or educational testing, counseling, and remediation. Any treatment of *mental health conditions* or substance abuse, including rehabilitative care in relation to these conditions, except as specifically stated in the "Mental Health Conditions or Substance Abuse" provision of MEDICAL CARE THAT IS COVERED. Any educational treatment or any services that are educational, vocational, or training in nature except as specifically provided or arranged by the *claims administrator*.

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

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

- Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a *member's* own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, *custodial care* center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.

Wilderness. Wilderness or other outdoor camps and/or programs.

Dental Devices for Snoring. Oral appliances for snoring.

Growth Hormone Treatment. Any treatment, device, *drug*, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

Orthodontia. Braces and other orthodontic appliances or services,

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

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

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

This exclusion does not apply to the following:

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

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

Hearing Aids or Tests. Hearing aids. Routine hearing tests, except as specifically provided under the "Preventive Care Services" provisions of MEDICAL CARE THAT IS COVERED.

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

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

Outpatient Speech Therapy. Outpatient speech therapy except as stated in the "Physical Therapy, Physical Medicine, Occupational Therapy, Speech Therapy and Chiropractic Services" provision of MEDICAL CARE THAT IS COVERED.

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

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

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

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

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

This exclusion does not apply to *medically necessary* treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as stated in the "Bariatric Surgery" provision of MEDICAL CARE THAT IS COVERED.

Sterilization Reversal. Reversal of an elective sterilization.

Infertility Services. Services or supplies furnished in connection with the diagnosis and treatment of *infertility*, except as specifically stated in the "Infertility Services" provision of MEDICAL CARE THAT IS COVERED.

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

Foot Orthotics. Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes.

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

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

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

Hospital Services Billed Separately. Services rendered by *hospital* resident *physicians* or interns that are billed separately. This includes separately billed charges for services rendered by employees of *hospitals*, labs or other institutions, and charges included in other duplicate billings.

Hyperhidrosis Treatment. Medical and surgical treatment of excessive sweating (hyperhidrosis).

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

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

Education or Counseling. Any educational treatment or nutritional counseling, or any services that are educational, vocational, or training in nature except as specifically provided or arranged by the *claims administrator*. Such services are provided under the "Diabetes" provision of MEDICAL CARE THAT IS COVERED. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

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

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

Telephone, Facsimile Machine, and Electronic Mail Consultations.

Consultations provided using telephone, facsimile machine, or electronic mail.

Routine Physicals and Immunizations. Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the "Preventive Care Services" provision of MEDICAL CARE THAT IS COVERED.

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

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

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

- **Delivery Charges.** Charges for the delivery of *prescription drugs*.
- **Clinically-Equivalent Alternatives.** Certain *prescription drugs* may not be covered if you could use a clinically equivalent *drug*, unless required by law. "Clinically equivalent" means *drugs* that for most *members*, will give you similar results for a disease or condition. If you have questions about whether a certain *drug* is covered and which *drugs* fall into this group, please call the number on the back of your ID card, or visit the *claims administrator's* website at www.anthem.com.

If you or your *physician* believes you need to use a different *prescription drug*, please have your *physician* or pharmacist get in touch with us. We will cover the other *prescription drug* only if we agree that it is *medically necessary* and appropriate over the clinically equivalent *drug*. We will review benefits for the *prescription drug* from time to time to make sure the *drug* is still *medically necessary*.

- **Compound Drugs.** *Compound drugs* unless all of the ingredients are FDA-approved in the form in which they are used in the *compound drug* and as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, require a prescription to dispense, and the *compound drug* is not essentially the same as an FDA-approved product from a *drug*

manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.

- **Drugs Contrary to Approved Medical and Professional Standards.** *Drugs* given to you or prescribed in a way that is against approved medical and professional standards of practice.
- **Drugs Over Quantity or Age Limits.** *Drugs* which are over any quantity or age limits set by the *plan* or us.
- **Drugs Over the Quantity Prescribed or Refills After One Year.** *Drugs* in amounts over the quantity prescribed or for any refill given more than one year after the date of the original *prescription*.
- **Drugs Prescribed by Providers Lacking Qualifications, Registrations and/or Certifications.** *Prescription drugs* prescribed by a provider that does not have the necessary qualifications, registrations and/or certifications as determined by us.
- **Drugs That Do Not Need a Prescription.** *Drugs* that do not need a *prescription* by federal law (including *drugs* that need a *prescription* by state law, but not by federal law), except for injectable insulin. This exclusion does not apply to over-the-counter *drugs* that we must cover under state law, or federal law when recommended by the U.S. Preventive Services Task Force, and prescribed by a *physician*.
- **Lost or Stolen Drugs.** Refills of lost or stolen *drugs*.
- **Non-Approved Drugs.** *Drugs* not approved by the FDA.

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

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

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specifically stated in the “Injectable Drugs and Implants for Birth Control” provision in MEDICAL CARE THAT IS COVERED.

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse except as specifically stated in the “Private Duty Nursing” provision in MEDICAL CARE THAT IS COVERED.

Autopsies. Autopsies and post-mortem testing.

Lifestyle Programs. Programs to alter one’s lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by the *claims administrator*.

Clinical Trials. Any investigational *drugs* or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a covered service under this *plan* for non-Investigative treatments, except as specifically stated in the “Clinical Trials” provision under the section MEDICAL CARE THAT IS COVERED.

COORDINATION OF BENEFITS

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

DEFINITIONS

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

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

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 trustee plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.
4. Medicare. This does not include Medicare when, by law, its benefits are secondary to those of any private insurance program or other non-governmental program.

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

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

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

EFFECT ON BENEFITS

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

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

ORDER OF BENEFITS DETERMINATION

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

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

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

Medicare will pay second, and the plan which covers you as a retired employee would pay last.

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

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

- a. If the parent with custody of that *child* for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that *child* as a dependent pays first.
 - b. If the parent with custody of that *child* for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:
 - i. The plan which covers that *child* as a dependent of the parent with custody.
 - ii. The plan which covers that *child* as a dependent of the stepparent (married to the parent with custody).
 - iii. The plan which covers that *child* as a dependent of the parent without custody.
 - iv. The plan which covers that *child* as a dependent of the stepparent (married to the parent without custody).
 - c. Regardless of a and b above, if there is a court decree which establishes a parent's financial responsibility for that *child's* health care coverage, a plan which covers that *child* as a dependent of that parent pays first.
4. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But if either plan does not have a provision regarding laid-off or retired employees, provision 6 applies.
 5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the

Other Plan do not agree under these circumstances with the Order of Benefit Determination provisions of This Plan, this rule will not apply.

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

OUR RIGHTS UNDER THIS PROVISION

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

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

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

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

BENEFITS FOR MEDICARE ELIGIBLE MEMBERS

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

If you are entitled to Medicare and covered under this *plan* as an active employee, or as a dependent of an active employee, this *plan* will generally pay first and Medicare will pay second, unless:

1. You are receiving treatment for end-stage renal disease following the first 30 months you are entitled to end-stage renal disease benefits under Medicare; or

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

In cases where either of the above exceptions 1 or 2 apply, payment will be determined according to the provisions in the section entitled COORDINATION OF BENEFITS and the provision “Coordinating Benefits With Medicare”, below.

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

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

UTILIZATION REVIEW PROGRAM

Your *plan* includes the process of utilization review to decide when services are *medically necessary* or *experimental / investigative* as those terms are defined in this booklet. Utilization review aids the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed.

REVIEWING WHERE SERVICES ARE PROVIDED

A service must be *medically necessary* to be a covered service. When level of care, setting or place of service is reviewed, services that can be safely given to you in a lower level of care or lower cost setting / place of care, will not be *medically necessary* if they are given in a higher level of care, or higher cost setting / place of care. This means that a request for a service may be denied because it is not *medically necessary* for the service to be provided where it is being requested. When this happens

the service can be requested again in another place and will be reviewed again for medical necessity. At times a different provider or facility may need to be used in order for the service to be considered *medically necessary*. Examples include, but are not limited to:

- A service may be denied on an inpatient basis at a *hospital* but may be approvable if provided on an outpatient basis at a *hospital*.
- A service may be denied on an outpatient basis at a *hospital* but may be approvable at a free standing imaging center, infusion center, ambulatory surgery center, or in a *physician's* office.
- A service may be denied at a *skilled nursing facility* but may be approvable in a home setting.

Utilization review criteria will be based on many sources including medical policy and clinical guidelines. The *claims administrator* may decide that a treatment that was asked for is not *medically necessary* if a clinically equivalent treatment that is more cost-effective is available and appropriate. "Clinically equivalent" means treatments that for most *members*, will give you similar results for a disease or condition.

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

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

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

TYPES OF REVIEWS

- **Pre-service Review** – A review of a service, treatment or admission for a benefit coverage determination which is done before the service or treatment begins or admission date.
 - **Precertification** – A required pre-service review for a benefit coverage determination for a service or treatment. Certain services require precertification in order for you to get benefits. The benefit coverage review will include a review to decide

whether the service meets the definition of medical necessity or is *experimental / investigative* as those terms are defined in this booklet.

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

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

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

- **Continued Stay / Concurrent Review** – A utilization review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment.
 - Both pre-service and continued stay / concurrent reviews may be considered urgent when, in the view of the treating provider or any *physician* with knowledge of your medical condition, without such care or treatment, your life or health or your ability to regain maximum function could be seriously threatened or you could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.
- **Post-service Review** – A review of a service, treatment or admission for a benefit coverage that is conducted after the service has been provided. Post-service reviews are performed when a service, treatment or admission did not need a precertification, or when a needed precertification was not obtained. Post-service reviews are done for a service, treatment or admission in which the *plan* has a related clinical coverage guideline and are typically initiated by the *claims administrator*.

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

- Scheduled, non-emergency inpatient *hospital stays* and *residential treatment center* admissions.

Exceptions: Pre-service review is not required for inpatient *hospital stays* for the following services:

- ◆ Maternity care of 48 hours or less following a normal delivery or 96 hours or less following a cesarean section, and
- ◆ Mastectomy and lymph node dissection.
- Specific non-emergency outpatient services, including diagnostic treatment and other services.
- Surgical procedures, wherever performed.
- Transplant services, including transplant travel expense. The following criteria must be met for certain transplants, as follows:
 - ◆ For bone, skin or cornea transplants, the *physicians* on the surgical team and the facility in which the transplant is to take place must be approved for the transplant requested.
 - ◆ For transplantation of heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney or bone marrow/stem cell and similar procedures, the providers of the related preoperative and postoperative services must be approved.
- Air ambulance in a non-medical *emergency*.
- Visits for physical therapy and physical medicine after the first 24 visits in a *year*.
- Speech therapy services.
- Acupuncture treatment.
- Specific durable medical equipment.
- Infusion therapy or home infusion therapy, if the attending physician has submitted both a prescription and a plan of treatment before services are rendered.
- Home health care. The following criteria must be met:
 - ◆ The services can be safely provided in your home, as certified by your attending *physician*;
 - ◆ Your attending *physician* manages and directs your medical care at home; and
 - ◆ Your attending *physician* has established a definitive treatment plan which must be consistent with your medical needs and lists

the services to be provided by the *home health agency*.

- Hospice care.
- Admissions to a *skilled nursing facility*, if you require daily skilled nursing or rehabilitation, as certified by your attending *physician*.
- Bariatric surgical services, such as gastric bypass and other surgical procedures for weight loss, including bariatric travel expense, if:
 - a. The services are to be performed for the treatment of morbid obesity; and
 - b. The *physicians* on the surgical team and the facility in which the surgical procedure is to take place are approved for the surgical procedure requested.
- Advanced imaging procedures, including but not limited to: Magnetic Resonance Imaging (MRI), Computerized Tomography (CT scan), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography and Nuclear Cardiac Imaging. You may call the toll-free Member Services telephone number on your ID card to find out if an imaging procedure requires pre-service review.
- Vision Therapy.
- All interventional spine pain, elective hip, knee, and shoulder arthroscopic/open sports medicine, and outpatient spine surgery procedures must be authorized in advance.
- *Prescription drugs* that require prior authorization as described under the "Prescription Drugs Obtained from or Administered by a Medical Provider" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.
- Transgender services, including transgender travel expense, as specified under the "Transgender Services" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED. You must be diagnosed with gender identity disorder or gender dysphoria by a *physician*.
- Sleep Studies.

The appropriate utilization reviews must be performed in accordance with this *plan*. When pre-service review is not performed as required for an inpatient *hospital, residential treatment center, skilled nursing facility* or transplant facility admission, for home health care services, home infusion therapy services or hospice care, the benefits to which you would have been otherwise entitled **will be reduced by 20%**.

For a list of current procedures requiring precertification, please call the toll-free number for Member Services printed on your ID card.

WHO IS RESPONSIBLE FOR PRECERTIFICATION?

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

Provider Network Status	Responsibility to Get Precertification	Comments
<i>Participating Providers</i>	Provider	<ul style="list-style-type: none"> The provider must get precertification when required.
<i>Non-Participating Providers</i>	<i>Member</i>	<ul style="list-style-type: none"> <i>Member</i> must get precertification when required. (Call Member Services.) <i>Member</i> may be financially responsible for charges or costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be <i>medically necessary</i>.
Blue Card Provider	<i>Member (Except Inpatient Admissions) for</i>	<ul style="list-style-type: none"> <i>Member</i> must get precertification when required. (Call Member Services.)

Provider Network Status	Responsibility to Get Precertification	Comments
		<ul style="list-style-type: none"> • <i>Member</i> may be financially responsible for charges or costs related to the service and/or setting in whole or in part if the service and or setting is found to not be <i>medically necessary</i>. • Blue Card Providers must obtain precertification for all Inpatient Admissions.
<p>NOTE: For an <i>emergency</i> admission, precertification is not required. However, you, your authorized representative or <i>physician</i> must notify the <i>claims administrator</i> within 24 hours of the admission or as soon as possible within a reasonable period of time.</p>		

HOW DECISIONS ARE MADE

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

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the precertification phone number on the back of your ID card.

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

DECISION AND NOTICE REQUIREMENTS

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

Request Category	Timeframe Requirement for Decision
Urgent Pre-Service Review	72 hours from the receipt of the request
Non-Urgent Pre-Service Review	15 business days from the receipt of the request
Continued Stay / Concurrent Review when hospitalized at the time of the request and no previous authorization exists	72 hours from the receipt of the request
Urgent Continued Stay / Concurrent Review when request is received at least 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Urgent Continued Stay / Concurrent Review when request is received less than 24 hours before the end of the previous authorization	72 hours from the receipt of the request
Non-Urgent Continued Stay / Concurrent Review	15 business days from the receipt of the request
Post-Service Review	30 calendar days from the receipt of the request

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

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

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

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

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

HEALTH PLAN INDIVIDUAL CASE MANAGEMENT

The health plan individual case management program enables you to obtain medically appropriate care in a more economical, cost-effective and coordinated manner during prolonged periods of intensive medical care. Through a case manager, the *claims administrator* has the right to recommend an alternative plan of treatment which may include services not covered under this *plan*. It is not your right to receive individual case management, nor does the *claims administrator* have an obligation to provide it; the *claims administrator* provides these services at their sole and absolute discretion.

HOW HEALTH PLAN INDIVIDUAL CASE MANAGEMENT WORKS

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

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

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

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

Alternative Treatment Plan. In certain cases of severe or chronic illness or injury, the *plan* may provide benefits for alternate care that is not listed as a covered service. The *claims administrator* may also extend services beyond the benefit maximums of this *plan*. A decision will be made on a case-by-case basis by the *claims administrator* if it determines in its sole discretion that the alternate or extended benefit is in the best interest for you and the *plan* and you or your authorized representative agree to the alternate or extended benefit in writing. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to you or to any other member. The *claims administrator* reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, the *claims administrator* will notify you or your authorized representative in writing.

EXCEPTIONS TO THE UTILIZATION REVIEW PROGRAM

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

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

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

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

HOW COVERAGE BEGINS AND ENDS

HOW COVERAGE BEGINS

ELIGIBLE STATUS

1. **Subscribers.** The *subscribers* eligible to participate in the *plan* described in this *benefit booklet* are determined by the *plan administrator* based on conditions pertaining to *subscriber's* employment with them. The documents describing how these determinations are made are maintained by the *plan administrator*.
2. **Dependents.** The following are eligible to enroll as *dependents*: (a) Either the *subscriber's spouse or domestic partner*; and (b) *A child*.

Definition of Dependent

1. **Spouse** is the *subscriber's* spouse as recognized under state or federal law. This includes same sex spouses when legally married in a state that recognizes same sex marriages. Spouse does not include any person who is: (a) covered as a *subscriber*, or (b) in active service in the armed forces.
2. **Domestic partner** is the *subscriber's* domestic partner under a legally registered and valid domestic partnership. Domestic partner does not include any person who is: (a) covered as a *subscriber*, or (b) in active service in the armed forces.
3. **Child** is the *subscriber's, spouse's or domestic partner's* natural child, stepchild, or legally adopted child, subject to the following:
 - a. The child is under 26 years of age.
 - b. The unmarried child is 26 years of age, or older and: (i) is chiefly dependent on the *subscriber, spouse or domestic partner* for support and maintenance, and (ii) is incapable of self-sustaining employment due to a physical or mental condition. A *physician* must certify in writing that the child is incapable of self-sustaining employment due to a physical or mental condition. We must receive the certification, at no expense to us, within 60-days of the date the *subscriber* receives our request. We may request proof of continuing dependency and that a physical or mental condition still exists, but not more often than once each year after the initial certification. This exception will last until the child is no longer chiefly dependent on the *subscriber, spouse or domestic partner* for support and maintenance due to a continuing physical or mental condition. A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

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

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

- d. The term "child" does not include any child for whom the *subscriber, spouse or domestic partner* is the legal guardian, but who is not the *subscriber's, spouse's or domestic partner's* natural child, stepchild or adopted child.

ELIGIBILITY DATE

1. For *subscribers*, you become eligible for coverage in accordance with rules established by your employer. For specific information about your employer's eligibility rules for coverage, please contact your Human Resources or Benefits Department.
2. For *dependents*, you become eligible for coverage on the later of:
(a) the date the *subscriber* becomes eligible for coverage; or, (b) the date you meet the *dependent* definition.

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

ENROLLMENT

To enroll as a *subscriber*, or to enroll *dependents*, the *subscriber* must properly file an application. An application is considered properly filed, only if it is personally signed, dated, and given to the *plan administrator* within 31 days from your eligibility date. If any of these steps are not followed, your coverage may be denied.

EFFECTIVE DATE

Your effective date of coverage is subject to the timely payment of required monthly contributions. The date you become covered is determined as follows:

1. **Timely Enrollment:** If you enroll for coverage before, on, or within 31 days after your eligibility date, then your coverage will begin as follows: (a) for *subscribers*, on your eligibility date; and (b) for *dependents*, on the later of (i) the date the *subscriber's* coverage begins, or (ii) the first day of the month after the *dependent* becomes eligible. If you become eligible before the *plan* takes effect, coverage begins on the effective date of the *plan*, provided the enrollment application is on time and in order.
2. **Late Enrollment:** If you enroll more than 31 days after your eligibility date, you must wait until the next Open Enrollment Period to enroll.
3. **Disenrollment:** If you voluntarily choose to disenroll from coverage under this *plan*, you will be eligible to reapply for coverage as set forth in the "Enrollment" provision above, during the next Open Enrollment period (see OPEN ENROLLMENT PERIOD).

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

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

In both cases, the *subscriber* must enroll the *child* under this *plan* within 31 days from the date of birth or date of adoption or placement for adoption for coverage to be effective as of the date of birth, adoption, or placement for adoption.

Special Enrollment Periods

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

1. You have met all of the following requirements:
 - a. You were covered as an individual or dependent under either:
 - i. Another employer group health plan or health insurance coverage, including coverage under a COBRA or CalCOBRA continuation; or
 - ii. A state Medicaid plan or under a state child health insurance program (SCHIP), including the Healthy Families Program or the Access for Infants and Mothers (AIM) Program.
 - b. You certified in writing at the time you became eligible for coverage under this *plan* that you were declining coverage under this *plan* or disenrolling because you were covered under another health plan as stated above and you were given written notice that if you choose to enroll later, you may be required to wait until the *plan administrator's* next open enrollment period to do so.
 - c. Your coverage under the other health plan wherein you were covered as an individual or dependent ended as follows:
 - i. If the other health plan was another employer group health plan or health insurance coverage, including coverage under a COBRA or CalCOBRA continuation, coverage ended because you lost eligibility under the other plan, your coverage under a COBRA or CalCOBRA continuation was exhausted, or employer contributions toward coverage under the other plan terminated. You must properly file an application with the *plan administrator* within 31 days after the date your coverage ends or the date employer contributions toward coverage under the other plan terminate.

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

- ii. If the other health plan was a state Medicaid plan or a state child health insurance program (SCHIP), including the Healthy Families Program or the Access for Infants and Mothers (AIM) Program, coverage ended because you lost eligibility under the program. You must properly file an application with the *plan administrator* within 60 days after the date your coverage ended.
2. A court has ordered coverage be provided for a *spouse*, *domestic partner* or dependent *child* under your employee health plan and an application is filed within 31 days from the date the court order is issued.
3. The *claims administrator* does not have a written statement from the *plan administrator* stating that prior to declining coverage or disenrolling, you received and signed acknowledgment of a written notice specifying that if you do not enroll for coverage within 31 days after your eligibility date, or if you disenroll, and later file an enrollment application, your coverage may not begin until the first day of the month following the end of the *plan administrator's* next open enrollment period.
4. You have a change in family status through either marriage or domestic partnership, or the birth, adoption, or placement for adoption of a *child*:
 - a. If you are enrolling following marriage or domestic partnership, you and your new *spouse* or *domestic partner* must enroll within 31 days of the date of marriage or domestic partnership. Your new *spouse* or *domestic partner's* children may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above.
 - b. If you are enrolling following the birth, adoption, or placement for adoption of a *child*, your *spouse* (if you are already married) or *domestic partner*, who is eligible but not enrolled, may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above. Application must be made within 31 days of the birth or date of adoption or placement for adoption.
5. You meet or exceed a lifetime limit on all benefits under another health plan. Application must be made within 31 days of the date a claim or a portion of a claim is denied due to your meeting or exceeding the lifetime limit on all benefits under the other plan.
6. You become eligible for assistance, with respect to the cost of coverage under the employer's group *plan*, under a state Medicaid or SCHIP health plan, including any waiver or demonstration project

conducted under or in relation to these plans. You must properly file an application with the *plan administrator* within 60 days after the date you are determined to be eligible for this assistance.

7. You are an employee who is a reservist as defined by state or federal law, who terminated coverage as a result of being ordered to military service as defined under state or federal law, and apply for reinstatement of coverage following reemployment with your employer. Your coverage will be reinstated without any waiting period. The coverage of any dependents whose coverage was also terminated will also be reinstated. For dependents, this applies only to dependents who were covered under the plan and whose coverage terminated when the employee's coverage terminated. Other dependents who were not covered may not enroll at this time unless they qualify under another of the circumstances listed above.

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

1. If a court has ordered that coverage be provided for a dependent *child*, coverage will become effective for that *child* on the earlier of (a) the first day of the month following the date you file the enrollment application or (b) within 30 days after a copy of the court order is received or of a request from the district attorney, either parent or the person having custody of the *child*, or the employer.
2. For enrollments following the birth, adoption, or placement for adoption of a *child*, coverage will be effective as of the date of birth, adoption, or placement for adoption.
3. For reservists and their dependents applying for reinstatement of coverage following reemployment with the employer, coverage will be effective as of the date of reemployment.

OPEN ENROLLMENT PERIOD

There is an open enrollment period once each *year*. During that time, an individual who meets the eligibility requirements as a *subscriber* under this *plan* may enroll. A *subscriber* may also enroll any eligible *dependents* at that time. Persons eligible to enroll as *dependents* may enroll only under the *subscriber's plan*.

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

HOW COVERAGE ENDS

Your coverage ends without notice as provided below:

1. If the *plan* terminates, your coverage ends at the same time. This *plan* may be canceled or changed without notice to you.
2. If the *plan* no longer provides coverage for the class of *members* to which you belong, your coverage ends on the effective date of that change. If this *plan* is amended to delete coverage for *dependents*, a *dependent's* coverage ends on the effective date of that change.
3. Coverage for *dependents* ends when *subscriber's* coverage ends.
4. Coverage ends at the end of the period for which the required monthly contribution has been paid on your behalf when the required monthly contribution for the next period is not paid.
5. If you voluntarily cancel coverage at any time, coverage ends on the due date for the required monthly contribution coinciding with or following the date of voluntary cancellation which you provide to us.
6. If you no longer meet the requirements set forth in the "Eligible Status" provision of HOW COVERAGE BEGINS, your coverage ends as of the due date for the required monthly contribution coinciding with or following the date you cease to meet such requirements.

Exceptions to item 6:

- a. **Leave of Absence.** If you are a *subscriber* and the required monthly contributions are paid, your coverage may continue during an approved temporary leave of absence. This time period may be extended if required by law.
- b. **Handicapped Children:** If a *child* reaches the age limits shown in the "Eligible Status" provision of this section, the *child* will continue to qualify as a *dependent* if he or she is (i) covered under this *plan*, (ii) still chiefly dependent on the *subscriber*, *spouse* or *domestic partner* for support and maintenance, and (iii) incapable of self-sustaining employment due to a physical or mental condition. A *physician* must certify in writing that the *child* has a physical or mental condition that makes the *child* incapable of obtaining self-sustaining employment. We will notify the *subscriber* that the *child's* coverage will end when the *child* reaches the *plan's* upper age limit at least 90-days prior to the date the *child* reaches that age. The *subscriber* must send proof of the *child's* physical or mental condition within 60-days of the date the *subscriber* receives our request. If we do not complete our determination of the *child's* continuing eligibility by the date the *child* reaches the *plan's* upper age limit, the *child* will remain

covered pending our determination. When a period of two years has passed, we may request proof of continuing dependency due to a continuing physical or mental condition, but not more often than once each year. This exception will last until the *child* is no longer chiefly dependent on the *subscriber*, *spouse* or *domestic partner* for support and maintenance or a physical or mental condition no longer exists. A *child* is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

Note: If a marriage or domestic partnership terminates, the *subscriber* must give or send to the *plan administrator* written notice of the termination. Coverage for a former *spouse* or *domestic partners*, and their dependent *children*, if any, ends according to the “Eligible Status” provisions. Failure to provide written notice to the *plan administrator* will not delay or prevent termination of the marriage or domestic partnership. If the *subscriber* notifies the *plan administrator* in writing to cancel coverage for a former *spouse* or *domestic partner* and the *children* of the *spouse* or *domestic partner*, if any, immediately upon termination of the *subscriber's* marriage or domestic partnership, such notice will be considered compliance with the requirements of this provision.

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

CONTINUATION OF COVERAGE

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

DEFINITIONS

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

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

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

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

1. For Subscribers and Dependents:

- a. The *subscriber's* termination of employment, for any reason other than gross misconduct; or
- b. Loss of coverage under an employer's health plan due to a reduction in the *subscriber's* work hours.

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

- a. The *plan* expressly includes coverage for retirees; and
- b. Such cancellation or reduction of benefits occurs within one year before or after the *plan's* filing for bankruptcy.

3. For Dependents:

- a. The death of the *subscriber*;
- b. The *spouse's* divorce or legal separation from the *subscriber*;
- c. The end of a *child's* status as a dependent *child*, as defined by the *plan*; or
- d. The *subscriber's* entitlement to Medicare.

ELIGIBILITY FOR COBRA CONTINUATION

A *subscriber* or *dependent*, **other than a *domestic partner*, and a *child of a domestic partner***, may choose to continue coverage under the *plan* if his or her coverage would otherwise end due to a Qualifying Event.

TERMS OF COBRA CONTINUATION

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

1. For Qualifying Events 1, or 2, the *plan administrator* will notify the *subscriber* of the right to continue coverage.
2. For Qualifying Events 3(a) or 3(d) above, a *dependent* will be notified of the COBRA continuation right.
3. You must inform the *plan administrator* within 60 days of Qualifying Events 3(b) or 3(c) above if you wish to continue coverage. The *plan administrator* in turn will promptly give you official notice of the COBRA continuation right.

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

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

Notice of continued coverage, along with the initial required monthly contribution, must be delivered to us within 45 days after you elect COBRA continuation coverage.

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

Cost of Coverage. You may be required to pay the entire cost of your COBRA continuation coverage. This cost, called the "required monthly contribution", must be remitted to the *plan administrator* each month during the COBRA continuation period.

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

1. A *spouse* whose COBRA continuation began due to divorce, separation or death of the *subscriber*;
2. A *child* if neither the *subscriber* nor the *spouse* has enrolled for this COBRA continuation coverage (if more than one *child* is so enrolled, the required monthly contribution will be the two-party or three-party rate depending on the number of *children* enrolled); and
3. A *child* whose COBRA continuation began due to the person no longer meeting the dependent *child* definition.

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

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

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

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

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

1. The end of 18 months from the Qualifying Event, if the Qualifying Event was termination of employment or reduction in work hours;*

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

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

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

Other Coverage Options Besides COBRA Continuation Coverage.

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a *spouse's* plan) through the conditions listed under the SPECIAL ENROLLMENT PERIODS provision. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

EXTENSION OF CONTINUATION DURING TOTAL DISABILITY

If at the time of termination of employment or reduction in hours, or at any time during the first 60 days of the COBRA continuation, a Qualified Beneficiary is determined to be disabled for Social Security purposes, all

covered *members* may be entitled to up to 29 months of continuation coverage after the original Qualifying Event.

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

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

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

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

Cost of Coverage. For the 19th through 29th months that the total disability continues, the cost for the extended continuation coverage must be remitted to us. This cost (called the "required monthly contribution") shall be subject to the following conditions:

1. If the disabled *member* continues coverage during this extension, this charge shall be **150%** of the applicable rate for the length of time the disabled *member* remains covered, depending upon the number of covered dependents. If the disabled *member* does not continue coverage during this extension, this charge shall remain at **102%** of the applicable rate.
2. The cost for extended continuation coverage must be remitted to us each month during the period of extended continuation coverage. We must receive timely payment of the required monthly contribution in order to maintain the extended continuation coverage in force.
3. You may be required to pay the entire cost of the extended continuation coverage.

If a second Qualifying Event occurs during this extended continuation, the total COBRA continuation may continue for up to 36 months from the date of the first Qualifying Event. The required monthly contribution shall then be **150%** of the applicable rate for the 19th through 36th months if

the disabled *member* remains covered. The charge will be **102%** of the applicable rate for any periods of time the disabled *member* is not covered following the 18th month.

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

1. The end of the month following a period of 30 days after the Social Security Administration's final determination that you are no longer totally disabled;
2. The end of 29 months from the Qualifying Event;
3. The date the *plan* terminates;
4. The end of the period for which required monthly contributions are last paid;
5. The date, following the election of COBRA, the *member* first becomes covered under any other group health plan; or
6. The date, following the election of COBRA, the *member* first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

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

EXTENSION OF BENEFITS

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

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

by your *physician* of the total disability. We must receive this certification within 90 days of the date coverage ends under this *plan*. At least once every 90 days while benefits are extended, we must receive proof that your total disability is continuing.

3. Your extension of benefits will end when any one of the following circumstances occurs:
 - a. You are no longer totally disabled.
 - b. The maximum benefits available to you under this *plan* are paid.
 - c. You become covered under another group health plan that provides benefits without limitation for your disabling condition.
 - d. A period of up to 12 months has passed since your extension began.

GENERAL PROVISIONS

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

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

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

Inter-Plan Arrangements

Out-of-Area Services

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

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

Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are *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, the *claims administrator* will still fulfill the plan’s contractual obligations. But, the Host Blue is responsible for: (a) contracting with its providers; and (b) handling its interactions with those providers.

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

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

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

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

B. Negotiated (non–BlueCard Program) Arrangements

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

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

C. Special Cases: Value-Based Programs

BlueCard[®] Program

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

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

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

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

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

E. Non-participating Providers Outside Our Service Area

1. Allowed Amounts and Member Liability Calculation

When covered services are provided outside of Anthem Blue Cross's Service Area by non-participating providers, the *claims administrator* may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services as deductible or co-insurance will be based on that allowed amount. Also, you may be responsible for the difference between the amount that the non-

participating provider bills and the payment the *claims administrator* will make for the covered services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network *emergency* services.

2. **Exceptions**

In certain situations, the *claims administrator* may use other pricing methods, such as billed charges or the pricing we would use if the healthcare services had been obtained within the Anthem Blue Cross Service Area, or a special negotiated price to determine the amount 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.

F. BlueCard Worldwide[®] Program

If you plan to travel outside the United States, call Member Services for information about your BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States.

When you are traveling abroad and need medical care, you can call the BlueCard Worldwide Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is **(800) 810-BLUE (2583)**. Or you can call them collect at **(804) 673-1177**.

If you need inpatient hospital care, you or someone on your behalf, should contact the *claims administrator* for preauthorization. Keep in mind, if you need *emergency* medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the "Utilization Review Program" section in this booklet for further information. You can learn how to get pre-authorization when you need to be admitted to the hospital for *emergency* or non-emergency care.

How Claims are Paid with BlueCard Worldwide

In most cases, when you arrange inpatient hospital care with BlueCard Worldwide, claims will be filed for you. The only amounts that you may need to pay up front are any co-insurance or deductible amounts that may apply.

You will typically need to pay for the following services up front:

- *Physician* services;

- Inpatient hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

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

When you need BlueCard Worldwide claim forms you can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bcbs.com/bluecardworldwide.

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

Terms of Coverage

1. In order for you to be entitled to benefits under the *plan*, both the *plan* and your coverage under the *plan* must be in effect on the date the expense giving rise to a claim for benefits is incurred.
2. The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date you receive the service or supply for which the charge is made.
3. The *plan* is subject to amendment, modification or termination according to the provisions of the *plan* without your consent or concurrence.

Nondiscrimination. No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age.

Protection of Coverage. We do not have the right to cancel your coverage under this *plan* while: (1) this *plan* is in effect; (2) you are eligible; and (3) your required monthly contributions are paid according to the terms of the *plan*.

Free Choice of Provider. This *plan* in no way interferes with your right as a *member* entitled to *hospital* benefits to select a *hospital*. You may choose any *physician* who holds a valid *physician* and surgeon's certificate and who is a member of, or acceptable to, the attending staff and board of directors of the *hospital* where services are received. You may also choose any other health care professional or facility which provides care covered under this *plan*, and is properly licensed according to appropriate state and local laws. But your choice may affect the benefits payable according to this *plan*.

Medical Necessity. The benefits of this *plan* are provided only for services which are *medically necessary*. The services must be ordered by the attending *physician* for the direct care and treatment of a covered condition. They must be standard medical practice where received for the condition being treated and must be legal in the United States.

Expense in Excess of Benefits. We are not liable for any expense you incur in excess of the benefits of this *plan*.

Benefits Not Transferable. Only the *member* is entitled to receive benefits under this *plan*. The right to benefits cannot be transferred.

Notice of Claim. You must send the *claims administrator* properly and fully completed claim forms within 90 days of the date you receive the service or supply for which a claim is made. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 21 months will be allowed. The *plan administrator* is not liable for the benefits of the *plan* if you do not file claims within the required time period, unless an extension is required by federal law. The *plan administrator* will not be liable for benefits if the *claims administrator* does not receive written proof of loss on time.

Services received and charges for the services must be itemized, and clearly and accurately described. Claim forms must be used; canceled checks or receipts are not acceptable.

To obtain a claim form you or someone on your behalf may call the Member Services phone number shown on your ID Card or go to the website at www.anthem.com/ca and download and print one.

Member's Cooperation. You will be expected to complete and submit to the *claims administrator* all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If you fail to cooperate (including if you fail to enroll under Part B of the Medicare program where Medicare is the responsible payer), you will be responsible for any charge for services.

Payment of Benefits. *Physicians* and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. *Hospitals* or other health care Facilities may be paid either a fixed fee or on a discounted fee-for-service basis. The benefits of this booklet will be paid directly to *participating providers* (e.g., and medical transportation providers). *Hospitals, physicians and other health care providers* or the person or persons having paid for your *hospital* or medical services will be paid directly when you assign benefits in writing no later than the time of submitting a claim. These payments fulfill the *plan's* obligation to you for those services.

Non-participating providers and other health care providers will be paid directly when *emergency medical condition* services and care are provided to you or one of your *dependents*. The *plan* will continue such direct payment until the *emergency* care results in stabilization.

If you or one of your *dependents* receives covered services other than *emergency* care from a *non-participating provider*, payment may be made directly to the *member* and you will be responsible for payment to that provider. An assignment of benefits to a *non-participating provider*, even if assignment includes the provider's right to receive payment, is generally void. However, there are certain situations in which an assignment of benefits is permitted. For example, if you receive services from a *participating provider* facility at which, or as a result of which, you receive *non-emergency services* from a *non-participating provider* such as a radiologist, anesthesiologist or pathologist, an assignment of benefits to such *non-participating provider* will be permitted. Please see "Member Cost Share" in the "Maximum Allowed Amount" section for more information. Any payments for the assigned benefits fulfill our obligation to you for those services.

Assignment. You authorize the *claims administrator*, in its own discretion and on behalf of the employer, to make payments directly to providers for covered services. In no event, however, shall the *plan's* right to make payments directly to a provider be deemed to suggest that any provider is a beneficiary with independent claims and appeal rights under the *plan*. The *claims administrator* also reserves the right, in its own discretion, to make payments directly to you as opposed to any provider for covered service. In the event that payment is made directly to you, you have the responsibility to apply this payment to the claim from the *non-participating provider*. Payments and notice regarding the receipt and/or adjudication of claims may also be sent to an alternate recipient (which is defined herein as any child of a *subscriber* who is recognized under a "Qualified Medical Child Support Order" as having a right to enrollment under the employer's *plan*), or that person's custodial parent or designated representative. Any payments made by the claims administrator (whether to any provider for covered service or you) will discharge the employer's obligation to pay for covered services. You cannot assign your right to receive payment to anyone, except as required by a "Qualified Medical Child Support Order" as defined by, and if subject to, ERISA or any applicable Federal law.

Once a provider performs a covered service, the *claims administrator* will not honor a request to withhold payment of the claims submitted.

The coverage, rights, and benefits under the *plan* are not assignable by any *member* without the written consent of the *plan*, except as provided above. This prohibition against assignment includes rights to receive

payment, claim benefits under the *plan* and/or law, sue or otherwise begin legal action, or request *plan* documents or any other information that a participant or beneficiary may request under ERISA. Any assignment made without written consent from the *plan* will be void and unenforceable.

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

Right of Recovery. Whenever payment has been made in error, the *claims administrator* will have the right to make appropriate adjustment to claims, recover such payment from you or, if applicable, the provider, in accordance with applicable laws and regulations. In the event the *claims administrator* recovers a payment made in error from the provider, except in cases of fraud or misrepresentation on the part of the provider, the *claims administrator* will only recover such payment from the provider within 365 days of the date the payment was made on a claim submitted by the provider. The *claims administrator* reserves the right to deduct or offset any amounts paid in error from any pending or future claim.

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

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

The *claims administrator* has established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses, and whether to settle or compromise recovery amounts. The *claims administrator* will not pursue recoveries for overpayments if the cost of

collection exceeds the overpayment amount. The *claims administrator* may not provide you with notice of overpayments made by them or you if the recovery method makes providing such notice administratively burdensome.

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.

Plan Administrator - COBRA and ERISA. In no event will the *claims administrator* be plan administrator for the purposes of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) or the Employee Retirement Income Security Act (ERISA). The term "plan administrator" refers to Leidos or to a person or entity other than the *claims administrator*, engaged by Leidos to perform or assist in performing administrative tasks in connection with the plan. The *plan administrator* is responsible for satisfaction of notice, disclosure and other obligations of administrators under ERISA. In providing notices and otherwise performing under the CONTINUATION OF COVERAGE section of this *benefit* booklet, the *plan administrator* is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as your agent.

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

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

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

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

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

party, including all persons covered under the *plan*.

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

Continuity of Care after Termination of Provider: Subject to the terms and conditions set forth below, benefits will be provided at the *participating provider* level for covered services (subject to applicable copayments, coinsurance, deductibles and other terms) received from a provider at the time the provider's contract is terminated by a Blue Cross or Blue Shield plan (unless the provider's contract is terminated for reasons of medical disciplinary cause or reason, fraud, or other criminal activity). This does not apply to a provider who voluntarily terminates his or her contract.

You must be under the care of the *participating provider* at the time the provider's contract terminates. The terminated provider must agree in writing to provide services to you in accordance with the terms and conditions of his or her agreement with the Blue Cross or Blue Shield plan prior to termination. The provider must also agree in writing to accept the terms and reimbursement rates under his or her agreement with the Blue Cross or Blue Shield plan prior to termination. If the provider does not agree with these contractual terms and conditions, the provider's services will not be continued beyond the contract termination date.

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

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion

of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the *claims administrator* in consultation with you and the terminated provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.

3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.
4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.
5. The care of a newborn *child* between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.
6. Performance of a surgery or other procedure that the *claims administrator* has authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the date the provider's contract terminates.

Please contact Member Services at the telephone number listed on your ID card to request continuity of care or to obtain a copy of the written policy. Eligibility is based on your clinical condition and is not determined by diagnostic classifications. Continuity of care does not provide coverage for services not otherwise covered under the *plan*.

You will be notified by telephone, and the provider by telephone and fax, as to whether or not your request for continuity of care is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the *plan*. Financial arrangements with terminated providers are negotiated on a case-by-case basis. The terminated provider will be asked to agree to accept reimbursement and contractual requirements that apply to *participating providers*, including payment terms. If the terminated provider does not agree to accept the same reimbursement and contractual requirements, that provider's services will not be continued. If you disagree with the determination regarding continuity of care, you may file a complaint as described in the COMPLAINT NOTICE.

Value-Added Programs. The *claims administrator* may offer health or fitness related programs to its *members*, through which they may access discounted rates from certain vendors for products and services

available to the general public. Products and services available under this program are not covered services under the *plan* but are in addition to *plan* benefits. As such, program features are not guaranteed under this health *plan* contract and could be discontinued at any time. The *claims administrator* does not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

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

Voluntary Wellness Incentive Programs. The claims administrator may offer health or fitness related program options for purchase by the plan administrator to help you achieve your best health. These programs are not covered services under your plan, but are separate components, which are not guaranteed under this plan and could be discontinued at any time. If the plan administrator has selected one of these options to make available to all employees, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options the plan administrator may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact the Member Services number on your ID card

and the claims administrator will work with you (and, if you wish, your physician) to find a wellness program with the same reward that is right for you in light of your health status. If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.

New Program Incentives. The *plan administrator* may offer incentives from time to time at their discretion in order to introduce you to new programs and services available under this *plan*. The purpose of these incentives include, but is not limited to, making you aware of cost effective benefit options or services, helping you achieve your best health, and encouraging you to update member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards and health-related merchandise. Acceptance of these incentives is voluntary as long as the *plan* offers the incentives program. The *plan administrator* may discontinue an incentive for a particular new service or program at any time. If you have any questions about whether receipt of an incentive or retailer coupon results in taxable income to you, please consult your tax advisor.

Protecting your privacy

Where to find our Notice of Privacy Practices

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

We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy Rule:

For payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan.

For health care operations: We use and share PHI for health care operations.

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

- We keep information about your premium and deductible payments.
- We may give information to a doctor's office to confirm your benefits.
- We may share explanation of benefits (EOB) with the subscriber of your plan for payment purposes.
- We may share PHI with your health care provider so that the provider may treat you.
- We may use PHI to review the quality of care and services you get.
- We may use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.
- We may also use and share PHI directly or indirectly with or through health information exchanges for payment, health care operations and treatment. If you do not want your PHI to be shared for payment, health care operations, or treatment purposes in health information exchanges, please visit <https://www.anthem.com/ca/health-insurance/about-us/privacy> for more information.

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

You may obtain a copy of our Notice of Privacy Practices on our website at <https://www.anthem.com/ca/health-insurance/about-us/privacy> or you may contact Member Services using the contact information on your ID card.

BINDING ARBITRATION

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

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this *plan*, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract,

tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

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

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

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

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

The arbitration is begun by the *member* making written demand on the *plan administrator*. The arbitration will be conducted by Judicial Arbitration and Mediation Services (“JAMS”) according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the *member* and the *plan administrator*, or by order of the court, if the *member* and the *plan administrator* cannot agree.

DEFINITIONS

The meanings of key terms used in this *benefit booklet* are shown below. Whenever any of the key terms shown below appear, it will appear in italicized letters. When any of the terms below are italicized in your *benefit booklet*, you should refer to this section.

Accidental injury is physical harm or disability which is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental injury does not include illness or infection, except infection of a cut or wound.

Ambulatory surgical center is a freestanding outpatient surgical facility. It must be licensed as an outpatient clinic according to state and local

laws and must meet all requirements of an outpatient clinic providing surgical services. It must also meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations or the Accreditation Association of Ambulatory Health Care.

Authorized referral occurs when you, because of your medical needs, require the services of a specialist who is to a *non-participating provider*, or require special services or facilities not available at a contracting hospital, but only when the referral has been authorized by the *plan administrator* before services are rendered and when the following conditions are met:

- there is no *participating provider* who practices in the appropriate specialty, or there is no *contracting hospital* which provides the required services or has the necessary facilities;
- that meets the adequacy and accessibility requirements of state or federal law; and
- you are referred to *hospital* or *physician* that does not have an agreement with Anthem for a covered service by a *participating provider*.

Benefits for *medically necessary* and appropriate *authorized referral* services received from a *non-participating provider* will be payable as shown in the Exceptions under the SUMMARY OF BENEFITS: CO-INSURANCE.

You or your *physician* must call the toll-free telephone number printed on your ID card prior to scheduling an admission to, or receiving the services of, a *non-participating provider*.

Such authorized referrals are not available to bariatric surgical services.

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

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

Blue Distinction Centers for Specialty Care (BDCSC) are health care providers designated by the *claims administrator* as a selected facility for specified medical services. A provider participating in a BDCSC network has an agreement in effect with the *claims administrator* at the time services are rendered or is available through their affiliate companies or their relationship with the Blue Cross and Blue Shield Association. BDCSC agree to accept the *maximum allowed amount* as payment in full for covered services. A *participating provider* is not necessarily a *BDCSC*.

Centers of Medical Excellence (CME) are health care providers designated by the *claims administrator* as a selected facility for specified medical services. A provider participating in a CME network has an agreement in effect with the *claims administrator* at the time services are rendered or is available through their affiliate companies or their relationship with the Blue Cross and Blue Shield Association. CME agree to accept the *maximum allowed amount* as payment in full for covered services. A *participating provider* is not necessarily a CME.

Chat Therapy is a synchronous text-message style communication session between a licensed Psychologist, Clinical Social Worker (L.C.S.W.), Marriage and Family Therapist (L.M.F.T.) or Professional Counselor (L.P.C.) and a patient that provides one-to-one virtual interactive counseling sessions. Each scheduled session lasts approximately one hour and can be accessed via a computer or mobile device using a [secured platform arranged for by the *claims administrator*](#).

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

Chiropractic services means *medically necessary* care by means of adjustment of the spine (to correct a subluxation) performed by a legally licensed chiropractor pursuant to the terms of their license. (Subluxation is a term used in the chiropractic field to describe what happens when one of the vertebrae in your spine moves out of position.)

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

Custodial care is care provided primarily to meet your personal needs. This includes help in walking, bathing or dressing. It also includes: preparing food or special diets; feeding by utensil, tube or gastrostomy; suctioning and administration of medicine which is usually self-administered or any other care which does not require continuing services of medical personnel.

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

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

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

Designated pharmacy provider is a *participating pharmacy* that has executed a Designated Pharmacy Provider Agreement with the *plan* or a *participating provider* that is designated to provide *prescription drugs*, including *specialty drugs*, to treat certain conditions.

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

Effective date is the date your coverage begins under this *plan*.

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

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

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

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

Emergency services are services provided in connection with the initial treatment of a medical or psychiatric *emergency*.

Experimental procedures are those that are mainly limited to laboratory and/or animal research.

Full-time employee meets the *plan's* eligibility requirements for full-time employees as outlined under HOW COVERAGE BEGINS AND ENDS.

Home health agencies are home health care providers which are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in your home, and recognized as home health providers under Medicare and/or accredited by a recognized accrediting agency such as The Joint Commission (TJC).

Home infusion therapy provider is a provider licensed according to state and local laws as a pharmacy, and must be either certified as a home health care provider by Medicare, or accredited as a home pharmacy by The Joint Commission (TJC).

Hospice is an agency or organization primarily engaged in providing palliative care (pain control and symptom relief) to terminally ill persons and supportive care to those persons and their families to help them cope with terminal illness. This care may be provided in the home or on an inpatient basis. A hospice must be: (1) certified by Medicare as a hospice; (2) recognized by Medicare as a hospice demonstration site; or (3) accredited as a hospice by the Joint Commission on Accreditation of Hospitals. A list of hospices meeting these criteria is available upon request.

Hospital is a facility which provides diagnosis, treatment and care of persons who need acute inpatient hospital care under the supervision of *physicians*. It must be licensed as a general acute care hospital according to state and local laws. It must also be registered as a general hospital by the American Hospital Association and meet accreditation standards of The Joint Commission (TJC).

For the limited purpose of inpatient care, the definition of hospital also includes: (1) *psychiatric health facilities* (only for the acute phase of a *mental health condition* or substance abuse), and (2) *residential treatment centers*.

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

Intensive Outpatient Program is a 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.

Investigative procedures or medications are those that have progressed to limited use on humans, but which are not widely accepted as proven and effective within the organized medical community.

Maximum allowed amount is the maximum amount of reimbursement the *claims administrator* will allow for covered medical services and supplies under this *plan*. See YOUR MEDICAL BENEFITS: MAXIMUM ALLOWED AMOUNT.

Medically necessary procedures, supplies, equipment or services are those considered to be:

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease
3. Provided for the diagnosis or direct care and treatment of the medical condition;
4. Within standards of good medical practice within the organized medical community;
5. Not primarily for your convenience, or for the convenience of your *physician* or another provider;
6. Not more costly than an equivalent service, including the same service in an alternative setting, or sequence of services that is medically appropriate and is likely to produce equivalent therapeutic or diagnostic results in regard to the diagnosis or treatment of the patient's illness, injury, or condition; and
7. The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:
 - a. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and
 - b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable.

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

Mental health conditions, including substance abuse, for the purposes of this *plan*, are conditions that are listed in the most current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders. Mental health conditions include *severe mental disorders* as defined in this plan (see definition of “severe mental disorders”).

Non-participating provider is one of the following providers which is NOT participating in a Blue Cross and/or Blue Shield Plan at the time services are rendered:

- *A hospital*
- *A physician*
- *An ambulatory surgical center*
- *A home health agency*
- A facility which provides diagnostic imaging services
- A durable medical equipment outlet
- *A skilled nursing facility*
- A clinical laboratory
- *A home infusion therapy provider*
- *An urgent care center*
- *A retail health clinic*
- *A hospice*
- A licensed ambulance company

They are not *participating providers*. Remember that the *maximum allowed amount* may only represent a portion of the amount which a *non-participating provider* charges for services. See YOUR MEDICAL BENEFITS: MAXIMUM ALLOWED AMOUNT.

Other health care provider is one of the following providers:

- A certified registered nurse anesthetist
- A blood bank

The provider must be licensed according to state and local laws to provide covered medical services.

Partial Hospitalization Program is a structured, multidisciplinary 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.

Participating provider is one of the following providers or other licensed health care professionals who are participating in a Blue Cross and/or Blue Shield Plan at the time services are rendered:

- *A hospital*
- *A physician*
- *An ambulatory surgical center*
- *A home health agency*
- *A facility which provides diagnostic imaging services*
- *A durable medical equipment outlet*
- *A skilled nursing facility*
- *A clinical laboratory*
- *A home infusion therapy provider*
- *An urgent care center*
- *Centers for Medical Excellence (CME)*
- *Blue Distinction Centers for Specialty Care (BDCSC)*
- *A retail health clinic*
- *A hospice*
- *A licensed ambulance company*

Participating providers agree to accept the *maximum allowed amount* as payment for covered services. A directory of *participating providers* is available upon request.

Physician means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or
2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license and such license is required to render that service, and is providing a service for which benefits are specified in this booklet:
 - A dentist (D.D.S. or D.M.D.)
 - An optometrist (O.D.)
 - A dispensing optician
 - A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
 - A licensed clinical psychologist
 - A chiropractor (D.C.)
 - An acupuncturist (A.C.)
 - A nurse midwife
 - A nurse practitioner

- A physician assistant
- A licensed clinical social worker (L.C.S.W.)
- A marriage and family therapist (M.F.T.)
- A licensed professional clinical counselor (L.P.C.C.)*
- A physical therapist (P.T. or R.P.T.)*
- A speech pathologist*
- An audiologist*
- An occupational therapist (O.T.R.)*
- A respiratory care practitioner (R.C.P.)*
- A *psychiatric mental health nurse* (R.N.)*
- Any agency licensed by the state to provide services for the treatment of *mental health conditions* or substance abuse, when required by law to cover those services.
- A registered dietitian (R.D.)* or another nutritional professional* with a master's or higher degree in a field covering clinical nutrition sciences, from a college or university accredited by a regional accreditation agency, who is deemed qualified to provide these services by the referring M.D. or D.O. A registered dietitian or other nutritional professional as described here are covered for the provision of diabetic medical nutrition therapy and nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa only.

***Note:** The providers indicated by asterisks (*) are covered only by referral of a physician as defined in 1 above.

Plan is the set of benefits described in this *benefit booklet* and in the amendments to this *benefit booklet*, if any. These benefits are subject to the terms and conditions of the *plan*. If changes are made to the plan, an amendment or revised *benefit booklet* will be issued to each *subscriber* affected by the change. (The word "plan" here does not mean the same as "plan" as used in ERISA.)

Plan administrator refers to Leidos, the entity which is responsible for the administration of the *plan*.

Preventive Care Services include routine examinations, screenings, tests, education, and immunizations administered with the intent of preventing future disease, illness, or injury. Services are considered preventive if you have no current symptoms or prior history of a medical condition associated with that screening or service. These services shall meet requirements as determined by federal and state law. Sources for determining which services are recommended include the following:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF);
2. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.

Please call the Member Services number listed on your ID card for additional information about services that are covered by this *plan* as preventive care services. You may also refer to the following websites that are maintained by the U.S. Department of Health & Human Services.

<https://www.healthcare.gov/what-are-my-preventive-care-benefits>

<http://www.ahrq.gov>

<http://www.cdc.gov/vaccines/acip/index.html>

Prior plan is a plan sponsored by us which was replaced by this *plan* within 60 days. You are considered covered under the prior plan if you: (1) were covered under the prior plan on the date that plan terminated; (2) properly enrolled for coverage within 31 days of this *plan's* Effective Date; and (3) had coverage terminate solely due to the prior plan's termination.

Prosthetic devices are appliances which replace all or part of a function of a permanently inoperative, absent or malfunctioning body part. The term "prosthetic devices" includes orthotic devices, rigid or semi-supportive devices which restrict or eliminate motion of a weak or diseased part of the body.

Psychiatric emergency medical condition is a mental disorder that manifests itself by acute symptoms of sufficient severity that the patient is either (1) an immediate danger to himself or herself or to others, or (2) immediately unable to provide for or utilize food, shelter, or clothing due to the mental disorder.

Psychiatric health facility is an acute 24-hour facility operating within the scope of a state license, or in accordance with a license waiver issued by the State. It must be:

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

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

Residential treatment center is an inpatient treatment facility where the patient resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation of a *mental health condition* or substance abuse. The facility must be licensed to provide psychiatric treatment of *mental health conditions* or substance abuse according to state and local laws and requires a minimum of one *physician* visit per week in the facility. 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).

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

Severe mental disorders include the following psychiatric diagnoses specified in California Insurance Code section 10144.5: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, and bulimia.

"Severe mental disorders" also includes serious emotional disturbances of a child as indicated by the presence of one or more mental disorders as identified in the Diagnostic and Statistical Manual (DSM) of Mental Disorders, other than primary substance abuse or developmental disorder, resulting in behavior inappropriate to the *child's* age according to expected developmental norms. The child must also meet one or more of the following criteria:

1. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school

functioning, family relationships, or ability to function in the community and is at risk of being removed from the home or has already been removed from the home or the mental disorder has been present for more than six months or is likely to continue for more than one year without treatment.

2. The child is psychotic, suicidal, or potentially violent.
3. The child meets special education eligibility requirements under California law (Government Code Section 7570).

Skilled nursing facility is an institution that provides continuous skilled nursing services. It must be licensed according to state and local laws and be recognized as a skilled nursing facility under Medicare.

Special care units are special areas of a *hospital* which have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

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

Specialty drugs are typically high-cost, injectable, infused, oral or inhaled medications that generally require close supervision and monitoring of their effect on the patient by a medical professional. Certain specified *specialty drugs* may require special handling, such as temperature controlled packaging and overnight delivery, and therefore, certain specified *specialty drugs* will be required to be obtained through the specialty pharmacy program, unless you qualify for an exception.

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

Stay is inpatient confinement which begins when you are admitted to a facility and ends when you are discharged from that facility.

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

Totally disabled dependent is a *dependent* who is unable to perform all activities usual for persons of that age.

Totally disabled subscriber is a *subscriber* who, because of illness or injury, is unable to work for income in any job for which he/she is qualified or for which they become qualified by training or experience, and who are in fact unemployed.

Urgent care is the services received for a sudden, serious, or unexpected illness, injury or condition, other than one which is life threatening, which requires immediate care for the relief of severe pain or diagnosis and treatment of such condition.

Urgent care center is a physician's office or a similar facility which meets established ambulatory care criteria and provides medical care outside of a hospital emergency department, usually on an unscheduled, walk-in basis. Urgent care centers are staffed by medical doctors, nurse practitioners and physician assistants primarily for the purpose of treating patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room.

To find an urgent care center, please call the Member Services number listed on your ID card or you can also search online using the "Find a Doctor" function on the website at www.anthem.com/ca. Please call the *urgent care center* directly for hours of operation and to verify that the center can help with the specific care that is needed.

We (us, our) refers to Leidos.

Year or **calendar year** is a 12 month period starting January 1 at 12:01 a.m. Pacific Standard Time.

You (your) refers to the *subscriber* and *dependents* who are enrolled for benefits under this *plan*.

YOUR RIGHT TO APPEALS

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

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

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

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

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

Notice of Adverse Benefit Determination

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

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

- information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision; and
- information regarding your potential right to an External Appeal pursuant to federal law.

For claims involving urgent/concurrent care:

- the *claims administrator's* notice will also include a description of the applicable urgent/concurrent review process; and
- the *claims administrator* may notify you or your authorized representative within 72 hours orally and then furnish a written notification.

Appeals

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

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

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

- the identity of the claimant;
- the date (s) of the medical service;

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

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

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

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

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

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

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

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

How Your Appeal will be Decided

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

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

Notification of the Outcome of the Appeal

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

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

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

Appeal Denial

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

Voluntary Second Level Appeals

If you are dissatisfied with the *Plan's* mandatory first level appeal decision, a voluntary second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals must be submitted within 60 calendar days of

the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.

External Review

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

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

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

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

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

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

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

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

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

Requirement to file an Appeal before filing a lawsuit

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

If your health benefit *plan* is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA within one year of the appeal decision.

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

FOR YOUR INFORMATION

WEB SITE

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

IDENTITY PROTECTION SERVICES

The *claims administrator* has made identity protection services available to *members*. To learn more about these services, please visit <https://anthemcares.allclearid.com/>.

LANGUAGE ASSISTANCE PROGRAM

Anthem Blue Cross Life and Health introduced its Language Assistance Program to provide certain written translation and oral interpretation services to California *members* with limited English proficiency.

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

Written materials available for translation include grievance and appeal letters, consent forms, claim denial letters, and explanations of benefits. These materials are available in the following languages:

- Spanish
- Chinese
- Vietnamese
- Korean
- Tagalog

Oral interpretation services are available in additional languages.

Requesting a written or oral translation is easy. Just contact Member Services by calling the phone number on your ID card to update your language preference to receive future translated documents or to request interpretation assistance. Anthem Blue Cross Life and Health also sends/receives TDD/TTY messages at **866-333-4823** or by using the National Relay Service through **711**.

For more information about the Language Assistance Program visit www.anthem.com/ca.

STATEMENT OF RIGHTS UNDER THE NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However the plan or issuer may pay for a shorter stay if the attending *physician* (e.g., your *physician*, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a *physician* or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, please call the Member Services telephone number listed on your ID card.

STATEMENT OF RIGHTS UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

This *plan*, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). If you have any questions about this coverage, please call the Member Services telephone number listed on your ID card.

CLAIMS DISCLOSURE NOTICE REQUIRED BY ERISA

The plan document and this booklet entitled "Benefit Booklet," contain information on reporting claims, including the time limitations on submitting a claim. Claim forms may be obtained from the Plan Administrator or from the Claims Administrator. (Note that the Claims Administrator is not the Plan Administrator nor the administrator for the purposes of ERISA.) In addition to this information, if this plan is subject to ERISA, ERISA applies some additional claim procedure rules. The additional rules required by ERISA are set forth below. To the extent that the ERISA claim procedure rules are more beneficial to you, they will apply in place of any similar claim procedure rules included in the certificate. This Claims Disclosure Notice Required By ERISA is not a part of your Benefit Booklet.

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

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

Non-Urgent Care Pre-Service (when care has not yet been received). The Claims Administrator must notify you within 15 days after they receive your request for benefits that they have it and what they have determined your benefits to be. If they need more than 15 days to determine your benefits, due to reasons beyond their control, they must notify you within that 15-day period that they need more time to

determine your benefits. But, in any case, even with an extension, they cannot take more than 30 days to determine your benefits. If you do not properly submit all the necessary information for your request for benefits to them, they must notify you, within 5 days after they get it and tell you what information is missing. You have 45 days to provide them with the information they need to process your request for benefits. The time period during which the Claims Administrator is waiting for receipt of the necessary information is not counted toward the time frame in which the Claims Administrator must make the benefit determination.

If your request for benefits is denied in whole or in part, you will receive a written notice of the denial within the time frame stated above after the Claims Administrator has all the information they need to process your request for benefits, if the information is received within the time frame noted above. The written notice will explain the reason for the adverse benefit determination and the plan provisions upon which the denial decision is based. You have 180 days to appeal their adverse benefit determination. Your appeal must be in writing. Within 30 days after they receive your appeal, they must notify you of their decision about it. Their notice of their decision will be in writing.

Concurrent Care Decisions:

- **Reduction of Benefits** – If, after approving a request for benefits in connection with your illness or injury, the Claims Administrator decides to reduce or end the benefits they have approved for you, in whole or in part:
 - They must notify you sufficiently in advance of the reduction in benefits, or the end of benefits, to allow you the opportunity to appeal their decision before the reduction in benefits or end of benefits occurs. In their notice to you, the Claims Administrator must explain their reason for reducing or ending your benefits and the plan provisions upon which the decision was made.
 - To keep the benefits you already have approved, you must successfully appeal the Claims Administrator's decision to reduce or end those benefits. You must make your appeal to them at least 24 hours prior to the occurrence of the reduction or ending of benefits. If you appeal the decision to reduce or end your benefits when there is less than 24 hours to the occurrence of the reduction or ending of benefits, your appeal may be treated as if you were appealing an urgent care denial of benefits (see the section "Urgent Care," above), depending upon the circumstances of your condition.
 - If the Claims Administrator receives your appeal for benefits at least 24 hours prior to the occurrence of the reduction or ending

of benefits, they must notify you of their decision regarding your appeal within 24 hours of their receipt of it. If the Claims Administrator denies your appeal of their decision to reduce or end your benefits, in whole or in part, they must explain the reason for their denial of benefits and the plan provisions upon which the decision was made. You may further appeal the denial of benefits according to the rules for appeal of an urgent care denial of benefits (see the section "Urgent Care," above).

- **Extension of Benefits** – If, while you are undergoing a course of treatment in connection with your illness or injury, for which benefits have been approved, you would like to request an extension of benefits for additional treatments:
 - You must make a request to the Claims Administrator for the additional benefits at least 24 hours prior to the end of the initial course of treatment that had been previously approved for benefits. If you request additional benefits when there is less than 24 hours till the end of the initially prescribed course of treatment, your request will be handled as if it was a new request for benefits and not an extension and, depending on the circumstances, it may be handled as an Urgent or Non-Urgent Care Pre-service request for benefits.
 - If the Claims Administrator receives your request for additional benefits at least 24 hours prior to the end of the initial course of treatment, previously approved for benefits, they must notify you of their decision regarding your request within 24 hours of their receipt of it if your request is for urgent care benefits. If the Claims Administrator denies your request for additional benefits, in whole or in part, they must explain the reason for their denial of benefits and the plan provisions upon which the decision was made. You may appeal the adverse benefit determination according to the rules for appeal for Urgent, Pre-Service or Post-Service adverse benefit determinations, depending upon the circumstances.

Non - Urgent Care Post-Service (reimbursement for cost of medical care). The Claims Administrator must notify you, within 30 days after they receive your claim for benefits, that they have it and what they determine your benefits to be. If they need more than 30 days to determine your benefits, due to reasons beyond their control, they must notify you within that 30-day period that they need more time to determine your benefits. But, in any case, even with an extension, they cannot take more than 45 days to determine your benefits. If you do not submit all the necessary information for your claim to them, they must notify you, within 30 days after they get it and tell you what information is missing. You have 45 days to provide them with the information they

need to process your claim. The time period during which the Claims Administrator is waiting for receipt of the necessary information is not counted toward the time frame in which the Claims Administrator must make the benefit determination.

If your claim is denied in whole or in part, you will receive a written notice of the adverse benefit determination within the time frame stated above, or after the Claims Administrator has all the information they need to process your claim, if the information is received within the time frame noted above. The written notice will explain the reason for the adverse benefit determination and the plan provisions upon which the denial decision is based. You have 180 days to appeal their decision. Your appeal must be in writing. Within 60 days after they receive your appeal, they must notify you of their decision about it. Their notice to you or their decision will be in writing.

Note: You, your beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits with the Claims Administrator and request a review of the denial. In connection with such a request:

- Documents pertinent to the administration of the Plan may be reviewed free of charge; and
- Issues outlining the basis of the appeal may be submitted.

You may have representation throughout the appeal and review procedure.

For the purposes of this provision, the meanings of the terms “urgent care,” “Non-Urgent Care Pre-Service,” and “Non - Urgent Care Post-Service,” used in this provision, have the meanings set forth by ERISA for a “claim involving urgent care,” “pre-service claim,” and “post-service claim,” respectively.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

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

Separate from our language assistance program, 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 Member Services telephone number on the back of your ID card.

Spanish

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

Arabic

يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجاناً. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك

(TTY/TDD: 711) للمساعدة)

Armenian

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

Chinese

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

Farsi

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

Hindi

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

Hmong

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

Japanese

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

Khmer

អ្នកមានសិទ្ធិក្នុងការទទួលបានព័ត៌មាននេះ
និងទទួលបានជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើប័ណ្ណ ID
របស់អ្នកដើម្បីទទួលបានជំនួយ។(TTY/TDD: 711)

Korean

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

Punjabi

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

Russian

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

Tagalog

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

Thai

ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ (TTY/TDD: 711)

Vietnamese

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

It's important 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>