

YOUR MEDICAL BENEFITS

MAXIMUM ALLOWED AMOUNT

General

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

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

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

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

- The *member* receives services from a *participating* surgeon. The charge is \$2,000. The *maximum allowed amount* under the plan for the surgery is \$1,000. The *member’s* Co-Payment responsibility when a *participating* surgeon is used is 30% of \$1,000, or \$300. This is what the *member* pays. 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-Payment of 50% for *non-participating provider* services after the Deductible has been met.

- The *member* receives services from a *non-participating* surgeon. The charge is \$2,000. The *maximum allowed amount* under the plan for the surgery is \$1,000. The *member’s* Co-Payment responsibility when a *non-participating* surgeon is used is 50% of \$1,000, or \$500. 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 and CME. For covered services performed by a *participating provider* or *CME*, the *maximum allowed amount* for this *plan* will be the rate the *participating provider* or *CME* has agreed with the *claims administrator* to accept as reimbursement for the covered services. Because *participating providers* have agreed to accept the *maximum allowed amount* as payment in full for those covered services, they should not send you a bill or collect for amounts above the *maximum allowed amount*. However, you may receive a bill or be asked to pay all or a portion of the *maximum allowed amount* to the extent you have not met your Deductible or have a Co-Payment. Please call the Member Services telephone number on your ID card for help in finding a *participating provider* or visit www.anthem.com/ca.

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

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

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

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

Non-Participating Providers and Other Health Care Providers.*

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

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

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

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

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

***Exceptions:**

- **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.

MEMBER COST SHARE

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

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

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

AUTHORIZED REFERRALS

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

Federal/State Taxes/Surcharges/Fees

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

MEDICAL AND PRESCRIPTION DRUG 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 or *prescription drug* 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 or *prescription drug* 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. Once the Family Deductible is satisfied, no further Calendar Year Deductible expense will be required for any enrolled member of that family.

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 expense under this *plan*.

Additional Deductible

Each time you are admitted to a *hospital* or *residential treatment center* or have outpatient surgery at an *ambulatory surgical center* without properly obtaining certification, you are responsible for paying the Non-Certification Deductible. This deductible will not apply to an *emergency* admission or procedure, nor to services provided at a *participating provider*. Certification is explained in UTILIZATION REVIEW PROGRAM.

MEDICAL AND PRESCRIPTION DRUG OUT-OF-POCKET AMOUNTS

Satisfaction of the Out-of-Pocket Amount. If, after you have met your Calendar Year Deductibles, you pay Co-Payments equal to your Out-of-Pocket Amount per *member* during a *calendar year*, you will no longer be required to make Co-Payments for any 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.

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

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

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

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

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

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

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

CO-PAYMENTS AND MEDICAL BENEFIT MAXIMUMS

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

CO-PAYMENTS

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

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

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:

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.

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.

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

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

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

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

- Transportation for the *member* to and from the *CME* for a maximum of three (3) trips (one pre-surgical visit, the initial surgery and one follow-up visit).
- Transportation for one companion to and from the *CME* for a maximum of two (2) trips (the initial surgery and one follow-up visit).
- Hotel accommodations for the *member* and one companion for the pre-surgical visit and the follow-up visit, up to two (2) days per trip or as *medically necessary*. Limited to one room, double occupancy.
- Hotel accommodations for one companion for the duration of the *member's* initial surgery stay, up to four (4) days. Limited to one room, double occupancy.
- Other reasonable expenses, up to four (4) days per trip. Tobacco, alcohol, drug and meal expenses are excluded from coverage.

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

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.

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.
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.

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

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

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

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

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

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

Dental Care

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

ambulatory surgical center. This applies only if (a) the *member* is less than seven years old, (b) the *member* is developmentally disabled, or (c) the *member's* health is compromised and general anesthesia is *medically necessary*. Charges for the dental procedure itself, including professional fees of a dentist, may not be covered.

3. **Dental Injury.** Services of a *physician* (M.D.) or dentist (D.D.S. or D.M.D.) solely to treat an *accidental injury* to natural teeth. Coverage shall be limited to only such services that are *medically necessary* to repair the damage done by *accidental injury* and/or restore function lost as a direct result of the *accidental injury*. Damage to natural teeth due to chewing or biting is not *accidental injury* unless the chewing or biting results from a medical or mental condition.
4. **Cleft Palate.** *Medically necessary* dental or orthodontic services that are an integral part of *reconstructive surgery* for cleft palate procedures. "Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.
5. **Orthognathic Surgery.** Orthognathic surgery for a physical abnormality that prevents normal function of the upper or lower jaw and is *medically necessary* to attain functional capacity of the affected part.

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

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

1. The following equipment and supplies:
 - a. Glucose monitors, including monitors designed to assist the visually impaired, and blood glucose testing strips.
 - b. Insulin pumps.
 - c. Pen delivery systems for insulin administration (non-disposable).
 - d. Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin.

- e. Podiatric devices, such as therapeutic shoes and shoe inserts, 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 under your *prescription drug* benefits:

- a. Insulin, glucagon, and other *prescription drugs* for the treatment of diabetes.
- b. Insulin syringes, disposable pen delivery systems for insulin administration.
- c. Testing strips, lancets, and alcohol swabs.

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

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

Diagnostic Services. Outpatient diagnostic imaging, laboratory services and genetic tests. Genetic tests are subject to pre-service review to determine medical necessity. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews. 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.

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.

The *claims administrator* will determine whether the item satisfies the conditions above.

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

1. Audiological evaluations to measure the extent of hearing loss and determine the most appropriate make and model of hearing aid. These evaluations will be covered under *plan* benefits for office visits to *physicians*.
2. Hearing aids (monaural or binaural) including ear mold(s), bone-anchored hearing aids, the hearing aid instrument, batteries, cords and other ancillary equipment.
3. Visits for fitting, counseling, adjustments and repairs for a one year period after receiving the covered hearing aid.

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

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

The following renal dialysis services are covered:

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

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

1. Services of a registered nurse or licensed vocational nurse under the supervision of a registered nurse or a *physician*.
2. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy, or respiratory therapy.
3. Services of a medical social service worker.
4. Services of a health aide who is employed by (or who contracts with) a *home health agency*. Services must be ordered and supervised by a registered nurse employed by the *home health agency* as professional coordinator. These services are covered only if you are also receiving the services listed in 1 or 2 above. Other organizations may give services only when approved by 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 and Substance Use Disorder" provision.

In no event will benefits exceed 120 visits during a *calendar year*. A visit of four hours or less by a home health aide shall be considered as one home health visit.

Home health care services are 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 caregiver 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*.

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

Hospital

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

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

Infertility Services. Covered services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, semen analysis and services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency).

Infertility Treatment. The following services and supplies furnished in connection with the diagnosis and treatment of infertility, as *medically necessary*, provided you are 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.
6. Supplies and appliances.
7. In-vitro fertilization.

Treatment for *infertility* will not include elective sterilization reversal, gamete intrafallopian transfer or any other services for infertility not specifically stated above. In no event will benefit payments exceed **\$10,000** for all covered services and supplies during a calendar year.

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

1. Medication (*specialty drugs* must be obtained through the specialty drug program (see the "Specialty Drugs," provision of this section MEDICAL CARE THAT IS COVERED), ancillary medical supplies and supply delivery, (not to exceed a 14-day supply); however, medication which is delivered but not administered is not covered);
2. Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications (if outpatient prescription drug benefits are provided under this *plan*, *compound medications* must be obtained from a *participating pharmacy*);
3. *Hospital* and home clinical visits related to the administration of infusion therapy, including skilled nursing services including those provided for: (a) patient or alternative caregiver training; and (b) visits to monitor the therapy;
4. Rental and purchase charges for durable medical equipment; 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).

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

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.

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

- **Inpatient Services:** Inpatient *hospital* services and services from a *residential treatment center* (including crisis residential treatment), for inpatient services and supplies, and *physician* visits during a covered inpatient stay.
- **Outpatient Office Visits** for the following:
 - virtual visits,
 - individual and group mental health evaluation and treatment,
 - *intensive in-home behavioral health services*, when available in your area,
 - nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa,
 - drug therapy monitoring,
 - individual and group chemical dependency counseling,
 - medical treatment for withdrawal symptoms,
 - methadone maintenance treatment, and
 - Behavioral health treatment for autism spectrum disorders delivered in an office setting.
- **Other Outpatient Items and Services:**
 - *partial hospitalization programs*, including *intensive outpatient programs* and visits to a *day treatment center*,
 - psychological testing,
 - multidisciplinary treatment in an intensive outpatient psychiatric treatment program, and

- behavioral health treatment for autism spectrum disorders delivered at home.
- **Behavioral health treatment for autism spectrum disorders.** Inpatient services, office visits, and other outpatient items and services are covered under this section. See the section BENEFITS FOR AUTISM SPECTRUM DISORDERS for a description of the services that are covered. **Note:** You must obtain pre-service review for all behavioral health treatment services for the treatment of autism spectrum disorders in order for these services to be covered by this *plan* (see UTILIZATION REVIEW PROGRAM for details).
- Treatment for substance use disorder does not include smoking cessation programs, nor treatment for nicotine dependency or tobacco use. Certain services are covered under the “Preventive Care Services” benefit or as specified in the “Preventive Prescription Drugs and Other Items” covered under YOUR PRESCRIPTION DRUG BENEFITS. Please see those provisions for further details.

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

- Psychiatrist,
- Psychologist,
- Registered psychological assistant, as described in the CA Business and Professions Code,
- Psychology trainee or person supervised as set forth in the CA Business and Professions Code,
- Licensed clinical social worker (L.C.S.W.),
- Associate clinical social worker functioning pursuant to the CA Business and Professions Code,
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to the CA Business and Professions Code,
- Licensed professional counselor (L.P.C.),
- Associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to the CA Business and Professions Code, and

Qualified Autism Service Providers, Qualified Autism Service Professionals, and Qualified Autism Service Paraprofessionals. See the definitions of these in the “Benefits for Autism Spectrum Disorders” section below.

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

“Telemedicine / Telehealth” means the delivery of health care or other health services using electronic communications and information technology, including: live (synchronous) secure videoconferencing or secure instant messaging through our mobile app or website. Covered services are provided to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient’s physical and/or mental health. Benefits for Telehealth are provided on the same basis and to the same extent as the same covered services provided through in-person contact. In-person contact between a health care *physician* and the patient is not required for these services, and the type of setting where these services are provided is not limited.

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

Benefits do not include the use of facsimile, audio-only telephone, texting (outside of our mobile app), website, electronic mail, or non-secure instant messaging. Benefits also do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to *physicians* outside our network, benefit precertification or *physician* to *physician* discussions.

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

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

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*.

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

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

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 dietitian upon referral by a health care provider authorized to prescribe dietary treatments, and is *medically necessary* for the treatment of PKU. Formulas and special food products used in the treatment of PKU that are obtained from a *pharmacy* are covered as prescription drugs (see YOUR PRESCRIPTION DRUG BENEFITS). Formulas and special food products that are not obtained from a *pharmacy* are covered under this benefit.

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

- 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.

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

1. Physical therapy and physical medicine provided on an outpatient basis for the treatment of illness or injury including the therapeutic use of heat, cold, exercise, electricity, ultra violet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care which are customarily provided by chiropractors, physical therapists and osteopaths. It does not include massage therapy services at spas or health clubs.)
2. Occupational therapy provided on an outpatient basis when the ability to perform daily life tasks has been lost or reduced by, or has not been developed due to, illness or injury including programs which are designed to rehabilitate mentally, physically or emotionally handicapped persons. Occupational therapy programs are designed to maximize or improve a patient's upper extremity function, perceptual motor skills and ability to function in daily living activities.

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

Up to 24 visits in a year for all covered services are payable, if *medically necessary*. If additional visits are needed after receiving 24 visits in a year, pre-service review must be obtained prior to receiving the services.

If it is determined that an additional period of physical therapy, physical medicine or occupational therapy is *medically necessary*, the *claims administrator* will authorize a specific number of additional visits. Such additional visits are not payable if pre-service review is not obtained. (See UTILIZATION REVIEW PROGRAM.)

There is no limit on the number of covered visits for *medically necessary* physical therapy, physical medicine, and occupational therapy. But additional visits in excess of the number of visits stated above must be authorized in advance.

Pregnancy and Maternity Care

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

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

2. Medical *hospital* benefits for routine nursery care of a newborn *child*, (for additional information, please see the "Important Note for Newborn and Newly-Adopted Children" under HOW COVERAGE BEGINS AND ENDS). Routine nursery care of a newborn child includes screening of a newborn for genetic diseases, congenital conditions, and other health conditions provided through a program established by law or regulation.
3. Certain services are covered under the "Preventive Care Services" benefit. Please see that provision for further details.

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

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

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

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

Prior Authorization. Your *plan* includes certain features to determine when *prescription drugs* should be covered, which are described below. As part of these features, your prescribing *physician* may be asked to give more details before the *claims administrator* can decide if the *drug* is eligible for coverage. In order to determine if the *prescription drug* is eligible for coverage, the following criteria has been established.

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

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

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

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

Covered Prescription Drugs. To be a covered service, *prescription drugs* must be approved by the Food and Drug Administration (FDA) and, under federal law, require a *prescription*. *Prescription drugs* must be prescribed by a licensed *physician* and *controlled substances* must be prescribed by a licensed *physician* with an active DEA license.

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

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

Precertification: You or your *physician* can get the list of the *prescription drugs* that require prior authorization by calling the phone number on the back of your ID card or check the *claims administrator's* website at www.anthem.com. The list will be reviewed and updated from time to time. Including a *prescription drug* or related item on the list does not guarantee coverage under your *plan*. Your *physician* may check with the *plan* to verify *prescription drug* coverage, to find out which *prescription drug* are covered under this section and if any *drug edits* apply. However, if it is 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 submit a request to the *plan* using the required uniform prior authorization request form. If you're requesting an exception to the step therapy process, your *physician* must use the same form. The request, for either prior authorization or step therapy exceptions, may be made by mail, telephone, facsimile, or it may be made electronically. At the time the request is initiated, specific clinical information will be requested from your *physician* based on medical policy and/or clinical guidelines, based specifically on your diagnosis and/or the *physician's* statement in the request or clinical rationale for the *specialty pharmacy drug*.

After the *plan* receives the request from your *physician*, the *claims administrator* will review the request and respond within the following time periods:

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

If you have any questions regarding whether a *specialty pharmacy drug* requires prior authorization, please call 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.

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

1. A *physician's* services for routine physical examinations.
2. Immunizations prescribed by 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, including screenings for preexposure prophylaxis (PrEP) for prevention of HIV infection.
6. Counseling and risk factor reduction intervention services for sexually transmitted infections, human immunodeficiency virus (HIV), contraception, tobacco use, smoking cessation and tobacco use-related diseases.
7. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
 - a. All FDA-approved contraceptive *drugs*, devices and other products for women, including over-the-counter items, if prescribed by a *physician*. This includes contraceptive *drugs*, 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 either *generic* oral contraceptives or a *brand name drug*. *Brand name drugs* will be covered as *preventive care services* when *medically necessary* according to your attending *physician*, otherwise they will be covered under your *plan's* prescription drug benefits (see YOUR PRESCRIPTION DRUG BENEFITS).

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

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 co-payment 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*.

Professional Services

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

Prosthetic Devices

- 1. Breast prostheses and surgical bras following a mastectomy.
- 2. *Prosthetic devices* to restore a method of speaking when required as a result of a covered *medically necessary* laryngectomy.
- 3. Wigs 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.

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

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

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

Skilled Nursing Facility. Inpatient services and supplies provided by a *skilled nursing facility*, for up to 120 days per *calendar year*. The amount by which your room charge exceeds the prevailing two-bed room rate of the *skilled nursing facility* is not considered covered under this plan.

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

Specified Transplants

You must obtain our prior authorization for all services including, but not limited to, preoperative tests and postoperative care related to the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. Specified transplants must be performed at *Centers of Medical Excellence (CME)*. **Charges for services provided**

for or in connection with a specified transplant performed at a facility other than a CME will not be covered under this plan. Call the toll-free telephone number for pre-service review on your identification card if your physician recommends a specified transplant for your medical care. A case manager transplant coordinator will assist in facilitating your access to a CME. See UTILIZATION REVIEW PROGRAM for details.

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

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.

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

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

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

Transgender Travel Expense. Certain travel expenses incurred in connection with an approved transgender surgery, when the *hospital* at which the surgery is performed is 75 miles or more from your place of residence, provided the expenses are authorized in advance by the *claims administrator*. The following travel expenses incurred by you and one companion are considered covered travel expenses:

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

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

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

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

1. The recipient; or
2. The donor.

If you are the recipient, an organ or tissue donor who is not a *member* is also eligible for services as described. Benefits are reduced by any amounts paid or payable by that donor's own coverage. The *maximum allowed amount* for a donor, including donor testing and donor search, is limited to expense incurred for *medically necessary* medical services only. The *maximum allowed amount* for services incident to obtaining the transplanted material from a living donor or a human organ transplant bank will be covered. Such charges, including complications from the donor procedure for up to six weeks from the date of procurement, are covered. Services for treatment of a condition that is not directly related to, or a direct result of, the transplant are not covered.

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

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

1. For the recipient and a companion, per transplant episode, up to six trips per episode:
 - a. Round trip coach airfare to the CME.
 - b. Hotel accommodations, for up to 21 days per trip, limited to one room, double occupancy.
 - c. Other reasonable expenses, for up to 21 days per trip. Tobacco, alcohol, drug, and meal expenses are excluded.
2. For the donor, per transplant episode, limited to one trip:
 - a. Round trip coach airfare to the CME.
 - b. Hotel accommodations, for up to 7 days.
 - c. Other reasonable expenses, for up to 7 days. Tobacco, alcohol, drug, and meal expenses are excluded.

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.)

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.

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*.

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

Autopsies. Autopsies and post-mortem testing.

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.

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.

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

Cosmetic Surgery. Cosmetic surgery or other services performed to alter or reshape normal (including aged) structures or tissues of the body to improve appearance.

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

Dental Devices for Snoring. Oral appliances for snoring.

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.

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

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*, 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.

Educational or Academic Services. Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.

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

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

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.

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.

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.

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.

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.

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.

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

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

Health Club Memberships. 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.

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

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).

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

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

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

In-vitro Fertilization. Services or supplies for in-vitro fertilization (IVF) for purposes of pre-implant genetic diagnosis (PGD) of embryos, regardless of whether they are provided in connection with infertility treatment.

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

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.

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

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.

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use, if the program is not affiliated with Anthem. Smoking cessation *drugs*, except as specifically stated under YOUR PRESCRIPTION DRUG BENEFITS section of this booklet.

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

Non-Licensed Providers. Treatment or services rendered by non-licensed health care providers and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed provider under the supervision of a licensed *physician*, except as specifically provided or arranged by the *claims administrator*. This exclusion does not apply to the *medically necessary* treatment of autism, to the extent stated in the section BENEFITS FOR AUTISM SPECTRUM DISORDERS.

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

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

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

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.

Outpatient Occupational Therapy. Outpatient occupational therapy, except as specifically stated in the "Infusion Therapy" provision of MEDICAL

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

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

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

Physical Therapy or Physical Medicine. Services of a *physician* for physical therapy or physical medicine, except when provided during a covered inpatient confinement, or as specifically stated in the "Home Health Care", "Hospice Care", "Infusion Therapy" or "Physical Therapy, Physical Medicine and Occupational Therapy" provisions of MEDICAL CARE THAT IS COVERED. This exclusion also does not apply to the *medically necessary treatment of mental health and substance use disorder*, or to the *medically necessary treatment of autism spectrum disorders*, to the extent stated in the section BENEFITS FOR AUTISM SPECTRUM DISORDERS.

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.

Private Duty Nursing. Private duty nursing services given in a *hospital* or *skilled nursing facility*. Private duty nursing services are a covered service only when given as part of the "Home Health Care" benefit.

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

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

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

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

Scalp hair prostheses. Scalp hair prostheses, including wigs or any form of hair replacement.

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*.

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

Specialty drugs. *Specialty drugs* that must be obtained from the specialty drug program, but, which are obtained from a retail *pharmacy* are not covered by this *plan*. **You will have to pay the full cost of the specialty drugs you get from a retail *pharmacy* that you should have obtained from the specialty drug program.**

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

Sterilization Reversal. Reversal of an elective sterilization.

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). If you enter into a Surrogacy Arrangement and you or any other payee are entitled to receive payments or other compensation under the Surrogacy Arrangement, you must reimburse Anthem for Covered Services you receive related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement to the maximum extent allowed under California Civil Code Section 3040.

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

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

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

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

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

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

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

BENEFITS FOR AUTISM SPECTRUM DISORDERS

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

Behavioral health treatment services covered under this *plan* are subject to the same deductibles, co-payments and co-insurance that apply to services provided for other covered medical conditions. Services provided by Qualified Autism Service Providers, Qualified Autism Service Professionals, and Qualified Autism Service Paraprofessionals (see the "Definitions" below) will be covered under *plan* benefits that apply for outpatient office visits or other outpatient items and services. Services provided in a facility, such as the outpatient department of a *hospital*, will be covered under *plan* benefits that apply to such facilities. See also "MENTAL HEALTH AND SUBSTANCE USE DISORDER".

You must obtain pre-service review for all behavioral health treatment services for the treatment of autism spectrum disorders in order for these services to be covered by this *plan* (see UTILIZATION REVIEW PROGRAM for details).

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

DEFINITIONS

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

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

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

Qualified Autism Service Provider is either of the following:

- A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the

National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for autism spectrum disorders, provided the services are within the experience and competence of the person, entity, or group that is nationally certified; or

- A person licensed as a physician and surgeon (M.D. or D.O.), physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to state law, who designs, supervises, or provides treatment for autism spectrum disorders, provided the services are within the experience and competence of the licensee.

The *claims administrator's* network of *participating providers* may be limited to licensed Qualified Autism Service Providers who contract with the *claims administrator* or a Blue Cross and/or Blue Shield Plan and who may supervise and employ Qualified Autism Service Professionals or Qualified Autism Service Paraprofessionals who provide and administer Behavioral Health Treatment.

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

- Provides behavioral health treatment,
- Is employed and supervised by a Qualified Autism Service Provider,
- Provides treatment according to a treatment plan developed and approved by the Qualified Autism Service Provider,
- Is a behavioral service provider approved as a vendor by a California regional center to provide services as an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program as defined in state regulation or who meets equivalent criteria in the state in which he or she practices if not providing services in California, and
- Has training and experience in providing services for autism spectrum disorders pursuant to applicable state law.

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

- Is employed and supervised by a Qualified Autism Service Provider,
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider,

- Meets the criteria set forth in any applicable state regulations adopted pursuant to state law concerning the use of paraprofessionals in group practice provider behavioral intervention services, and
- Has adequate education, training, and experience, as certified by a Qualified Autism Service Provider.

BEHAVIORAL HEALTH TREATMENT SERVICES COVERED

The behavioral health treatment services covered by this *plan* for the treatment of autism spectrum disorders are limited to those professional services and treatment programs, including Applied Behavior Analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with autism spectrum disorders and that meet all of the following requirements:

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

- ◆ Discontinues Intensive Behavioral Intervention services when the treatment goals and objectives are achieved or no longer appropriate, and
- ◆ The treatment plan is not used for purposes of providing or for the reimbursement of respite care, day care, or educational services, and is not used to reimburse a parent for participating in the treatment program. The treatment plan must be made available to the *claims administrator* upon request.

SUBROGATION AND REIMBURSEMENT

These provisions apply when the *plan* pays benefits as a result of injuries or illnesses you sustained and you have a right to a Recovery or have received a Recovery from any source. A "Recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, worker's compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements characterize the money you receive as a Recovery, it shall be subject to these provisions.

Subrogation

The *plan* has the right to recover payments it makes on your behalf from any party responsible for compensating you for your illnesses or injuries. The following apply:

- The *plan* has first priority from any Recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- You and your legal representative must do whatever is necessary to enable the *plan* to exercise the *plan*'s rights and do nothing to prejudice those rights.
- In the event that you or your legal representative fails to do whatever is necessary to enable the *plan* to exercise its subrogation rights, the *plan* shall be entitled to deduct the amount the *plan* paid from any future benefits under the *plan*.
- The *plan* has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the *plan*.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the *plan*'s subrogation claim and any claim held by you, the *plan*'s subrogation claim shall be first satisfied

before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.

- The *plan* is not responsible for any attorney fees, attorney liens, other expenses or costs you incur. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the *plan*.

Reimbursement

If you obtain a Recovery and the *plan* has not been repaid for the benefits the *plan* paid on your behalf, the *plan* shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following provisions will apply:

- You must reimburse the *plan* from any Recovery to the extent of benefits the *plan* paid on your behalf regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- Notwithstanding any allocation or designation of your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the *plan* shall have a right of full recovery, in first priority, against any Recovery. Further, the *plan*'s rights will not be reduced due to your negligence.
- You and your legal representative must hold in trust for the *plan* the proceeds of the gross Recovery (*i.e.*, the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the *plan* immediately upon your receipt of the Recovery. You and your legal representative acknowledge that the portion of the Recovery to which the *plan*'s equitable lien applies is a *plan* asset.
- Any Recovery you obtain must not be dissipated or disbursed until such time as the *plan* has been repaid in accordance with these provisions.
- You must reimburse the *plan*, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the *plan*.
- If you fail to repay the *plan*, the *plan* shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the *plan* has paid or the amount of your Recovery whichever is less, from any future benefit under the *plan* if:

- 1. The amount the *plan* paid on your behalf is not repaid or otherwise recovered by the *plan*; or
- 2. You fail to cooperate.
- In the event that you fail to disclose the amount of your settlement to the *plan*, the *plan* shall be entitled to deduct the amount of the *plan's* lien from any future benefit under the *plan*.
- The *plan* shall also be entitled to recover any of the unsatisfied portion of the amount the *plan* has paid or the amount of your Recovery, whichever is less, directly from the Providers to whom the *plan* has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the *plan* will not have any obligation to pay the Provider or reimburse you.
- The *plan* is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or make you whole.

Your Duties

- You must promptly notify the *plan* of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved and any other information requested by the *plan*.
- You must cooperate with the *plan* in the investigation, settlement and protection of the *plan's* rights. In the event that you or your legal representative fail to do whatever is necessary to enable the *plan* to exercise its subrogation or reimbursement rights, the *plan* shall be entitled to deduct the amount the *plan* paid from any future benefits under the *plan*.
- You must not do anything to prejudice the *plan's* rights.
- You must send the *plan* copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify the *plan* if you retain an attorney or if a lawsuit is filed on your behalf.
- You must immediately notify the *plan* if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

The *plan administrator* has sole discretion to interpret the terms of the Subrogation and Reimbursement provision of this *plan* in its entirety and reserves the right to make changes as it deems necessary.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, that Recovery shall be subject to this provision.

The *plan* is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

The *plan* shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal injury protection policy regardless of any election made by you to the contrary. The *plan* shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

YOUR PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG COVERED EXPENSE

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

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

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

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

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

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

PRESCRIPTION DRUG CO-PAYMENTS

CO-PAYMENTS

After the *pharmacy benefits manager* determines *prescription drug covered expense*, they will subtract your Prescription Drug Co-Payment for each *prescription*.

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

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

HOW TO USE YOUR PRESCRIPTION DRUG BENEFITS

When You Go to a Participating Pharmacy. To identify you as a member covered for *prescription drug* benefits, you will be issued an ID card. You must present this card to *participating pharmacies* when you have a *prescription* filled. Provided you have properly identified yourself as a *member*, a *participating pharmacy* will only charge your Co-Payment.

Generic drugs will be dispensed by *participating pharmacies* when the *prescription* indicates a *generic drug*. When a *brand name drug* is specified, but a *generic drug* equivalent exists, the *generic drug* will be substituted. *Brand name drugs* will be dispensed by *participating pharmacies* when the *prescription* specifies a *brand name* and states "dispense as written" or no *generic drug* equivalent exists.

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

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

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

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

Important Note: If the *claims administrator* determines that you may be using *prescription drugs* in a harmful or abusive manner, or with harmful frequency, your selection of *participating pharmacies* may be limited. If

this happens, the *plan* may require you to select a single *participating pharmacy* that will provide and coordinate all future pharmacy services. Benefits will only be paid if you use the single *participating pharmacy*. The *claims administrator* will contact you if they determine that use of a single *participating pharmacy* is needed and give you options as to which *participating pharmacy* you may use. If you do not select one of the *participating pharmacies* that the *plan* offers within 31 days, the *claims administrator* will select a single *participating pharmacy* for you. If you disagree with the *claims administrator's* decision, you may file complaint as described in the COMPLAINT NOTICE.

In addition, if the *claims administrator* determines that you may be using *controlled substance prescription drugs* in a harmful or abusive manner, or with harmful frequency, your selection of *participating providers* for *controlled substance prescriptions* may be limited. If this happens, the *claims administrator* may require you to select a single *participating provider* that will provide and coordinate all *controlled substance prescriptions*. Benefits for *controlled substance prescriptions* will only be paid if you use the single *participating provider*. The *claims administrator* will contact you if it determines that use of a single *participating provider* is needed and give you options as to which *participating provider* you may use. If you do not select one of the *participating providers* that is offered within 31 days, the *claims administrator* will select a single *participating provider* for you. If you disagree with the *claims administrator's* decision, you may file complaint as described in the COMPLAINT NOTICE.

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

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

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

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

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

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

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

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

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

When You Order Your Prescription Through Specialty Drug Program. Certain specified *specialty drugs* must be obtained through the specialty drug program unless you are given a temporary exception from certain requirements of the specialty drug program (see PRESCRIPTION DRUG CONDITIONS OF SERVICE), but any exception will be subject to all applicable copay requirements, including, but not limited to, the requirement of additional copays for more than a 30-day supply (e.g., a 90-day supply will require a payment of three times the 30-day copay). These specified *specialty drugs* that must be obtained through the Specialty Drug Program are limited up to a 30-day supply absent an approved exception and subject to the payment of additional copays for each additional 30-day supply. The Specialty Drug Program will deliver your medication to you by mail or common carrier (you cannot pick up your medication at Anthem Blue Cross Life and Health).

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

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

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

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

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

PREScription DRUG UTILIZATION REVIEW

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

PREFERRED DRUG PROGRAM

The presence of a *drug* on the *plan's preferred drug list* does not guarantee that you will be prescribed that *drug* by your *physician*. These medications, which include both generic and *brand name drugs*, are listed in the *preferred drug list*. The *preferred drug list* is updated quarterly to ensure that the list includes *drugs* that are safe and effective. **Note:** The *formulary drugs* may change from time to time.

Some *drugs* may require prior authorization. Non-preferred *drugs* are not available through the home delivery program. If you have a question regarding whether a particular *drug* is on the *preferred drug* list or requires prior authorization please call the number on the back of your ID Card. Information about the *drugs* on the *preferred drug* list is also available on the *claims administrator's* internet website www.anthem.com/ca.

Exception request for a drug not on the prescription drug formulary (non-formulary exceptions).

Your *prescription drug* benefit covers *drugs* listed in a *prescription drug formulary*. This *prescription drug formulary* contains a limited number of *prescription drugs*, and may be different than the *prescription drug formulary* for other Anthem products. In cases where your *physician prescribes a medication that is not on the prescription drug formulary*, it may be necessary to obtain a non-formulary exception in order for the *prescription drug* to be a covered benefit. Your *physician* must complete a non-formulary exception form and return it to the *claims administrator*. You or your *physician* can get the form online at www.anthem.com or by calling the number listed on the back of your ID card.

When the *claims administrator* receives a non-formulary exception request, they will make a coverage decision within a certain period of time, depending on whether exigent circumstances exist.

Exigent circumstances exist if you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if you are undergoing a current course of treatment using a drug not covered by the *plan*. In this case, the *claims administrator* will make a coverage decision within 24 hours of receiving your request. If the *drug* is approved, coverage of the *drug* will be provided for the duration of the exigency. If the *drug* coverage is denied, you have the right to request an external review.

When exigent circumstances do not exist, the *claims administrator* will make a coverage decision within 72 hours of receiving your request. If the *drug* is approved, coverage of the *drug* will be provided for the duration of the *prescription*, including refills. If the *drug* coverage is denied, you have the right to request an external review.

Requesting a non-formulary exception does not affect your right to submit an appeal.

Coverage of a *drug* approved as a result of your request or your *physician's* request for an exception will only be provided if you are a member enrolled under the *plan*.

Prior Authorization. *Physicians* must obtain prior authorization in order for you to get benefits for certain *prescription drugs*. At times, your *physician* will initiate a prior authorization on your behalf before your *pharmacy* fills your prescription. At other times, the *pharmacy* may make you or your *physician* aware that a prior authorization or other information is needed. In order to determine if the *prescription drug* is eligible for coverage, the following criteria has been established.

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

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

You or your *physician* can get the list of the *prescription drug* that require prior authorization by calling the phone number on the back of your ID card or check the *claims administrator's* website at www.anthem.com. The list will be reviewed and updated from time to time. Including a *prescription drug* or related item on the list does not guarantee coverage under your *plan*. Your *physician* may check with the *claims administrator* to verify *prescription drug* coverage, to find out which *prescription drug* are covered under this section and if any drug edits apply.

In order for you to get a *drug* that requires prior authorization, your *physician* must send a written request to the *claims administrator* for the *drug* using the required uniform prior authorization request form. If you're requesting an exception to the step therapy process, your *physician* must use the same form. The request, for either prior authorization or step therapy exceptions, can be facsimiled, mailed or submitted electronically to the *claims administrator*. If your *physician* needs a copy of the request form, he or she may call the *claims administrator* at the number on the

back of your ID Card to request one. The form is also available on-line at www.anthem.com/ca.

Upon receiving the completed uniform prior authorization request form, the *claims administrator* will review the request and respond within the following time periods:

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

While the *claims administrator* is reviewing the request, a 72-hour emergency supply of medication may be dispensed to you if your *physician* or pharmacist determines that it is appropriate and *medically necessary*. You may have to pay the applicable co-payment shown in SUMMARY OF BENEFITS: PRESCRIPTION DRUG BENEFITS: PRESCRIPTION DRUG CO-PAYMENTS for the 72-hour supply of your *drug*. If the *plan* approves the request for the *drug* after you have received a 72-hour supply, you will receive the remainder of the 30-day supply of the *drug* with no additional co-payment.

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

If the *claims administrator* denies a request for prior authorization of a *drug*, you or your prescribing *physician* may appeal the decision by calling the number on the back of your ID Card.

Revoking or modifying a prior authorization. A prior authorization of benefits for *prescription drugs* may be revoked or modified prior to your receiving the *drugs* for reasons including but not limited to the following:

- Your coverage under this *plan* ends;
- The *plan* with the *plan administrator* terminates;
- You reach a benefit maximum that applies to *prescription drugs*, if the *plan* includes such a maximum;
- Your *prescription drug* benefits under the *plan* change so that *prescription drugs* are no longer covered or are covered in a different way.

A revocation or modification of a prior authorization of benefits for *prescription drugs* applies only to unfilled portions or remaining refills of the *prescription*, if any, and not to *drugs* you have already received.

New drugs and changes in the *prescription drugs* covered by the plan. The outpatient *prescription drugs* included on the list of *preferred drugs* covered by the *plan* is decided by the *Pharmacy and Therapeutics Process*, which is comprised of independent nurses, *physicians* and pharmacists. The *Pharmacy and Therapeutics Process* meets quarterly and decides on changes to make in the *preferred drugs* list based on recommendations from the *claims administrator* and a review of relevant information, including current medical literature.

PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS

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

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

- All FDA-approved contraceptives for women, including oral contraceptives, diaphragms, patches, and over-the-counter contraceptives. In order to be covered as a *preventive care service*, in addition to the requirements stated above, contraceptive *prescription drugs* must be *generic* oral contraceptives or *brand name drugs*.
- Vaccinations prescribed by a *physician* and obtained from a *participating pharmacy*.
- Tobacco cessation *drugs*, medications, and other items for *members* age 18 and older as recommended by the United States Preventive Services Task Force including:
 - *Prescription drugs* to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products.
 - FDA-approved smoking cessation products including over-the-counter (OTC) nicotine gum, lozenges and patches when obtained with a *physician's* prescription.

- Aspirin to reduce the risk of heart attack or stroke, for men ages 45-79 and women ages 55-79.
- Aspirin after 12 weeks of gestation in pregnant women who are at high risk for preeclampsia.
- Generic low to moderate dose statins for *members* that are 40-75 years and have one or more risk factors for cardiovascular disease.
- Folic acid supplementation for women age 55 years and younger (folic acid supplement or a multivitamin).
- Medications for risk reduction of primary breast cancer in women (such as tamoxifen or raloxifene) for women who are at increased risk for breast cancer and at low risk for adverse medication effects.
- **Bowel preparations when prescribed for a preventive colon screening.**
- Fluoride supplements for children from birth through 6 years old (drops or tablets).
- **Dental fluoride varnish to prevent tooth decay of primary teeth for children from birth to 5 years old.**

PREScription DRUG CONDITIONS OF SERVICE

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

1. It must be prescribed by a licensed prescriber and be dispensed within one year of being prescribed, subject to federal and state laws. This requirement will not apply to covered vaccinations provided at a *participating pharmacy*.
2. It must be approved for general use by the Food and Drug Administration (FDA).
3. It must be for the direct care and treatment of your illness, injury or condition. Dietary supplements, health aids or drugs for cosmetic purposes are not included. However the following items are covered:
 - a. Formulas prescribed by a *physician* for the treatment of phenylketonuria.
 - b. Vaccinations provided at a *participating pharmacy* as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS, subject to all terms of this *plan* that apply to those benefits.
 - c. Vitamins, supplements, and health aids as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS, subject to all terms of this *plan* that apply to those benefits.

4. It must be dispensed from a licensed retail *pharmacy*, through the home delivery program or through the specialty drug program.
5. **If it is an approved compound medication, be dispensed by a participating pharmacy.** Call the number on the back of your ID Card to find out where to take your prescription for an approved *compound medication* to be filled. (You can also find a *participating pharmacy* at www.anthem.com/ca.) **Some compound medications must be approved before you can get them** (See PRESCRIPTION DRUG FORMULARY: PRIOR AUTHORIZATION). You will have to pay the full cost of the *compound medications* you get from a *pharmacy* that is not a *participating pharmacy*.
6. **If it is a specified specialty drug, be obtained by using the specialty drug program.** See the section HOW TO USE YOUR PRESCRIPTION DRUG BENEFITS: WHEN YOU ORDER YOUR PRESCRIPTION THROUGH SPECIALTY DRUG PROGRAM for how to get your *drugs* by using the specialty drug program. **You will have to pay the full cost of any specialty drugs you get from a retail *pharmacy* that you should have obtained from the specialty drug program.** If you order a *specialty drug* that must be obtained using the specialty pharmacy program through the home delivery program, it will be forwarded to the specialty drug program for processing and will be processed according to specialty drug program rules.

Exceptions to specialty drug program. This requirement does not apply to:

- a. The first one month supply of a specified *specialty drug* which is available through a participating retail *pharmacy*;
- b. *Drugs*, which due to medical necessity, must be obtained immediately;
- c. A *member* who is unable to pay for delivery of their medication (i.e., no credit card); or
- d. A *member* for whom, according to the Coordination of Benefit rules, this *plan* is not the primary plan.

How to obtain a temporary exception to the specialty drug program. If you believe that you should not be required to get your medication through the specialty drug program, for any of the reasons listed above, except for d., you must complete an Exception to Specialty Drug Program form to request an exception and send it to the *claims administrator*. The form can be faxed or mailed to the *claims administrator*. If you need a copy of the form, you may call the number on the back of your ID Card to request one. You can also get the form on-line at www.anthem.com/ca. If the *claims administrator*

has given you an exception, it will be good for a limited period of time based on the reason for the exception, and it does not mean that a similar exception will again be provided. When the exception period ends, if you believe that you should still not be required to get your medication through the specialty drug program, you must again request an exception. If the *claims administrator* denies your request for an exception, it will be in writing and will tell you why the exception was not approved.

Urgent or emergency need of a specialty drug subject to the specialty drug program. If you are out of a *specialty drug* which must be obtained through the specialty drug program, the *claims administrator* will authorize an override of the specialty drug program requirement for 72-hours, or until the next business day following a holiday or weekend, to allow you to get an emergency supply of medication if your doctor decides that it is appropriate and *medically necessary*. You may have to pay the applicable co-payment shown under SUMMARY OF BENEFITS: PRESCRIPTION DRUG BENEFITS: PRESCRIPTION DRUG CO-PAYMENTS for the 72-hour supply of your *drug*.

If you order your *specialty drug* through the specialty drug program and it does not arrive, if your *physician* decides that it is *medically necessary* for you to have the *drug* immediately, the *claims administrator* will authorize an override of the specialty drug program requirement for only a 30-day supply or less, to allow you to get an emergency supply of medication from a *participating pharmacy* near you. A Dedicated Care Coordinator from the specialty drug program will coordinate the exception.

7. It must not be used while you are confined in a *hospital, skilled nursing facility*, rest home, sanitarium, convalescent hospital, or similar facility. Also, it must not be dispensed in or administered by a *hospital, skilled nursing facility*, rest home, sanitarium, convalescent hospital, or similar facility. Other *drugs* that may be prescribed by your *physician* while you are confined in a rest home, sanitarium, convalescent hospital or similar facility, may be purchased at a *pharmacy* by the member, or a friend, relative or care giver on your behalf, and are covered under this *prescription drug* benefit.
8. For a retail *pharmacy* or specialty drug program, the *prescription* must not exceed a 30-day supply.

Prescription drugs federally-classified as Schedule II which are FDA-approved for the treatment of attention deficit disorder must not exceed a 60-day supply. If the *physician* prescribes a 60-day supply for *drugs* classified as Schedule II for the treatment of attention deficit disorders, the *member* has to pay double the amount of co-payment for retail *pharmacies*. If the *drugs* are obtained through the home

delivery program, the co-payment will remain the same as for any other *prescription drug*.

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

9. Certain *drugs* have specific quantity supply limits based on the analysis of prescription dispensing trends and the Food and Drug Administration dosing recommendations.
10. For the home delivery program, the *prescription* must not exceed a 90-day supply.
11. The *drug* will be covered under YOUR PRESCRIPTION DRUG BENEFITS only if it is not covered under another benefit of your *plan*.
12. *Drugs* for the treatment of impotence and/or sexual dysfunction are limited to six tablets/units for a 30-day period and are available at retail *pharmacies* only. Documented evidence of contributing medical condition must be submitted to the *claims administrator* for review.
13. It must be prescribed by a licensed *physician* with an active Drug Enforcement Administration (DEA) license, if the *drug* is considered a *controlled substance*.

PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED

1. Outpatient *drugs* and medications which the law restricts to sale by *prescription*, except as specifically stated in this section. Formulas prescribed by a *physician* for the treatment of phenylketonuria. These formulas are subject to the co-payment for *brand name drugs*.
2. Insulin.
3. Syringes when dispensed for use with insulin and other self-injectable *drugs* or medications.
4. *Drugs* with Food and Drug Administration (FDA) labeling for self-administration.
5. All compound *prescription drugs* when a commercially available dosage form of a *medically necessary* medication is not available, all the ingredients of the compound *drug* are FDA approved in the form in which they are used in the *compound medication*, require a prescription to dispense and are not essentially the same as an FDA approved product from a *drug* manufacturer. Non-FDA approved non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.

6. Diabetic supplies (i.e. test strips and lancets).
7. Inhaler spacers and peak flow meters for the treatment of pediatric asthma. These items are subject to the co-payment for *brand name drugs*.
8. *Prescription drugs*, vaccinations (including administration), vitamins, supplements, and certain over-the-counter items as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS, subject to all terms of this *plan* that apply to those benefits.
9. *Prescription drugs* for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.
10. *Drugs* used for the purpose of treating infertility, limited to a lifetime maximum of **\$15,000** for any *member*.

PREScription DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED

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

1. Hypodermic syringes and/or needles except when dispensed for use with insulin and other self-injectable *drugs* or medications. While not covered under this *prescription drug* benefit, these items are covered under the "Home Health Care," "Hospice Care," "Infusion Therapy or Home Infusion Therapy," and "Diabetes" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.
2. *Drugs* and medications used to induce spontaneous and non-spontaneous abortions. While not covered under this *prescription drug* benefit, FDA approved medications that may only be dispensed by or under direct supervision of a *physician*, such as *drugs* and medications used to induce non-spontaneous abortions, are covered as specifically stated in the "Prescription Drug for Abortion" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to the benefit.

3. Drugs and medications dispensed or administered in an outpatient setting; including, but not limited to, outpatient hospital facilities and physicians' offices. While not covered under this *prescription drug* benefit, these services are covered as specified under the "Hospital," "Home Health Care," "Hospice Care," and "Infusion Therapy or Home Infusion Therapy" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.
 4. Professional charges in connection with administering, injecting or dispensing of *drugs*. While not covered under this *prescription drug* benefit, these services are covered as specified under the "Professional Services" and "Infusion Therapy or Home Infusion Therapy" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.
 5. Drugs and medications which may be obtained without a physician's written *prescription*, except insulin or niacin for cholesterol reduction.
- Note:** Vitamins, supplements, and certain over-the-counter items as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS are covered under this *plan* only when obtained with a physician's *prescription*, subject to all terms of this *plan* that apply to those benefits.
6. Drugs and medications dispensed by or while you are confined in a hospital, skilled nursing facility, rest home, sanitarium, convalescent hospital, or similar facility. While not covered under this *prescription drug* benefit, such *drugs* are covered as specified under the "Hospital", "Skilled Nursing Facility", and "Hospice Care", provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits. While you are confined in a rest home, sanitarium, convalescent hospital or similar facility, *drugs* and medications supplied and administered by your physician are covered as specified under the "Professional Services" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to the benefit. Other *drugs* that may be prescribed by your physician while you are confined in a rest home, sanitarium, convalescent hospital or similar facility, may be purchased at a pharmacy by the member, or a friend, relative or care giver on your behalf, and are covered under this *prescription drug* benefit.

7. Durable medical equipment, devices, appliances and supplies, even if prescribed by a *physician*, except *prescription contraceptives* as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS. While not covered under this *prescription drug* benefit, these items are covered as specified under the "Durable Medical Equipment", "Hearing Aid Services", and "Diabetes" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.
8. Services or supplies for which you are not charged.
9. Oxygen. While not covered under this *prescription drug* benefit, oxygen is covered as specified under the "Hospital", "Skilled Nursing Facility", "Home Health Care" and "Hospice Care" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.
10. Cosmetics and health or beauty aids. However, health aids that are *medically necessary* and meet the requirements for durable medical equipment as specified under the "Durable Medical Equipment" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), are covered, subject to all terms of this *plan* that apply to that benefit.
11. Drugs labeled "Caution, Limited by Federal Law to Investigational Use" or Non-FDA approved investigational drugs. Any drugs or medications prescribed for *experimental* indications. If you are denied a *drug* because the *claims administrator* determines that the *drug* is *experimental* or *investigative*, you may ask that the denial be reviewed.
12. Any expense incurred for a *drug* or medication in excess of: *prescription drug maximum allowed amount*.
13. Drugs which have not been approved for general use by the Food and Drug Administration. This does not apply to drugs that are *medically necessary* for a covered condition.
14. Drugs used primarily for cosmetic purposes (e.g., Retin-A for wrinkles). However, this will not apply to the use of this type of *drug* for *medically necessary* treatment of a medical condition other than one that is cosmetic.
15. Anorexiants and *drugs* used for weight loss except when used to treat morbid obesity (e.g., diet pills and appetite suppressants). This exclusion does not apply to *drugs* used for weight loss which are listed as covered under the PreventiveRx program, if included.

16. Drugs obtained outside of the United States unless they are furnished in connection with *urgent care* or an *emergency*.
17. Allergy desensitization products or allergy serum. While not covered under this *prescription drug* benefit, such *drugs* are covered as specified under the "Hospital", "Skilled Nursing Facility", and "Professional Services" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.
18. Infusion *drugs*, except *drugs* that are self-administered subcutaneously. While not covered under this *prescription drug* benefit, infusion *drugs* are covered as specified under the "Professional Services" and "Infusion Therapy or Home Infusion Therapy" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.
19. Select classes of *drugs* where non-preferred medications, which have therapeutic alternatives, have shown no benefit regarding efficacy or side effect over *preferred drugs*. However, this will not apply if the prescriber denotes "dispense as written" or "do not substitute" or requests prior authorization by calling the number on the back of your ID Card.
20. Herbal supplements, nutritional and dietary supplements, except as described in this *plan* or what must be covered by law. This exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written *prescription* or from a licensed pharmacist.

However, formulas prescribed by a *physician* for the treatment of phenylketonuria that are obtained from a *pharmacy* are covered as specified under PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED. Special food products that are not available from a *pharmacy* are covered as specified under the "Phenylketonuria (PKU)" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to the benefit. Also, vitamins, supplements, and certain over-the-counter items as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS are covered under this *plan* only when obtained with a *physician's prescription*, subject to all terms of this *plan* that apply to those benefits.
21. *Prescription drugs* with a non-prescription (over-the-counter) chemical and dose equivalent except insulin, even if written as a *prescription*. This does not apply if an over-the-counter equivalent was tried and was ineffective.

22. Onychomycosis (toenail fungus) *drugs* except to treat *members* who are immuno-compromised or diabetic.
23. *Prescription drugs* that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material, thus treating a disease or abnormal medical condition.
24. All compound *prescription drugs* when a commercially available dosage form of a *medically necessary* medication is not available, all the ingredients of the *compound drug* are FDA approved in the form in which they are used in the *compound medication*, require a prescription to dispense and are not essentially the same as an FDA approved product from a *drug* manufacturer. Non-FDA approved non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered. **You will have to pay the full cost of the *compound medications* you get from a *non-participating pharmacy*.**
25. *Specialty drugs* that must be obtained from the specialty pharmacy program, but, which are obtained from a retail *pharmacy* or through the home delivery program. Unless you qualify for an exception, these *drugs* are not covered by this *plan* (please see YOUR PRESCRIPTION DRUG BENEFITS: PRESCRIPTION DRUG CONDITIONS OF SERVICE). **You will have to pay the full cost of the *specialty drugs* you get from a retail *pharmacy* that you should have obtained from the specialty pharmacy program.**

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

26. Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.
27. *Drugs* which are over any quantity or age limits set by the *plan* or the *claims administrator*.
28. *Prescription drugs* prescribed by a provider that does not have the necessary qualifications, registrations and/or certifications.
29. *Drugs* prescribed, ordered, referred by or given by a member of your immediate family, including your *spouse, child, brother, sister, parent, in-law or self*.
30. Services the *claims administrator* concludes are not *medically necessary*. This includes services that do not meet medical policy, clinical coverage, or benefit policy guidelines.

31. Any *investigative drugs* or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a covered service under this *plan* for non-*investigative* treatments.
32. Any treatment, device, *drug*, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
33. *Prescription drugs* related to the medical and surgical treatment of excessive sweating (hyperhidrosis).
34. 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*.
35. Certain *prescription drugs* may not be covered if you could use a clinically equivalent *drug*, unless required by law. “Clinically equivalent” means *drugs* that for most *members*, will give you similar results for a disease or condition. If you have questions about whether a certain *drug* is covered and which *drugs* fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com.

If you or your *physician* believes you need to use a different *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 *prescription drug* is still *medically necessary*.

COORDINATION OF BENEFITS

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

DEFINITIONS

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

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

The following are not Allowable Expense:

1. Use of a private hospital room is not an Allowable Expense unless the patient's stay in a private *hospital* room is *medically necessary* in terms of generally accepted medical practice, or one of the 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, including a self-insured program.

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

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

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

EFFECT ON BENEFITS

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

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

ORDER OF BENEFITS DETERMINATION

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

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

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

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

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

- a. If the parent with custody of that *child* for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that *child* as a dependent pays first.
- b. If the parent with custody of that *child* for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:
 - i. The plan which covers that *child* as a dependent of the parent with custody.
 - ii. The plan which covers that *child* as a dependent of the stepparent (married to the parent with custody).
 - iii. The plan which covers that *child* as a dependent of the parent without custody.

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

OUR RIGHTS UNDER THIS PROVISION

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

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

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

Right of Recovery. If payments made under This Plan exceed the maximum payment necessary to satisfy the intent of this provision, we have the right to recover that excess amount from any persons or

organizations to or for whom those payments were made, or from any insurance company or service plan.

BENEFITS FOR MEDICARE ELIGIBLE MEMBERS

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

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

1. You are receiving treatment for end-stage renal disease following the first 30 months you are entitled to end-stage renal disease benefits under Medicare; or
2. You are entitled to Medicare benefits as a disabled person, unless you have a current employment status as determined by Medicare rules through a group of 100 or more employees (according to federal OBRA legislation).

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

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

Except when federal law requires us to be the primary payer, the benefits under this *plan* for *members* age 65 and older, or for *members* who are otherwise eligible for Medicare (such as due to a disability or receiving treatment for end-stage renal disease), will not duplicate any benefit for which *members* are entitled under Medicare, including Medicare Part B. Where Medicare is the responsible primary payer, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to the *claims administrator*, to the extent the *claims administrator* has made primary payment for such services. If you do not enroll in Medicare Part B when you are eligible, you may have large out-of-pocket

costs. Please refer to [Medicare.gov](#) for more details on when you should enroll, and when you are allowed to delay enrollment without penalties.

UTILIZATION REVIEW PROGRAM

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

REVIEWING WHERE SERVICES ARE PROVIDED

A service must be *medically necessary* to be a covered service. When level of care, setting or place of service is reviewed, services that can be safely given to you in a lower level of care or lower cost setting / place of care, will not be *medically necessary* if they are given in a higher level of care, or higher cost setting / place of care. This means that a request for a service may be denied because it is not *medically necessary* for the service to be provided where it is being requested. When this happens the service can be requested again in another place and will be reviewed again for medical necessity. At times a different provider or facility may need to be used in order for the service to be considered *medically necessary*. Examples include, but are not limited to:

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

Utilization review criteria will be based on many sources including medical policy and clinical guidelines. 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 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 setting or place of service that they are performed.

- Pre-service Review – A review of a service, treatment or admission for a benefit coverage determination prior to the service or treatment begins or admission date.

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.

– Both pre-service and continued stay / concurrent reviews may be conducted 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

1. You must be eligible for benefits; an standard reviews.
2. The service or supply must be a covered service under your plan; for a benefit coverage that is conducted after the service has been

3. The service ~~cannot~~ be subject to an exclusion under your *plan* (please see MEDICAL CARE THAT IS NOT COVERED for more information) and a needed precertification was not obtained. Post-service reviews are done for a service, treatment or admission if ~~when~~ *HealthPlan* has a related clinical coverage guideline and are typically initiated by the claims administrator.
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. 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:

- **Precertification** – A required pre-service review for a benefit

Note: coverage determination for a service or treatment. Certain services require precertification in order for you to get benefits. required for services the results of which you would have been otherwise entitled will be subject to the Non-Certification Deductible shown in the SUMMARY OF BENEFITS. *Investigative* as those terms are defined in this booklet.

- Scheduled, non-emergency inpatient hospital stays and 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.

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

◆ 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.

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

- Organ and tissue transplants, including transplant travel, as

- **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.

◆ For kidney, bone, skin or cornea transplants, if the physician

◆ on the surgical team and the facility in which the transplant is

◆ to take place are approved for the transplant requested.

- 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, number of additional visits may be authorized. While there is no

treatment or admission did not need pre-certification or when a needed pre-certification 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.

- Infusion therapy or home infusion therapy, if the attending Services for which pre-certification 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:

- Admissions to a skilled nursing facility if you require daily skilled

Note: The appropriate utilization reviews must be performed in accordance with this plan. When pre-service review is not performed as required for services, the benefits to which you would have been otherwise entitled will be subject to the Non-Certification Deductible shown in the SUMMARY OF BENEFITS.

- The services are to be performed for the treatment of morbid scheduled; non-emergency inpatient hospital stays and residential treatment center admissions, including detoxification and rehabilitation on the surgical team and the facility in which the surgical procedure is to take place are approved for the

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

- The obstetric surgery procedure will be performed at a CME facility, or 96 hours or less following a cesarean section, and
- Mastectomy and lymph node dissection limited to: Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scan), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and Nuclear Cardiac Imaging. You may call the toll-free member services telephone number on your identification card to find information on our services pre-service review.
- For kidney, bone, skin or corneal transplants if the physicians on the surgical team and the facility in which the transplant is to take place are approved for the transplant requested.
- All interventional spine pain, elective hip, knee, and shoulder
- For transplantation of liver, heart, heart-lung, lung, kidney, pancreas or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures if the providers of the related preoperative and postoperative services are approved and the transplant will be performed at a Centers of Medical Excellence (CME) facility.
- 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.
- Visits for physical therapy, physical medicine and occupational therapy beyond those described under the "Physical Therapy, Physical Medicine and Occupational Therapy" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED. A specified number of additional visits may be authorized. While there is no limit on the number of covered visits for medically necessary

- physical therapy, physical medicine, and occupational therapy, additional visits in excess of the stated number of visits must be authorized in advance; transgender services.

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

WHO IS RESPONSIBLE FOR PRECERTIFICATION?

- Admissions to a skilled nursing facility if you require daily skilled nursing or rehabilitation, as certified by your attending physician. Typically, participating providers know which services need precertification and will get any precertification when needed. Your physician or other participating provider has been given detailed information about those procedures and responsible for meeting those requirements. Generally, the ordering provider, hospital or attending physician ("requesting provider") will get in touch with the claims administrator. The services are to be performed for the treatment of morbid obesity, 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.

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

Provider Network	Responsibility to Get Precertification	Comments
Participating Providers	<p>• Select imaging procedures, including but not limited to: Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scan), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and Nuclear Cardiac Imaging. 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.</p>	<p>• The provider must get pre-certification when required.</p>
Non-Participating Providers	<p>• All interventional spine pain, elective hip, knee, and shoulder arthroscopic/open sports medicine, and outpatient spine surgery procedures must be authorized in advance.</p> <p>• 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.</p> <p>• Behavioral health treatment for autism spectrum disorders, as specified in the section BENEFITS FOR AUTISM SPECTRUM DISORDERS.</p>	<p>• Member must get pre-certification when required (Call Member Services).</p> <p>• Member may be financially responsible for charges or costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be medically necessary.</p>

Provider Network Status	Responsibility to Get Precertification	Comments
Participating	<ul style="list-style-type: none"> Inpatient admission related to transgender surgery services, including transgender travel expense. Precertification is not required for all other transgender services. 	For a list of current procedures requiring precertification, please call the toll-free number or Member Services printed on your ID card. Your provider (Except for admissions) 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 be medically necessary.
Non-Participating Providers	<p>HOW DECISIONS ARE MADE</p> <p>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 care. The claims administrator reserves the right to review and update these clinical coverage guidelines from time to time.</p>	<ul style="list-style-type: none"> The provider must get precertification for all inpatient admissions. The provider must get precertification when the admission or as soon as possible within a reasonable period of time. <p>Member may be financially responsible for charges or costs related to the service and/or setting in whole or in part if the service and/or setting is found to be medically necessary.</p>
		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.

Provider Network Status	Responsibility to Get Precertification	Comments
DECISION AND NOTICE REQUIREMENTS		
Blue Card Member Provider <small>(Except for Inpatient Admissions)</small>	<ul style="list-style-type: none"> Member must get precertification when required. (Call Member Services.) Member may plan be issued, other state-specific requirements may financially responsible 	Provider will review requests for medical necessity when required. 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 you are issued, other state-specific requirements may apply. You are responsible for charges or costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be medically necessary.
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	<ul style="list-style-type: none"> Blue Card Providers must obtain precertification for all Inpatient Admissions.
Urgent Continued Stay / Concurrent Review when hospitalized at the time of the request and no previous authorization exists	24 hours from the end of the request. We may request additional information within the first 24 hours and then extend to 24 hours from the receipt of the request.	<p>Note: For an emergency admission, precertification is not required. However, you, your authorized representative or physician must notify the claims administrator within 24 hours of the admission or as soon as possible within a reasonable period of time.</p>
HOW DECISIONS ARE MADE		
Urgent Continued Stay / Concurrent Review	72 hours from the receipt of the request	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.
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	

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. Within the required timeframe identified in the written notice, a decision will be based upon the information we have.

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.

Revoking or modifying a Precertification Review decision. The claims administrator will determine in advance the requirement for (including procedures and admissions) Decisionally necessary, including treatment of mental health or substance use disorder, 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:

Non-Urgent Pre-Service Review	15 business days from the receipt of the request
• Your coverage under this plan ends.	
• Urgent Continued Stay / Concurrent Review when hospitalized at the time of the request and no previous authorization exists	24 hours from the receipt of the request. We may request additional information within the first 24 hours and then extend to 72 hours from the receipt of the request.
• Your benefits under the plan change so that the service is no longer covered or is covered in a different way.	

Urgent Continued Stay / Concurrent Review when request is received at least 24 hours before the end of the previous authorization

The health plan individual case management program enables the claims administrator to assist you to obtain medically appropriate care in a more efficient and cost effective manner. Through a case manager, the claims administrator will discuss possible options for an alternative plan of care 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 the authority to provide concurrent review.

HOW HEALTH PLAN INDIVIDUAL CASE MANAGEMENT WORKS

Post-Service Review
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.

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

The claims administrator will notify you and your physician of the plan's decision as required by state and federal law. Notice may be given by one or more of the following methods: verbal, written and/or electronic, chosen authorized representative, treating physicians, and other providers. For a copy of the medical necessity review process, please contact Member Services at the telephone number on the back of your ID card 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. Revoking or modifying a Precertification Review decision. The claims administrator will determine in advance whether certain services (including procedures and admissions) are medically necessary, including treatment of mental health or substance use disorder, 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: A decision will be made on a case-by-case basis by the claims administrator if it determines that the alternate or extended benefit is in the best interest for you and the plan and you or your authorized representative agree to the alternate or extended benefit in writing. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to you or to any other member. The claims administrator may change the plan to reflect the fact that the service is no longer covered or is covered in a different way. In such case, the claims administrator will notify you or your authorized representative in writing.

HEALTH PLAN INDIVIDUAL CASE MANAGEMENT EXCEPTIONS TO THE UTILIZATION REVIEW PROGRAM

The health plan individual case management program enables the claims administrator to assist you to obtain medically appropriate care in a more economical, cost-effective and coordinated manner during prolonged periods of intensive medical care. Through a case manager, the claims administrator will discuss possible options for an alternative plan of treatment which may include services not covered under this plan. It is not your right to receive individual case management, nor does the claims administrator have an obligation to provide it. The claims administrator has certain procedural or medical management processes that would otherwise apply. The claims administrator may stop or modify any such exemption with or without advance notice.

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 claims administrator may stop or modify any such exemption with or without advance notice.

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. 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 members. 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 teamwork with you and/or your chosen authorized representative, treating physicians, and other providers. claims administrator's online provider directory on the website at www.anthem.com/cars or by calling the Member Services telephone number listed on your ID card. In addition, the claims administrator may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

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

EXCEPTIONS TO THE UTILIZATION REVIEW PROGRAM

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

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

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

You may determine whether a health care provider participates in certain programs or a provider arrangement by checking the *claims administrator*'s online provider directory on the website at www.anthem.com/ca or by calling the Member Services telephone number listed on your ID card. When any of the key terms shown below appear in these provisions, the first letter of each word will appear in capital letters. When you see these capitalized words, you should refer to this "Definitions" provision.

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

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

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

1. For Subscribers and Dependents:

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

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

3. For Dependents

CONTINUATION OF COVERAGE

a. The death of the subscriber:

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.

b. The end of a child's status as a dependent child:

as defined by the plan; or

DEFINITIONS

e. The subscriber's entitlement to Medicare.

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.

ELIGIBILITY FOR COBRA CONTINUATION

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

TERMS OF COBRA CONTINUATION

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

plan administrator will notify either the subscriber or dependent of the right to continue coverage under COBRA, as provided below. Qualified Beneficiary means: (a) a person enrolled for this COBRA continuation coverage who, on the day before the Qualifying Event, was covered under this plan as either a subscriber or dependent; and (b) a child who is born to or placed for adoption with the subscriber during the COBRA continuation period. Qualified Beneficiary does not include any person who was not enrolled during the Initial Enrollment Period, including any family members acquired during the COBRA continuation period with the exception of newborns and adoptees as specified above.

3. You must inform the plan administrator within 60 days of Qualifying Events 2(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.

The events will be referred to throughout this section by number.

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 rights. The subscriber's termination of employment, for any reason other than gross misconduct, members.

If you loss of coverage COBRA terminates after the initial enrollment Period, reduction in the subscriber's work hours at a later date.

2. For Retired Subscribers and their Dependents. Cancellation of substantial reduction of retiree benefits under the plan due to the company'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.

8.05 For Dependents: 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.

a. The death of the subscriber;

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

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

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

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

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

ELIGIBILITY FOR COBRA CONTINUATION

3. A child if neither the subscriber nor the spouse has enrolled for this COBRA continuation coverage (for example, if the subscriber or spouse is eligible for COBRA continuation coverage under another plan, the subscriber will be covered under that plan at the same rate depending on the number of children enrolled); and

TERMS OF COBRA CONTINUATION

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

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

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

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

For example, a child may have been originally eligible for this COBRA continuation due to termination of the subscriber's employment, and Events 3(b) or 3(c) above if you wish to continue coverage. The plan 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

should 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 initial Qualifying Event or to the point in coverage occurs.

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 according to the enrollment provisions of the plan.

Additional Dependents. A spouse, domestic partner or child acquired during the COBRA continuation period is eligible to be enrolled as a family member. The standard enrollment provisions of the policy apply to enrollees during the COBRA continuation period.^{*}

^{*}Event was termination of employment or reduction in work hours;*

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.

3. The end of 36 months from the date the subscriber became entitled to Medicare. If entitlement to Medicare does not result in coverage

1. A spouse whose COBRA continuation began due to divorce, separation or death of the subscriber; Medicare entitlement coverage for Qualified Beneficiaries other than

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

4. The date the plan terminates;

5. The end of the period for which required monthly contributions are last paid; the required monthly contribution will be the two-party or three-party rate depending on the number of children enrolled); and

6. The date, following the election of COBRA, the member first becomes covered under any other group health plan, or meeting the dependent child definition.

7. The date, following the election of COBRA, the member first becomes entitled to Medicare. However, entitlement to Medicare will not

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; this term will be dated from the time of the Qualifying Event under that prior plan.

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), 5 or 6 above.

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

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, the end of a domestic partnership or the end of dependent child status;
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 became entitled to Medicare, if the Qualifying Event was the subscriber's entitlement to coverage under a group health plan, the entitlement to Medicare does not result in coverage terminating and Qualifying Event 1 occurs within 18 months after 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
4. The date the plan terminates;
5. Be determined and certified to be so disabled by the Social Security Administration.

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.

2. The date on which the original Qualifying Event occurs;
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.

3. The date on which the Qualified Beneficiary loses coverage, or
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, if 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.

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.

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 the extension begins, 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;

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:

5. The date, following the election of COBRA, the member first becomes disabled;
1. The date of the Social Security Administration's determination of the disability;
6. The date, following the election of COBRA, the member first becomes disabled;
2. The date on which the original Qualifying Event occurs; care will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2;
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:

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 coverage during this extension, this charge shall remain at 102% of the applicable rate.

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 each month during the period of extended continuation coverage. We must receive timely payment of the required monthly contribution. Inability 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

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.

once every 90 days while benefits are extended, we must receive

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

3. 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:
 - a. 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;
 - d. A period of up to 12 months has passed since your extension
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. The physician and other healthcare professionals, hospitals, skilled nursing facilities and other community agencies are not the claims administrator's agents nor is the claims administrator an employee or agent of any hospital, medical group or medical care provider of any type. 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 Inter Plan Arrangements.

Out of Service 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. Assess within 90 days of the date of your discharge. Thereafter, we must

outs receive proof of your continuing total disability at least once every 90 days while benefits are extended. may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

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 you or we must receive ("proof that your total disability is continuing") from 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.

a. You are no longer totally disabled.

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.

d. A period of up to 12 months has passed since your extension A. BlueCard® Program

GENERAL PROVISIONS

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.

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. The amount you pay is calculated based on the lower of the billed charges for covered services, or the estimated price that the Host Blue makes available to the claims administrator.

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. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and other credits or charges.

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.

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. 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. 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.

Inter-Plan Arrangements Eligibility – Claim Types

C. Special Cases: Value-Based Programs 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.

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 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: for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program. The billed charges for covered services; or

D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees The negotiated price that the Host Blue makes available to the claims administrator.

Federal or state laws or regulations may require a surcharge, tax or other fee. 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.

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 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. be based on that allowed amount. Also, you may be responsible for the difference between the amount that the non-participating

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.

2. Exceptions

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

In certain situations, the claims administrator may use other pricing methods such as billed charges or the pricing we would use if the Health Care 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.

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.

If you plan to travel outside the United States, call Member Services for information about your Blue Cross Blue Shield Global Core benefits. Benefits for services received outside of the United States may be different from those in the United States. (non-BlueCard Program)

Arrangements

When you are traveling abroad and need medical care, you can call the Blue Cross Blue Shield Global Core Service Center. They will help you find a Host Blue (or another provider) that offers services in your destination. Anthem Blue Cross will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program. If you need inpatient hospital care, you or someone on your behalf, should contact the claims administrator for preauthorization. Keep in mind, if you

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

There is no need to call before you receive care.

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you. Get pre-authorization when you need to be admitted to the hospital for emergency or non-emergency care.

E. Non-participating Providers Outside Our Service Area

How Claims are Paid with Blue Cross Blue Shield Global Core

1. Allowed Amounts and Member Liability Calculation

In most cases, when you arrange inpatient hospital care with Blue Cross Blue Shield Global Core, claims will be paid for you. The only amounts that you may need to pay up front are any copayment or deductible amounts that may apply. 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 You will be required to pay applicable state or federal law. In these situations, the

- *Plan* amount you pay for such services as deductible or co-payment will be based on that allowed amount. Also, you may be responsible for the difference between the amount that the non-participating provider bills and the payment the *claims administrator* will make for the covered services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network
- *Outpatient services*. You will find the address for mailing the claim on the form for any payments made up front.

2. When can you get Blue Cross Blue Shield Global Core claim forms? You can get international claims forms in the following ways:

- In certain situations, the *claims administrator* may use other pricing methods, such as billed charges or the price 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.
- Online at www.hipspolare.com.

You will find the address for mailing the claim on the form for any payments made up front.

- 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.

F. Blue Cross Blue Shield Global Core Program
If you plan to travel outside the United States, call Member Services for information about your Blue Cross Blue Shield Global Core benefits. Benefits for services received outside of the United States may be different from services received in the United States.

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

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 gender expression.

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*.

How Claims are Paid with Blue Cross Blue Shield Global Core
Free Choice of Provider. This *plan* in no way interferes with your right to choose any other health care professional or facility which provides care covered under this *plan*, and is properly licensed according to appropriate

state Physician services; However, your choice may affect the benefits payable according to this plan.

- Inpatient hospital care not arranged through Blue Cross Blue Shield Pro Global Core, and

Outpatient services. Physicians and other professional providers

are paid on a fee-for-service basis, according to an agreed schedule. A participating physician may, after notice from the claims administrator, be subject to a reduced negotiated rate in the event the participating

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

When you need Blue Cross Blue Shield Global Core claim forms you can

get international claims forms in the following ways:

- Call the Blue Cross Blue Shield Global Core Service Center at the Other numbers above, or arrangement are Payment Innovation Programs.

These programs may include financial incentives to help improve quality of care and reduce costs of health care services in a cost-efficient

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

Terms of Coverage designed to tie a certain portion of a participating

provider's total compensation to pre-defined quality, cost, efficiency or

1. In order for you to be entitled to benefits under the plan, both the plan

may and your coverage under the plan must be in effect on the date the

expense giving rise to a claim for benefits is incurred.

The programs are not intended to affect the member's access to health care.

2. The benefits to which you may be entitled will depend on the terms of

The program payments are not made as payment for specific covered

coverage in effect on the date the expense giving rise to a claim for

services provided to the member, but instead are based on the

participating provider's achievement of these pre-defined standards. The

member is not responsible for any co-payment amounts related to

3. The plan is subject to amendment, modification or termination

member does not share in any payments made by participating providers

according to the provisions of the plan without your consent or

to the plan under the programs.

Availability of Care. If there is an epidemic or public disaster and you

cannot obtain care for covered services, we retain the unearned part of

the required monthly contribution paid. A written request for that refund

and satisfactory proof of the need for care must be sent to us within 31

days. This payment fulfills our obligation under this plan.

Protection of Coverage. We do not have the right to cancel your

Medical Necessity. The benefits of this plan are provided only for

services which the claims administrator determines to be medically

necessary. The services must be ordered by the attending physician for

the direct care and treatment of a covered condition. They must be

Free Choice of Provider. This plan in no way interferes with your right

as a member to receive 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 Transfer However, your choice may affect the benefits payable according to this plan. Right to benefits cannot be transferred.

Provider Reimbursement. Physicians and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. A participating physician may, after notice from the claims administrator, be subject to a reduced negotiated rate in the event the participating physician fails to make routine referrals to participating providers, except as otherwise allowed (such as for emergency services). Hospitals and other health care facilities may be paid either a fixed fee or on a discounted fee-for-service basis. If the claim does not include enough information, we will ask them for more details, and they will be required to supply these details within certain timeframes.

Other forms of payment arrangement are Payment Innovation Programs.

• Non-participating provider claims can be submitted by the physician if the physician is willing to file on your behalf. However, if the physician is not submitting on your behalf, you will be required to submit the claim. Claim forms are usually available from the Provider. If they do not have a claims form, you can send a written request to the claims provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, participating providers may be required to make payment to the plan under the program as a consequence of failing to meet these pre-defined standards. The programs are not intended to affect the member's access to health care.

The program payments are not made as payment for specific covered services provided to the member, but instead, are based on the participating provider's achievement of these pre-defined standards.

• **Name of patient.** The member is not responsible for any copayment amounts related to payments made by the plan or to the plan under the programs and the member does not share in any payments made by participating providers to the plan under the programs.

• Date, type, and place of service.

Availability of Care. If there is an epidemic or public disaster and you cannot obtain care for covered services, we refund the unearned part of the required monthly contribution paid. A written request for that refund and satisfactory proof of the need for care must be sent to us within 31 days. This payment fulfills our obligation under this plan.

Non-participating provider claims must be submitted within 180 days after the date of service. In certain cases, state or federal law may allow additional time to file a claim, if you could not reasonably file within the 180-day period.

Medical Necessity. The benefits of this plan are provided only for medical services which the claims administrator determines to be medically necessary. The services must be ordered by the attending physician for the direct care and treatment of a covered condition. They must be standard medical practice where received for the condition being treated and must be legal in the United States. The process used to authorize or deny health care services under this plan is available to you upon request.

Claims submitted by a public (government operated) hospital or clinic will be paid by us directly, as long as you have not already received benefit under that claim.

Expense in Excess of Benefits. We are not liable for any expense you incur in excess of the benefits of this plan. You may request that we review the claim a second time, and you may submit any additional relevant information.

Benefits Not Transferable Only the member is entitled to receive benefits under this plan. The right to benefits cannot be transferred unless state or federal law requires an extension. Please contact Member Services if you have any questions or concerns about how to submit claims.

After you get covered services, the *claims administrator* must receive written notice of your claim in order for benefits to be paid.

Member's Cooperation. You will be expected to complete and submit to the *claims administrator* all such authorizations, consents, releases,

- *Participating providers* will submit claims for you. They are responsible for ensuring that claims have the information we need to determine benefits. If the claim does not include enough information, we will ask them for more details, and they will be required to supply those details within certain timeframes.

- 61 - 253 / 2 - 104 You authorize the *claims administrator*, in its own discretion, and on behalf of the employer, to make payments directly to the physician if the physician is willing to file on your behalf. However, if the physician is not submitting on your behalf, you will be required to submit the claim. Claim forms are usually available from the Provider. If they do not have a claims form, you can send a written request to the *claims administrator*, or contact Member Services and ask for a claims form to be sent to you. If you do not receive the claims form, you can still submit written notice of the claim without the claim form. The same information that would be given on the claim form must be included in the written notice of claim, including:

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

Non-participating provider claims must be submitted within 180 days after the date of service.

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

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. A denial of a claim made without written consent from the plan will be valid and enforceable.

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

Please note that failure to submit the information we need by the time listed in our request could result in the denial of your claim, unless state or federal law requires an extension. Please contact Member Services if you have any questions or concerns about how to submit claims. 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 care. In some instances, participating providers may be required to make assignments and other documents that may be needed in order to obtain 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 other programs. If you fail to cooperate, you will be responsible for any charge for services.

Payment of Benefits. 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 200 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 coinsurance, the claims administrator may collect such amounts directly from you. You agree that the claims administrator has the right to recover such amounts from you. The obligation to pay for covered services remains with the plan. 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 if payment is not feasible.

The claims administrator has established recovery policies to determine 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' claims where the non-participating provider

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.

Plan Administrator: COBRA and ERISA. If the 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 CALIFORNIA INSTITUTE OF TECHNOLOGY or to a person or entity other than the claims administrator, engaged by CALIFORNIA INSTITUTE OF TECHNOLOGY to perform or assist in performing administrative tasks in connection with the plan. The plan administrator's responsibility to satisfaction of notice disclosure and other obligations of administration 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. Under certain circumstances, if the claims administrator pays your healthcare provider amounts that are your responsibility, such as deductibles, co-payments or co-insurance, the claims administrator may collect such amounts directly from you. You agree that the claims administrator has the right to recover such amounts from you if you contribute all or part of the costs of these required monthly contributions. 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.

Renewal Provisions. The plan is subject to renewal at certain intervals. 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.

Financial Arrangements with Providers. The claims administrator has entered into a contract with the healthcare provider and its affiliates (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. The claims administrator reserves the right to deduct or offset, including cross plan offsetting on participating provider claims and on non-participating providers claims where the non-participating providers

~~agrees to crossplan offsetting many amounts paid in error from any pending or future claim. In addition, 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 by affiliate for the same medical services. In negotiating the terms of the plan, the plan administrator was aware that the claims administrator owns affiliates offering several types of products and programs. The members, members and plan administrator are entitled to receive the benefits of any those discounts, payments, settlements, incentives, adjustments and/or allowances specifically set forth in the plan.~~

~~Also, under arrangements with some providers, certain discounts, payments, rebates, settlements, incentives, adjustments and/or allowances, including, but not limited, to pharmacy rebates, may be based to a person or entity other than the claims administrator, engaged by CALIFORNIA INSTITUTE OF TECHNOLOGY to perform or assist in respect to all health care services rendered to all persons who have performed 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.~~

Transition Assistance for New Members: Transition Assistance is a process that allows for completion of covered services for new members receiving services from a non-participating provider. If you are a new member, you may request transition assistance if any one of the following conditions applies:

Prepayment Fees. The plan administrator may require that you contribute all or part of the costs of these required monthly contributions.

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.

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 affiliate is a party, including all persons covered under the plan, within twelve (12) months from the time you enroll in this 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.

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

Transition Assistance for New Members: Transition Assistance is a process that allows for completion of covered services for new members receiving services from a non-participating provider. If you are a new member, you may request Transition Assistance if any one of the following conditions applies: non-participating providers are negotiated on a case-by-case basis. The non-participating provider will be asked to agree to accept reimbursement and contractual requirements that apply to participating providers, including payment terms. If the non-participating provider does not agree to accept said reimbursement and contractual requirements, the non-participating provider's services will not be provided for the duration of the acute condition.

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 disciplinary cause or reason, fraud or other criminal activity. If your physician leaves our network for any reason other than termination of cause and you are inactive treatment you may be able to continue seeing that provider for a limited period of time and still get the participating provider benefits.

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 with the claims administrator terminates (unless the provider's contract terminates for reasons of medical disciplinary cause or reason, fraud or other criminal activity). If your physician leaves our network for any reason other than termination of cause and you are inactive treatment you may be able to continue seeing that provider for a limited period of time and still get the participating provider benefits.

~~3. Our pregnancy definition covers the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services will be provided for the duration of the pregnancy with the terms and conditions of his or her agreement with the claims administrator prior to termination. The provider must also agree in writing to accept the terms and conditions 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.~~

~~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. 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.~~

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

~~6. Performance of a surgery or other procedure that the claims administrator have authorized as part of a documented course of treatment and that has been recommended and documented by the medical provider to occur within 180 days of the time you enroll in this plan. Completion of covered services shall be provided for the duration of the acute condition.~~

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

~~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, deductibles, co-insurance, and co-payments under the plan. Financial arrangements with non-participating providers are negotiated on a case-by-case basis. The non-participating provider will be asked to agree to accept reimbursement and contractual requirements that apply to participating providers, including payment terms. If the non-participating provider does not agree to accept said reimbursement and contractual requirements, the non-participating provider's services will not be continued. If you do not meet the criteria for Transition Assistance, you are afforded due process including having a physician review the request.~~

~~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.~~

Continuity of Care after Termination of Provider: Subject to the terms and conditions set forth below, benefits will be provided at the participating provider level for covered services (subject to applicable co-payments, co-insurance, deductibles and other terms) received from a provider at the time the provider's contract with the claims administrator terminates (unless the provider has contracted to terminate for reasons of medical disciplinary cause or reason of fraud or other criminal activity). If your physician leaves our network for any reason other than termination of cause, and you are in active treatment, you may be able to continue seeing that provider for a limited period of time and still get the participating provider benefits.

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

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. Continuity of care is based on your clinical condition and is not determined by diagnostic classifications. Continuity of care does not provide coverage for an acute condition. An acute condition is a medical condition that

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

A serious chronic condition is a medical basic condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full recovery 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.

Where to find our Notice of Privacy Practices

3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services is 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.

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.

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

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

- We may share explanation of benefits (EOB) with the subscriber if you file a claim with us.

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

We may share PHI to manage your account or benefits; or to pay claims for health care you get through your plan. If you do not want us to share your PHI for these purposes, please visit https://www.anthem.com/ca/health-insurance/about-us/privacy.

Protecting your privacy.

Where to find our Notice of Privacy Practices

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.

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.

BINDING ARBITRATION

For health care operations: We use and share PHI for health care operations. 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. We do not provide treatment, and this is not subject to Federal medical LEPs. We do not provide treatment, and this is not subject to 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. In a dispute which does not involve an adverse benefit decision, this BINDING ARBITRATION provision applies.

- o We keep information about your premium and deductible payments, of whatever nature, arising out of, in connection with, or in relation to this provision of coverage, or confirmation of care or benefits of care, including any claim based on contract, tort or statute. We may review information to determine if there is a conflict with the jurisdiction or limits of your plan or your state law governing your plan for payment purposes. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in your state.
- o We may give information to a doctor's office to confirm your care or benefits of care, including any claim based on contract, tort or statute. We may share explanation of benefits (EOB) with the subscriber or your plan for payment purposes.
- o We may use PHI to review the quality of care and services you get.
- o We may use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes, or traumatic injury.
- o 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

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

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 and Medication Services ("JAMS") according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the member and the plan administrator, or by order of the court, if the member and the plan administrator cannot agree.

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.

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 (JJC) or the Accreditation Association of Ambulatory Health Care.

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, provider who practices in the appropriate specialty, or there is no contracting hospital which provides the required services or has the necessary facilities.

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.

agreement with the claims administrator for a covered service by a 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.

Benefits for medically necessary and appropriate authorized referral services received from a non-participating provider will be payable as 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.

These services are only covered when performed at a designated bariatric CME.

Bariatric CME Coverage DEFINITIONS

within the 50-mile radius surrounding a designated bariatric CME.

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

Biosimilar (Biosimilars) is a type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA approved biological product known as the biological reference product (reference product) and has been shown to have no clinically meaningful differences from the reference product.

Accidental injury does not include illness or infection, except infection of a cut or wound.

Brand name prescription drugs (brand name drugs) are *prescription drugs* that are classified as *brand name drugs* under *the primary benefit manager*. As defined as *brand name drugs* that are used in an ambulatory surgical center.

It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services. It must also meet accreditation standards of The Joint Commission (TJC) or the Accreditation Association of Ambulatory Health Care.

Designated by us as a selected facility for specified medical services. A provider participating in a CME network has an agreement in effect with

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

- there is no *participating provider* who practices in the appropriate specialty, or there is no *contracting hospital* which provides the required services or has the necessary facilities;

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 or more vertebrae is moved out of its normal position.)

• the member is referred to *hospital* or *physician* that does not have an agreement with the *claims administrator* for a covered service by a *participating provider*.

Claims administrator refers to Anthem Blue Cross Life and Health Insurance Company. On behalf of Anthem Blue Cross Life and Health Benefits for medically necessary and appropriate authorized referral services received from a *non-participating provider* will be payable as shown in the Exceptions under the SUMMARY OF BENEFITS: CO-PAYMENTS.

Compound Medication is a mixture of *prescription drugs* when a commercially available dosage form of a medically necessary medication you not available in the form in which they are used in the compound medication requires a prescription to dispense and are not essentially the same as an FDA-approved product from a *drug manufacturer*. Non-FDA approved such pharmaceutical ingredients that are *medically necessary* services. Such authorized referrals are not available to bariatric surgical services. These services are only covered when performed at a designated bariatric CME.

Bariatric CME Coverage Area is the area within the 50-mile radius surrounding a designated bariatric/CME. See "2021 Notice" at the front of this booklet for details.

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

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

Biosimilar (Biosimilars) is a type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product.

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

Brand name prescription drugs (brand name drugs) are prescription drugs that are classified as brand name drugs or the pharmacy benefit manager has classified as brand name (in drugs through its set of an independent proprietary industry database).

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

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

Day treatment center is an outpatient psychiatric facility which is licensed according to state and local laws to provide outpatient programs and

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.)

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.

Compound Medication is a mixture of *prescription drugs* when a commercially available dosage form of a medically necessary medication is not available, all the ingredients of the compound drug are FDA-approved in the form in which they are used in the compound medication.

Drug (prescription drug) means a drug approved by the Food and Drug Administration for general use by the public which requires a prescription before it can be obtained. For the purposes of this *plan*, insulin will be considered a prescription drug.

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

Consolidated Appropriations Act of 2021 is a federal law described in the "Consolidated Appropriations Act of 2021 Notice" at the front of this booklet for details, including severe pain such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

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

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

- **Serious impairment to bodily functions or**
- **Serious dysfunction of any bodily organ or part.**

Cosmetic services are services or surgery performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance.

Custodial care is care provided primarily to meet your personal needs. This includes help in walking, bathing or dressing. It also includes:
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 administered or any other care which does not require continuing services 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, if medically necessary.
If medically necessary, benefits will be provided for feeding (by tube or gastrostomy) and suctioning.

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

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

Experimental is any medical, surgical and/or other procedures, services, products, drugs or devices including implants used for research except as specifically stated under the "Clinical Trials" provision from the section DEPENDENTS THAT COVERAGE

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

Formulary drug is a drug listed on the prescription drug formulary.

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.

Drug (prescription drug) means a drug approved by the Food and Drug Administration for general use by the public which requires a prescription before it can be obtained. For the purposes of this plan, insulin will be considered a prescription drug.

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 if the absence of immediate medical attention could reasonably be expected to result in any of the following: counseling, and behavioral health treatment pursuant to state law. Valid, evidence-based sources establishing generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines, and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

- 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. Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form. 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.

Medicare and/or accredited by a recognized accrediting agency such as The Joint Commission (TJC).

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

Experimental is any medical, surgical and/or other procedures, services, products, drugs or devices including implants used for research except as specifically stated under the "Clinical Trials" provision from the section MEDICAL CARE THAT IS COVERED.

Hospital is an organization providing a specialized form of interdisciplinary health care that provides palliative care (pain control and symptom relief) and alleviates the physical, emotional, social, and spiritual discomforts of a terminally ill person, as well as providing supportive care to the primary caregiver and the patient's family. A hospice must be:

Full-time employee meets the plan's eligibility requirements for full-time employees as outlined under HOW COVERAGE BEGINS AND ENDS. currently licensed as a hospice pursuant to Health and Safety Code section 1747 or a licensed *home health agency* with federal Medicare certification pursuant to Health and Safety Code sections 1726 and 1747.1. A list of hospices meeting these criteria is available upon request.

Hospital is a facility 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).

Generally Accepted Standards of Mental Health and Substance Use Disorder Care

Disorder Care are standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment pursuant to state law. Valid, evidence based sources establishing generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

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

Intensive Outpatient Program is a structured, multidisciplinary 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.

Generic prescription drugs (generic drugs) are *prescription drugs* that are classified as *generic drugs* or that the PBM has classified as *generic interchangeable Biologics Product* is a type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product known as the *biological reference product*.

Reference product and has been shown to have no clinically meaningful differences from the *reference product*. In addition to meeting the biosimilarity standard, it is expected to produce the same clinical results as the *reference product* in any given patient.

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).

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.

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).

YOUR MEDICAL BENEFITS: MAXIMUM ALLOWED AMOUNT.

Hospice is an agency or organization providing a specialized form of interdisciplinary health care that provides palliative care (pain control and symptom relief) and alleviates the physical, emotional, social, and spiritual discomforts of a terminally ill person, as well as providing supportive care to the primary caregiver and the patient's family. A hospice must be currently licensed as a hospice pursuant to Health and Safety Code section 1747 or a licensed *home health agency* with federal Medicare certification pursuant to Health and Safety Code sections 1726 and 1747.1. A list of hospices meeting these criteria is available upon request.

Hospital is a facility 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 or substance use disorder), and
- (2) residential treatment centers.⁶

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

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:

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.

- 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.

Interchangeable Biologic Product is a type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product. In addition to meeting the biosimilarity standard, it is expected to produce the same clinical result as the reference product in any given patient.

For purposes of treatment of *mental health* and *substance use disorder*, **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, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner **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 Substance Use Disorder Care.

Medically necessary procedures, supplies, equipment or services are those the claims administrator determines to be:

- (i) Clinically appropriate in terms of type, frequency, extent, site, and duration; and
- (ii) Not primarily for the economic benefit of the Claims Administrator and the Member or for the convenience of the patient, treating Physician, or the claims administrator.
- 2. **Clinically appropriate** in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or **Mental disease** of the subscriber or dependent. A member may enroll under only one health plan provided by the plan administrator, or any of its affiliates.
- 3. Provided for the diagnosis or direct care and treatment of the medical **Member** condition, and **substance use disorder** include conditions that are listed in the most current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders.
- 4. Within standards of good medical practice within the organized medical community;

Multi-source brand name drugs are drugs with at least one generic substitute.

5. Not primarily for your convenience, or for the convenience of your physician or another provider; the claims administrator at the time services are rendered.

6. Not more costly than an equivalent service, including the same service ~~Not in an alternative setting, or sequence of services that is medically contraindicated and this likely to produce equivalent therapeutic or diagnostic result in regard to the diagnosis or treatment of the patient's illness, injury, condition, and non-participating pharmacy.~~

7. ~~The most appropriate procedure, supply, equipment or service which NOT can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements and/or Blue Shield Plan at the time services are rendered:~~

- 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
- 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

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

- A clinical laboratory
- A home infusion therapy provider
- An urgent care center
- A retail health clinic
- A hospice

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

- A licensed qualified autism service provider

(ii) Clinically appropriate in terms of type, frequency, extent, site and duration, and ~~amount~~ may only represent a portion of the amount which a non-participating provider charges for services. See YOUR MEDICAL BENEFITS:

(iii) Not primarily for the economic benefit of the Claims Administrator and the Member or for the convenience of the patient, treating Physician, or Other health care Provider is one of the following providers:

- A certified registered nurse anesthetist

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.

The provider must be licensed according to state and local laws to provide **Mental health and substance use disorder** include conditions that are listed in the most current edition of the Diagnostic and Statistical Manual

(DSM) of Mental Disorders Program is a structured, multidisciplinary behavioral health treatment that offers nursing care and active individual, **Multi-source brand name drugs** are drugs with at least one generic substitute.

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

Participating pharmacy is a **pharmacy** which has a **Participating Non-participating pharmacy** is a **pharmacy** which does not have a contract in effect with the **pharmacy benefits manager** at the time services are rendered. In most cases, you will be responsible for a larger portion of your pharmaceutical bill when you go to a non-participating pharmacy.

Non-participating provider is one of the following providers which does NOT have a Prudent Buyer Plan Participating Provider Agreement in effect with the **claims administrator** or is NOT participating in a Blues Cross and/or Blue Shield Plan at the time services are rendered at the time services are rendered:

- A hospital
- A physician
- An ambulatory surgical center
- 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
- A home infusion therapy provider
- An urgent care center
- An urgent care center
- A retail health clinic
- A retail health clinic
- A hospice
- A licensed ambulance company
- A licensed qualified autism service provider
- A licensed qualified autism service provider

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

Other health care provider is one of the following providers:

• A certified registered nurse anesthetist
Pharmacy and Therapeutics Process is a process in which health care professionals including nurses, pharmacists, and physicians determine the clinical appropriateness of drugs and promote access to quality medications. The process also reviews drugs to determine the most cost effective use of benefits and advise on programs to help improve care.

The programs include, but are not limited to, drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-behavioral health treatment that offers nursing care and active individual, branded initiatives, and drug profiling initiatives.

group and family treatment in a program that operates no less than 6 hours per day, 5 days per week, on behalf of the claims administrator's PBM has a nationwide network of retail pharmacies, a home delivery pharmacy, and clinical services that include prescription drug management. Participating pharmacy is a pharmacy which has a Participating Pharmacy Agreement in effect with the pharmacy benefit manager at the time services are rendered. Call your local pharmacy to determine whether it is a participating pharmacy or call the toll-free Member Services telephone number. The management and other services the PBM provides include, but are not limited to, managing a network of retail pharmacies and operating a mail service pharmacy. The PBM, in consultation with the claims administrator, also provides services to promote and assist members in the appropriate use of pharmacy benefits, such as review for possible excessive use, proper dosage, drug interactions, or drug/pregnancy concerns.

are rendered:

• **Physicians:**

1. A physician
- An ambulatory surgical center
- A home health agency
2. A facility which provides diagnostic imaging services
- A durable medical equipment outlet, 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 the plan
- A clinical laboratory
- A home infusion therapy provider
 - A dentist (D.D.S. or D.M.D.)
- An urgent care center
 - An optometrist (O.D.)
- A retail health clinic
 - A dispensing optician
- A hospice
 - A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
- A licensed ambulance company
 - A licensed clinical psychologist
- A licensed qualified autism service provider
 - A licensed educational psychologist or other provider permitted by law to provide services under the plan

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

• A chiropractor (D.C.)

Pharmacy means a licensed retail pharmacy.

• A licensed clinical social worker (L.C.S.W.)

Pharmacy and Therapeutics Process is a process in which health care professionals including nurses, pharmacists, and physicians determine the clinical appropriateness of drugs and promote access to quality medications. The process also reviews drugs to determine the most cost effective use of benefits and advise on programs to help improve care. The programs include, but are not limited to, drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and drug profiling initiatives.

• An occupational therapist (O.T.R.)

Pharmacy Benefits Manager (PBM) a company that manages pharmacy benefits on the *claims administrator's* behalf. The *claims administrator's* PBM has a nationwide network of *retail pharmacies*, a *home delivery* pharmacy, and clinical services that include prescription drug list management, physician assistant

- A psychiatric mental health nurse (R.N.)*

The management and other services the PBM provides include, but are not limited to, managing a network of *retail pharmacies* and operating a mail service pharmacy. The PBM, in consultation with the *claims administrator*, also provides services to promote and assist members in the appropriate use of pharmacy benefits, such as review for possible excessive use, proper dosage, drug interactions or drug/pregnancy concerns.

the provision of diabetic medical nutrition therapy and nutritional

Physician means for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa only.

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

*Note: The provider must have a valid license to render that service, and is providing a service for which benefits are specified in this booklet:

**If there is no nurse midwife who is a *participating provider* in your area, you may contact M.D.s or D.O.s for their telephone number on your ID card for a referral to an OB/GYN.

- An optometrist (O.D.)

Plan is a dispensing optician 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. A licensed educational psychologist or other provider permitted as "plan" by law to provide behavioral health treatment services for the treatment of autism spectrum disorders only.

Plan administrator refers to CALIFORNIA INSTITUTE OF TECHNOLOGY, the entity which is responsible for the administration of the *plan*.

- An acupuncturist (A.C.)
- A licensed clinical social worker (L.C.S.W.)

Preferred drug is a *drug* listed on the *preferred drug program*.

- 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* may also get information about covered formulary drugs by calling the number on the back of your ID Card or going to our internet website anthem.com/ca.
- An audiologist*
- An occupational therapist (O.T.R.)*

Prescriber A respiratory care practitioner (R.C.P.) notice issued by a licensed prescriber.

- A nurse midwife**

Prescription drug expense is the expense you incur for a covered prescription drug, but not more than the *prescription drug maximum allowed amount*. Expense is incurred on the date you receive the service or supply.

- A physician assistant*

*A *physician assistant* is a medical professional who has completed a post-graduate program in physician assistant studies.

- A *psychiatric mental health nurse* (R.N.)*

Prescription drug maximum allowed amount is the maximum amount 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.

Prescription drug tiers are used to classify drugs for the purpose of setting their co-payment. The claims administrator will decide which drugs should be in each tier based on clinical decisions made by the *Pharmacy and Therapeutics Committee*. The claims administrator retains the right to determine coverage for dosage formulation in terms of covered dosage administration methods (for example, by mouth, injection, inhalation, enema, suppository).

Note: The providers indicated by asterisks (*) are covered only by referral of a physician as defined in above. If there is no nurse midwife who is a *participating provider* in your area, you may call the Member Services telephone number on your ID card for a referral to an OB/GYN. This is an explanation of what drugs each tier includes:

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.)

Tier 2 Drugs are those that have a higher co-payments than Tier 1 Drugs, but lower than Tier 3 Drugs. This tier may contain *preferred drugs* that may be generic, single source brand name drugs, biosimilars, interchangeable biologic products or multi-source brand name drugs.

Preferred drug is a drug listed on the *preferred drug program*.

Tier 3 Drugs are those that have the higher co-payments than Tier 2 Drugs, but lower than Tier 4 Drugs. This tier may contain higher cost preferred drugs and non-preferred drugs that may be generic, single source brand name drugs, biosimilars, interchangeable biologic products or multi-source brand name drugs.

Preferred drug program is a list which we have developed of outpatient prescription drugs which may be cost-effective, therapeutic choices. Any participating pharmacy can assist you in purchasing drugs listed on the preferred drug program. You may also get information about covered formulary drugs by calling the number on the back of your ID Card or going to our internet website anthem.com/ca. This tier may contain higher cost preferred drugs and non-preferred drugs that may be generic, single source brand name drugs,

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

Prescription drug covered expense is the expense you incur for a covered prescription drug, but not more than the **prescription drug maximum allowed amount**. Expense is incurred on the date you receive the service or supply. 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:

Prescription drug maximum allowed amount is the maximum amount provided to them by the **Pharmacy benefit manager**. The amount is subject to change. You may determine the prescription drug maximum allowed amount of a particular drug by calling the number on the back of your ID Card.

Immunization Practices of the Centers for Disease Control and Prevention and **Screening for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration**; and

Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.

Prior Authorization is a process where you must get approval from your plan before you can receive certain services or drugs. This is done to make sure that the service or drug is medically necessary. If you are denied coverage, you will need to get written prior authorization (see **PRESCRIPTION DRUG FORMULARY** or **PRIOR AUTHORIZATION** above) to get the plan to pay for the administrative form of the drug. This is an explanation of what drugs each tier includes.

Tier 1 Drugs are those that have the lowest co-payment. This tier contains low cost preferred drugs that may be generic, single source brand name drugs, biosimilars, interchangeable biologic products or multi-source brand name drugs.

Tier 2 Drugs are those that have a higher co-payments than Tier 1 Drugs, but lower than Tier 3 Drugs. This tier may contain preferred drugs that may be generic, single source brand name drugs, biosimilars, interchangeable biologic products or multi-source brand name drugs.

Tier 3 Drugs are those that have the higher co-payments than Tier 2 Drugs, but lower than Tier 4 Drugs. This tier may contain higher cost preferred drugs and non-preferred drugs that may be generic, single source brand name drugs, biosimilars, interchangeable biologic products or multi-source brand name drugs.

Tier 4 Drugs are those that have the higher co-payments than Tier 3 Drugs. This tier may contain higher cost preferred drugs and non-preferred drugs that may be generic, single source brand name drugs,

biosimilars are interchangeable biologic products or multi-source brand name drugs. Tests 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. **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. Accredited by The Joint Commission (TJC) and 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. Staffed by an organized medical or professional staff which includes a physician as medical director.

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

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

Please call the Member Services number listed on your ID card for additional information about services that are covered by this plan as reconstructive surgery is surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (a) improve function; or (b) create a normal appearance, to the extent possible.

<http://www.ahrq.gov> Residential treatment center is an inpatient treatment facility where the environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation.

Prior plan is a plan sponsored by us which was replaced by this plan or a mental health or substance use disorder. The facility must be licensed 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) according to state and local laws and regulations and minimum benefit plan, 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.

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.

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.

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.

1. Licensed by the California Department of Health Services;
2. Qualified to provide short-term inpatient treatment according to state laws and conditions. A non-physician specialist is a provider who has added training in a specific area of health care.

3. Accredited by The Joint Commission (TJC); and

4. Staffed by an organized medical or professional staff which includes a physician as medical director.

Stay is inpatient confinement which begins when you are admitted to a facility and ends when you are discharged from that facility. Benefits provided for treatment in a psychiatric health facility which does not have a Standard Hospital Contract in effect with the claims administrator will be subject to the non-contracting hospital penalty in effect at the time of services, 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.

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.

Act of 2021 Notice" at the front of this booklet for details.

Reconstructive surgery is surgery performed to correct or repair abnormal structures of the body because of congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (a) improve function; or (b) create a normal appearance, to the extent possible.

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.

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 or substance use disorder. The facility must be licensed to provide psychiatric treatment of mental health or substance use disorder 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).

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, or 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 trip to an emergency room.

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.

Single source brand name drugs are drugs with no generic substitute 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.

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.

The (us, cal) refers to CALIFORNIA INSTITUTE OF TECHNOLOGY.
The period starting January 1 at 12:01 a.m. Pacific Standard Time.

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.

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

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

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

Urgent care 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 CALIFORNIA INSTITUTE OF TECHNOLOGY.

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.

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 free of charge, along with a discussion of the claims denial decision; and

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.

- 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
- 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;
- information regarding your potential right to an External Appeal pursuant to federal law;
- A post-service claim is any other claim for benefits under the plan for which you have received the service.

For claims involving urgent/concurrent care:

- If your claim is denied or if your coverage is rescinded:
- The claims administrator's notice of denial will include a description of the applicable urgent/concurrent review process; and
 - you will be provided with a written notice of the denial or rescission;
 - and the claims administrator may notify you or your authorized representative within 72 hours orally and then furnish a written notification;
 - 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.

Appeals 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 information sufficient to identify the claim involved, whether it was submitted or considered in the initial benefit determination.

- the specific reason(s) for the denial;
- 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 perfect your claim;
- a description of any additional material or information needed to review involved (e.g. pre-service, concurrent, post-service, urgent, etc.);
- an explanation of why the additional material or information is needed;

For pre-service claims involving urgent/concurrent care, you may obtain an expedited appeal. You or your authorized representative may 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. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact the claims administrator at the

YOUR RIGHT TO APPEALS

- information about any internal rule, guideline, protocol or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision; and
 - the date(s) of the medical service;
 - 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
 - the specific medical condition or symptom;
 - the service or supply for which approval of benefits was sought and pursuant to federal law;
 - any reasons why the appeal should be processed on a more expedited basis.
- For claims involving urgent/concurrent care:

- 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:
- notification.

Anthem Blue Cross Life and Health Insurance Company Appeals

ATTN: Appeals

P.O. Box 4310, Woodland Hills, CA 91365-4310
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, record, 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 benefit determination on review based on a new or additional rationale, the claims administrator will provide you, free of charge, with the rationale.

phone number listed on your ID card and provide at least the following information:

Information means Providers must file appeals with the same plan to which the claim was filed.

- the identity of the claimant;

How Your Appeal will be Decided

- the date (s) of the medical service;

When the claims administrator considers your appeal, the claims administrator may rely upon the specific medical condition or symptom, 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 first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

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 a health care professional who has the requested 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 initial determination or who works for one who was consulted in making an initial determination.

P.O. Box 4310, Woodland Hills, CA 91365-4310

Notification of the Outcome of the Appeal

You must include Your Member Identification Number when submitting an appeal. If you submit an appeal involving urgent/concurrent care, the claims administrator will notify you of the outcome of the appeal as soon as possible. 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

If you were submitted, considered, or produced in the course of making the benefit determination, the appeal within 60 days after receipt of your request for appeal.

- 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
- If your appeal is denied, that denial will be considered an adverse benefit determination if it is contrary to the plan's policy or guidance about the treatment or benefit relative to your diagnosis set forth in the above subsection entitled "Notice of Adverse Benefit Determination."

The claims administrator will also provide you, free of charge, with any new and 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, a voluntary second-level appeal may be available. If you would like to

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

External Review: 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.

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

If you appeal a claim involving urgent/concurrent care, the claims administrator will notify you of the outcome of the appeal all as soon as

possible, but not later than 72 hours after receipt of your request for

appeal. In the claims administrator and you by telephone, facsimile or other

similar method. To proceed with an Expedited External Review, you or

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. If the identity of the claimant,

Appeal Denial: the specific medical condition or symptom;

- 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."
- any reasons why the appeal should be processed on a more expedited basis.

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.

Anthem Blue Cross Life and Health Insurance Company
ATTN: Appeals
P.O. Box 4310, Woodland Hills, CA 91365-4310

External Review

You must include Your Member Identification Number when
If the outcome of the mandatory first level appeal is adverse to you and it
was based on medical judgment, or if it pertained to a rescission of
coverage, you may be eligible for an independent External Review
pursuant to federal law.
External Review will not affect your rights to any other benefits under this
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, relief available through applicable state laws or
ERISA (if applicable).

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 internal appeal through the claims
administrator's internal appeal process. You before 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 claims administrator reserves the right to modify the policies,
procedures and timeframes in this section upon further clarification
from the Department of Health, Human Services and Department of
Labor.
- 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 WEBSITE

Anthem Blue Cross Life and Health Insurance Company

Information specific to your ~~ATTN: Appeals~~ claims history are available by calling the 800 P.O. Box 4310, Woodland Hills, CA 91365-4310. ~~Anthem Blue Cross is an affiliate of Anthem Blue Cross. You may use Anthem Blue Cross's website to access benefit information, claims payment status, service provider 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 Website. Once registered, simply click the "Login" button and enter your User ID and password to access the MemberAccess Website.~~ 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).

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

~~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.~~

~~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. 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.~~

- Korean
- Tagalog

Oral interpretation services are available in additional languages.

Requesting a written translation of this booklet? Just contact Member Services by calling the phone number on your ID card to update your ANTHEM BLUE CROSS WEBSITE information. Translated documents or to request interpretation assistance, Anthem Blue Cross Life and Health also sends/receives TDD/TTY messages at 800-333-4823 or by using the National Relay Service through 711.

STATEMENT OF RIGHTS UNDER THE NEWBORN 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 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.

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
Also, under federal law, plans and issuers may not set the level of benefits offered by Anthem Blue Cross Life and Health introduced the 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:

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

- Chinese
 - Vietnamese
 - Korean
 - Tagalog
- 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. Oral interpretation services are available in additional languages.

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

Requesting Adwritten or oral translation is easy. Just contact Member Services by calling the telephone 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. This will apply in place of any similar claim procedure rules included in the Benefit Booklet. For more information about the Language Assistance Program visit www.anthem.com/ca.

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. 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. 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 determination is based. You 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. If your request for benefits is denied and it is no longer considered urgent, it will be handled in the same manner as a Non-Urgent Care service. Your service appeal, depending upon the circumstances.

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. 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

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 to process your request for benefits. The time period during which the

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 Benefit Booklet. 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 received your request for benefits, that they have it and what they determined 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.

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.**

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.

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 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.

- **Extension of Benefits** – If, while you are undergoing a course of treatment, 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 may be handled as an Urgent or Non-Urgent Care Pre-service request for benefits.

- **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, 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 must explain your 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

Non - Urgent Care Post-Service (reimbursement for costs 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, having 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, 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 or after the Claims Administrator has all the information they need to

process according to the rules for appeal of an urgent care denial of noted above ("Appeals of Adverse Benefit Determinations," above) for the adverse benefit determination and the plan provisions upon which the denial decision is based. You have 180 days to appeal the decision. 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 to you of their decision will be in writing.

Note: You may 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

- Doc 24 hours until the end of the initially prescribed course of revit 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.

You may have representation throughout the appeal and review procedure.

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.

Get Help in your language

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

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:

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)

- Issues outlining the basis of the appeal may be submitted.

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 للمساعدة.(TTY/TDD: 711)

Armenian

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

Chinese

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

Farsi

شما را باید به زبان خودتان دریافت کنید. برای دریافت کمک بپردازید.

شماره مرکز خدمات اعفاء که بر روی کارت شناساییتان درج شده است را پنهان نمایید.

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

Hindi

आपके पास यह जानकारी भ्राता सदृश अपनी भाषा में समर्पित मापदंड का फ्री। Call the Member Services number on your ID card for help. (TTY/TDD: 711) इस के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर काल

करें।(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.

Japanese

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

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)

សមារូទ្យរដ្ឋុំនៃសេវាសមាជិកអេយោនមានលើប៊ែន

ID

Arabic

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

Korean

귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가

Armenian 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

:

ID

Punjabi

ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਸੁਫ਼ਲ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ।(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) **Право на получение информации и помощи бесплатно в вашем языке. Пожалуйста, звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)**

Parsi – это языковая карта мира.

شما این حق را دارید که این اطلاعات و کمکها را به صورت Tagalog رایگان به زبان خودتان دریافت کنید. برای دریافت مهارت های این زبان مراجع May karapatang kayong makuhang impormasyon at tulungan ito sa شماره مرنگ خدمت انسانی این زبان برای ginagamit ninyong wika nang (TTY/TDD: 711).
Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Hindi

Thai

आपके पास यह जानकारी आर मटद अपना भाषा म. मफ्त म. प्राप्त करन का ताबामस्तिखोरुपरलालूपतामखमुल्लालैकावामभायहेलैयानगाहायाखायहानपर अधिकार है। मटद के प्रति अपने ID कार्ड पर लालूपत्य तेग्राम चंबरा पात्र कॉल के (TTY/TDD: 711)

Vietnamese

Hmong Qu# vi có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của qu# vi. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của qu# vi Koj muaj cai tau txais choy lis 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

ID
711)

10

(TTY/TDD: 711)

Korean

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

Punjabi

Russian *important we treat you fairly*

Вы имеете право получить данную информацию и помочь на вашем языке бесплатно. Для получения языка помощи на вашем языке, звоните в программу поддержки участников по телефону, указанному на вашей идентификационной карте (TTY/TDD: 711) age or disability. For people with disabilities, we offer free aids and services. For people whose primary

Tagalog language isn't English, we offer free language assistance services through May katapatan kayong makuhang impormasyon at tulungan na itesang ginalagamit. Mainyong swikaenang walang bayad. Tumawag ngsa (TTY/TDD: 711). If you have a complaint based on race, color, national origin, age, disability, or sex, you can file a **Thai** 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 mailing a letter to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Washington, DC 20201.

Vietnamese Quý vị có quyền nhận miễn phí thông tin này và sự giúp đỡ 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) <http://www.hhs.gov/711/index.html>

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>.

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

DEFINITIONS

Blue Distinction Center Facility (BDC Facility) has met or exceeded national quality standards for care delivery (quality only).

Blue Distinction Center+ Facility (BDC+ Facility) has met or exceeded national quality standards for care delivery and has demonstrated that they operate more efficiently (quality and cost).

Designated Bariatric Surgery Provider is a provider who has achieved designation as a Blue Distinction Center+ or Blue Distinction Center for bariatric surgery procedures.

Designated Cardiac Provider is a provider who has achieved designation as a Blue Distinction+ or Blue Distinction Center for cardiac procedures.

BLUE DISTINCTION BENEFITS

Designated Orthopedic Provider is a provider who has achieved designation as a Blue Distinction+ or Blue Distinction Center for knee/hip replacement surgery. Your benefit booklet is changed by this amendment. All other provisions of the benefit booklet which do not conflict with this amendment remain in effect.

Designated Transplant Provider is a provider who has achieved designation as a Blue Distinction Center+ or Blue Distinction Center for transplant procedures.

Blue Distinction Surgery Benefits is a national designation program which recognizes hospitals that have demonstrated expertise in delivering quality specialty care for patients with highly complex medical needs.

The plan administrator has implemented the following benefit requirements related to the use of designated Blue Distinction facilities.

Procedures are subject to pre-service review to determine medical necessity. Please contact the claims administrator by calling the customer service number located on the back of your member identification card.

You or your provider must call for approval prior to the procedures, whether it is performed in an inpatient or outpatient setting.

- Revision knee replacement
- Total hip replacement
- Discectomy
- Decompression
- Revision spinal fusion

The meanings of key terms used in this amendment are shown below. This benefit includes services directly related to the covered orthopedic procedure facility, professional and ancillary services. Whenever any of the key terms shown below appear in this amendment, the first letter of each word will be capitalized. When you see these during the inpatient or outpatient stay, if the services are NOT directly related to the covered orthopedic procedure, services will not be covered based on your plan's standard medical benefit.

DEFINITIONS

Your Co-Payment for services provided by a BDC+ Facility will be 15% of the maximum allowed amount.

Your Co-Payment for services provided by a BDC+ Facility will be 15% of the maximum allowed amount.

Blue Distinction Cardiac Surgery Benefits

Designated Bariatric Surgery Provider is a provider who has achieved designation as a Blue Distinction Center+ or Blue Distinction Center for bariatric surgery procedures. Your plan administrator. Services and supplies are limited to the following procedures:

- Coronary artery bypass graft

Designated Cardiac Provider is a provider who has achieved designation as a Blue Distinction+ or Blue Distinction Center for cardiac procedures.

This benefit includes services directly related to the covered cardiac surgery (facility, professional and ancillary services) during the

Designated Orthopedic Provider is a provider who has achieved designation as a Blue Distinction+ or Blue Distinction Center for knee/hip replacement or spine surgical benefit.

Designated Transplant Provider is a provider who has achieved designation as a Blue Distinction+ or Blue Distinction Center for Transplant Procedures.

Your Co-Payment for services provided by a BDC Facility will be 15% of the maximum allowed amount.

Blue Distinction Orthopedic Surgery Benefits

Blue Distinction Bariatric Surgery Benefits
This benefit only applies to medically necessary knee/hip replacement or spine surgery procedures as designated by the claims administrator. Services and supplies are limited to the following procedures:

- Revision knee replacement
 - Total hip replacement
 - Revision hip replacement
 - Discectomy
- This benefit includes services directly related to the covered bariatric surgery (facility, professional and ancillary services) during the inpatient spinal fusion. If the services are NOT directly related to the covered bariatric surgery, services will not be covered based on your plan's standard medical benefit.

Your Co-Payment for services provided by a BDC+ Facility will be 15% of the maximum allowed amount.
Your Co-Payment for services provided by a BDC Facility will be 15% of the maximum allowed amount.

Blue Distinction Transplant Surgery Benefits

This benefit only applies to medically necessary human organ and stem cell/bone marrow transplant and transfusions as determined by the claims administrator including necessary acquisition procedures, collection and storage, and including medically necessary preparatory myeloablative therapy.

This benefit only applies to medically necessary cardiac procedures as designated by the claims administrator. Services and supplies are limited to the following procedures:
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 workup for a transplant. The claims administrator will help you maximize your benefits by giving you coverage information, including

~~• **Percutaneous coronary intervention** clinical coverage guidelines, medical policies, *Centers of Medical Excellence (CME)* or *Blue Distinction Centers for Specialty Care (BDCS)*. These are exclusions for surgery. *Call the customer service phone number on the back of your plan card and ask for the transplant services.*~~

~~Your plan's standard medical benefit. Transplant Department for pre-service review prior to the transplant, whether it is performed in an inpatient or outpatient setting. Prior authorization is required before we will provide benefits for a transplant. Your physician must certify, and we must agree, that the transplant is medically necessary. Your physician should send a written request for prior authorization to the claims administrator as soon as possible to start this process. Not getting prior authorization will result in a denial of benefits.~~

Blue Distinction Bariatric Surgery 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.~~

~~• **Gastric banding** or **Gastric stapling** A separate medical necessity decision will be needed for the This benefit includes services directly related to the covered bariatric surgery (facility, professional and ancillary services) during the inpatient or outpatient stay. If the services are NOT directly related to the covered bariatric surgery, services will not be covered based on your plan's standard medical benefit. The~~

~~Your Co-Payment for services provided by a BDC+ Facility will be 15% of the maximum allowed amount. Donor benefits are limited to benefits not available to the donor from any other source. 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~~

~~Your Co-Payment for services provided by a BDC+ Facility will be 15%~~

~~of the maximum allowed amount for listing donor or a human organ transplant bank will be covered. Such charges, including complications from the~~

~~Your Co-Payment for services provided by a BDC Facility will be 15% of the maximum allowed amount.~~

~~covered services are not covered if a condition 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.~~

~~This benefit only applies to medically necessary human organ and~~

~~stem cell/bone marrow transplant and transfusions as determined by~~

~~the claims administrator including necessary acquisition procedures~~

~~collection and storage, and including medically necessary preparatory~~

~~myeloablative therapy.~~

~~Note: Donor searches including donor testing are not covered~~

~~when provided by a BDC Facility, participating provider, or non-~~

~~participating provider.~~

~~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 customer service phone number on the back of your ID card and ask for the transplant coordinator.

Your Co-Payment for transplant surgery services provided by a BDC Facility will be 15% of the maximum allowed amount.
Your Co-Payment for the procurement of an organ from a live donor, when provided by a BDC Facility, is 15% of the maximum allowed amount.
Your physician must call our Transplant Department for pre-service review prior to the transplant, whether it is performed in an inpatient or outpatient setting. Prior authorization is required before we will provide benefits for a transplant. Your physician must certify and we must agree, that the transplant is *medically necessary*. Your physician should send a written request for prior authorization to 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.
Your Co-Payment for donor expenses, when provided by a BDC Facility, is 15% of the maximum allowed amount.
Your Co-Payment for donor expenses, when provided by a BDC Facility, is 15% of the maximum allowed amount.
A separate medical necessity decision will be needed for the transplant itself.

Your Co-Payment for donor expenses, when provided by a participating provider, is 15% of the maximum allowed amount.
Donor benefits are limited to benefits not available to the donor from any other source. 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.

Note: Donor searches including donor testing are not covered when provided by a BDC Facility, participating provider, or non-participating provider.

This benefit includes services directly related to the covered procedure (facility, professional and ancillary services) during the inpatient or outpatient stay. If the services are NOT directly related to

the covered procedure, services will not be covered based on your *plan's* standard medical benefit.

Your Co-Payment for transplant surgery services provided by a BDC+ Facility will be **15%** of the *maximum allowed amount*.

Your Co-Payment for transplant surgery services provided by a BDC Facility will be **15%** of the *maximum allowed amount*.

Your Co-Payment for the procurement of an organ from a live donor, when provided by a BDC+ Facility, is **15%** of the *maximum allowed amount*.

Your Co-Payment for the procurement of an organ from a live donor, when provided by a BDC Facility, is **15%** of the *maximum allowed amount*.

Your Co-Payment for the procurement of an organ from a live donor, when provided by a *participating provider*, is **15%** of the *maximum allowed amount*.

Your Co-Payment for donor expenses, when provided by a BDC+ Facility, is **15%** of the *maximum allowed amount*.

Your Co-Payment for donor expenses, when provided by a BDC Facility, is **15%** of the *maximum allowed amount*.

Your Co-Payment for donor expenses, when provided by a *participating provider*, is **15%** of the *maximum allowed amount*.