THE AEROSPACE CORPORATION

January 1, 2026

Your Anthem Blue Cross HMO Plan

Combined Evidence of Coverage and Disclosure Form

Anthem Blue Cross
21215 Burbank Blvd.
Woodland Hills, California 91367
Phone Number: 800-999-3643
www.anthem.com/ca

This Evidence of Coverage, called the "Combined Evidence of Coverage and Disclosure Form", gives you important information about your health Plan. The health Plan contract must be consulted to determine the exact terms and conditions of coverage. If you have special health care needs, you should read those sections of the Evidence of Coverage that apply to those needs. You can get a copy of the health Plan contract from your employer.

Many words used in this Evidence of Coverage are explained in the "Definitions" section. When reading through this Evidence of Coverage, check that section to be sure that you understand what these words mean. Each time these words are used they are capitalized.

NOTICE TO MemberS ABOUT HOW Plan BENEFITS ARE PROVIDED

Under the Minimum Premium Funding arrangement elected by the group for your Plan benefits, the group is liable for payment of a portion of the Plan benefits described in this Evidence of Coverage. The portion of the benefits which the group is responsible to provide are not covered by Anthem.

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Welcome to Anthem Blue Cross HMO

Thank you for choosing our health Plan.

Anthem Blue Cross HMO is here to serve you. This Evidence of Coverage tells you all about your health care Plan and its benefits.

- It tells you about what kinds of care this Plan covers and doesn't cover.
- It tells you what you have to do, or what has to happen so you can get benefits.
- It tells you what kinds of Doctors and other health care providers you can go to for care.
- It tells you about options you may have if your coverage ends.

Take some time to read it now.

- Keep this Evidence of Coverage handy for any questions you may have later on.

We're here to help you!!

We want to give you the help you need. If you have any questions,

- Please call us at the 800 number on your Member ID card for Anthem Blue Cross HMO Member Services.
- Or write us at:

Anthem Blue Cross

Attn.: Anthem Blue Cross HMO

P.O. Box 4089

Woodland Hills, CA. 91365

website: www.anthem.com/ca

We can help you get the health care you need.

Consolidated Appropriations Act of 2021 Notice

Consolidated Appropriations Act of 2021 (CAA)

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

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

Federal Surprise Billing Claims

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

- Non-Anthem Blue Cross HMO air ambulance services.

No Surprises Act Requirements

Out-of-Network Air Ambulance Services

When you receive covered services from a non-Anthem Blue Cross HMO air ambulance provider, your out-of-pocket costs will be limited to amounts that would apply if the covered service had been furnished by an Anthem Blue Cross HMO air ambulance provider.

How Copays Are Calculated

Your copays for Federal Surprise Billing Claims will be calculated based on the Recognized Amount. Any out-of-pocket copays you pay for covered services provided by a non-Anthem Blue Cross HMO air ambulance service provider will be applied to your Anthem Blue Cross HMO Health Care Provider Copay Limit.

Appeals

If you receive non-Anthem Blue Cross HMO air ambulance services and believe those services are covered by the No Surprise Billing Act, you have the right to appeal that claim. If your appeal of a Federal Surprise Billing Claim is denied, then you have a right to appeal the adverse decision to an Independent Review Organization as set out in the "How to Make a Complaint" section of this benefit book.

Provider Directories

Anthem is required to confirm the list of Anthem Blue Cross HMO Health Care Providers in its provider directory every 90 days. If you can show that you received inaccurate information from Anthem that an Anthem Blue Cross HMO Health Care Provider was an Anthem Blue Cross HMO Health Care Provider on a particular claim, then you will only be liable for the Anthem Blue Cross HMO Health Care Provider cost shares (i.e., Copayments, Deductibles, and/or Coinsurance) for that claim. Your Anthem Blue Cross HMO Health Care Provider cost shares will be calculated based upon the negotiated fee rate.

Transparency Requirements

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

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

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

- Cost Sharing information for covered items, services, and drugs, as required by the Centers for Medicare & Medicaid Services (CMS); and

- A listing / directory of all Anthem Blue Cross HMO Health Care Providers.

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

- Anthem Blue Cross HMO Health Care Provider negotiated rates; and

- Historical non-Anthem Blue Cross HMO Health Care Provider rates; and

- Drug pricing information.

Getting Started

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

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

Choosing Your Primary Care Doctor

When you enroll you should choose a Primary Care Doctor. Your Primary Care Doctor will be the first Doctor you see for all your health care needs. If you need special kinds of care, this Doctor will refer you to other kinds of health care providers.

Your Primary Care Doctor will be part of an Anthem Blue Cross HMO contracting Medical Group. There are two types of Anthem Blue Cross HMO Medical Groups.

- A primary Medical Group (PMG) is a group practice staffed by a team of Doctors, nurses, and other health care providers.
- An independent practice association (IPA) is a group of Doctors in private offices who usually have ties to the same hospital.

You and your family Members can enroll in whatever Medical Group is best for you, that is accepting new patients.

- You must live or work within our geographical Service Area.
- You and your family Members do not have to enroll in the same Medical Group.
- For a child, you may choose a Primary Care Doctor who is a pediatrician.

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

We publish a directory of Anthem Blue Cross HMO Health Care Providers. You can get a directory from your Plan administrator (usually your employer) or from us. The directory lists all Medical Groups, IPAs, and the Primary Care Doctors and hospitals that are affiliated with each Medical Group or IPA. You may call our Member Services Number on your Member ID card or you may write to us and ask us to send you a directory. You may also search for an Anthem Blue Cross HMO Health Care Provider using the "Provider Finder" function on our website at **www.anthem.com/ca**. The listings include the credentials of our Primary Care Doctors such as specialty designations and board certification.

Please note, your Primary Care Doctor, or Medical Group, must provide or coordinate all of your care, except for out-of-area Urgent Care or Emergency Services and Care.

If you receive Covered Services from a non-Anthem Blue Cross HMO Health Care Provider after we failed to provide you with accurate information in our provider directory, or after we failed to respond to your telephone or web-based inquiry within the time required by federal law, covered services will be covered at the Anthem Blue Cross HMO Health Care Provider level.

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

- Your Plan covers the telehealth visit just like an office visit with a Doctor under your Plan.
- Any out-of-pocket costs you have from the telehealth visit count toward your Plan's Deductible and Out of Pocket Maximum, just like any other care you receive.
- You have a right to review the medical records from your telehealth visit.
- If we have the necessary information, your medical records from your telehealth visit will be shared with your current and established Primary Care Doctor as permitted by state and federal law, unless you tell us not to share them.
- Receiving services in-person or via telehealth is available from your primary care physician, treating specialist, or from another Anthem Blue Cross HMO Health Care Provider, and these services will be consistent with the service and existing timeliness and geographic access standards defined in state law and regulation.

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

Community Assistance, Recovery, and Empowerment (CARE) Act

Benefits are provided for all health care services or Prescription Drugs a Member receives when required or recommended for the Member pursuant to a CARE agreement or CARE Plan approved by a court in accordance with the court's authority under Sections 5977.1, 5977.2, 5977.3, and 5982 of the Welfare and Institutions Code. Anthem will cover the cost of developing an evaluation pursuant to Section 5977.1 of the Welfare and Institutions Code and the provision of all healthcare services for a Member when required or recommended for the Member pursuant to a CARE agreement or a CARE Plan approved by a court in accordance with the court's authority, regardless of whether the service is provided by an Anthem Blue Cross HMO Health Care Provider or non-Anthem Blue Cross HMO Health Care Provider.

Precertification is not required for covered services in this provision, except for Prescription Drugs which will still require prior authorization. Covered services under this provision are subject to post claims review, however, to determine appropriate payment of a claim. Payment for covered services in this provision may be denied only if we reasonably determine that you were not insured at the time of service, that the services were never performed, or that the services were not provided by a health care provider appropriately licensed to provide the services.

Services provided to a Member pursuant to a CARE agreement or CARE Plan, excluding Prescription Drugs, are not subject to a copayment, coinsurance or deductible. Members cannot be billed for any services pursuant to a CARE agreement or CARE Plan, regardless if the services are received from Anthem Blue Cross

HMO Health Care Providers or non-Anthem Blue Cross HMO Health Care Providers.

Cost shares for Prescription Drugs are subject to the Plan's Prescription Drug maximum allowed amount. Please see the "Your Benefits at Anthem Blue Cross HMO" for details on your cost shares. Also, for more information on covered Prescription Drugs, please refer to your Plan's "Getting Prescription Drugs" and "Prescription Drugs Administered by a Medical Provider" benefits.

Notice of Reproductive Rights When Plan Exclusions Exist for Contraceptives, Abortion, and/or Sterilization

If you're enrolled with us through a religious employer that does not include coverage and benefits for abortion and contraception, this Plan does not include the below listed benefits. However, the below listed benefits may be available at no cost through the California Reproductive Health Equity Program.

- **Abortion**

  Abortion and abortion-related services, including pre-abortion and follow-up services.

- **Contraception**

  All FDA-approved contraceptive drugs, devices, and other products, including all FDA-approved contraceptive drugs, devices, and products available over-the-counter; clinical services related to the provision or use of contraception, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referrals, and counseling; follow-up services related to the FDA-approved contraceptive drugs, devices, products, and procedures, including, but not limited to, management of side effects, counseling for continued adherence, and device removal; sterilization services, such as vasectomy and tubal ligation.

Infertility and Fertility Services

You have a right to receive treatment for infertility and fertility services when you meet the requirements in Health and Safety Code section 1374.55.

If you have questions about how to obtain infertility treatment services or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on your health plan identification card; 2) call the California Department of Managed Health Care's Help Center at 1-888-466-2219; or 3) contact the California Department of Managed Health Care through its website at www.DMHC.ca.gov to request assistance in obtaining infertility treatment services.

Mental Health or Substance Use Disorder Services

You have a right to receive timely and geographically accessible Mental Health/Substance Use Disorder (MH/SUD) services when you need them. If Anthem fails to arrange those services for you with an appropriate provider who is in the health Plan's network, the health Plan must cover and arrange needed services for you from an out-of-network provider. If that happens, you do not have to pay anything other than your ordinary in-network cost-sharing.

If you do not need the services urgently, your health Plan must offer an appointment for you that is no more than 10 business days from when you requested the services from the health Plan. If you urgently need the services, your health Plan must offer you an appointment within 48 hours of your request (if the health Plan does not require prior authorization for the appointment) or within 96 hours (if the health Plan does require prior authorization).

If your health Plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health Plan's network. If that happens, you do not have to pay anything other than your ordinary in-network cost-sharing.

To be covered by your health Plan, your first appointment with the provider must be within 90 calendar days of the date you first asked the Plan for the MH/SUD services.

If you have questions about how to obtain MH/SUD services or are having difficulty obtaining services you can: 1) call your health Plan at the telephone number on the back of your health Plan identification card; 2) call the California Department of Managed Care's Help Center at 1-888-466-2219; or 3) contact the California Department of Managed Health Care through its website at www.healthhelp.ca.gov to request assistance in obtaining MH/SUD services.

Surprise Billing Claims

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

Connect with Us Using Our Mobile App

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

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

If You Need Help Choosing

We can help you choose a Doctor who will meet your needs. We can also answer questions about a health care provider's license or training.

- Call our Member Services Number on your Member ID card. Member services can help you determine the Doctor's name, address, telephone number, professional qualifications, specialty, medical school attended, and board certifications.

- Talk to the Anthem Blue Cross HMO coordinator at your Medical Group. Your Anthem Blue Cross HMO coordinator can also help you:
  - Understand the services and benefits you can get through Anthem Blue Cross HMO.
  - Get answers to any questions you may have about your Medical Group.

Changing Your Medical Group or Primary Care Doctor

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

- Choose a different Medical Group by using our website at www.anthem.com.

OR

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

We will approve your request for a change if the Primary Care Doctor within the new Medical Group you've picked is accepting new patients or is accepting new patients who are in the Course of Treatment. As when you first enroll, you must live or work within our geographical Service Area.

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

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

- When you are inpatient in an acute care facility; inpatient at a Skilled Nursing Facility at a skilled level of care; receiving other acute institutional care;
- When you are currently undergoing radiation or chemotherapy; or

- When you are pregnant and the pregnancy has reached the third trimester, defined as reaching the 27th week of pregnancy;
- When you are in the preparation and work up for a transplant;
- When you have been approved for an experimental or investigational procedure through your current participating Medical Group.

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

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

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

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

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

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

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

The actual effective date of the transfer will be the first day of the next month if your course of treatment ends prior to the 15th of the month. If your course of treatment ends after the 15th of the month, the effective date of the transfer will be the first day of the month following the next month.

Reproductive Health Care Services

Some hospitals and other providers do not provide one or more of the following services that may be covered under your Plan contract and that you or your family Member might need: family Planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective Doctor, Medical Group, independent practice association, or clinic, or call us at the Member Services Number listed on your Member ID card to ensure that you can obtain the health care services that you need.

When You Need Care

When You Need Routine Care

- **Call your Primary Care Doctor's office.**
- **Make an appointment.**

  When you call:

  - Tell them you are an Anthem Blue Cross HMO Member.
  - Have your Member ID card handy. They may ask you for:
    - Your group number
    - Member I.D. number
    - Office visit copay
  - Tell them the reason for your visit.
- **When you go for your appointment, bring your Member ID card.**
- **Please call your Doctor's office if you cannot come for your appointment, or if you will be late.**
- **If you need care after normal office hours, call your Primary Care Doctor's office for instructions.**

When You Need a Referral

Your Doctor may refer you to another Doctor or health care provider if you need special care. Your Primary Care Doctor must OK all the care you get except for Emergency Services and Care.

Your Doctor's Medical Group, or your Primary Care Doctor if they are not part of a Medical Group, has to agree that the service or care you will be getting from the other health care provider is Medically Necessary**.** Otherwise it won't be covered.

- You will need to make the appointment at the other Doctor's or health care provider's office.

- Your Primary Care Doctor will give you a referral form to take with you to your appointment. This form gives you the OK to get this care. If you don't get this form, ask for it or talk to your Anthem Blue Cross HMO coordinator.
- You may have to pay a copay. If your Primary Care Doctor refers you to a non-Anthem Blue Cross HMO Health Care Provider, and you have to pay a copay, any fixed dollar Copay will be the same as if you had the same service provided by an Anthem Blue Cross HMO Health Care Provider. But, if your Copay is other than a fixed dollar copay, while your benefits levels will not change, your out-of-pocket cost may be greater if the services are provided by a non-Anthem Blue Cross HMO Health Care Provider. You shouldn't get a bill, unless it is for a copay, for this service. If you do, send it to your Anthem Blue Cross HMO coordinator right away. The Medical Group, or Primary Care Doctor if they are not part of a Medical Group, will see that the bill is paid.
- If you receive authorized covered services from a non-Anthem Blue Cross HMO Health Care Provider at Anthem Blue Cross HMO Health Care Provider cost share amounts, you may be responsible for paying the difference between the reasonable and customary value and the non-Anthem Blue Cross HMO Health Care Provider's charges, unless your claim is a Federal Surprise Billing Claim.

Standing Referrals. If you have a condition or disease that requires continuing care from a specialist or is life-threatening, degenerative, or disabling (including HIV or AIDS), your Primary Care Doctor may give you a standing referral to a specialist or specialty care center. The referral will be made if your Primary Care Doctor, in consultation with you, and a specialist or specialty care center, if any, determine that continuing specialized care is Medically Necessary for your condition or disease.

If it is determined that you need a standing referral for your condition or disease, a treatment Plan will be set up for you. The treatment Plan:

- Will describe the specialized care you will receive;

- May limit the number of visits to the specialist; or
- May limit the period of time that visits may be made to the specialist.

If a standing referral is authorized, your Primary Care Doctor will determine which specialist or specialty care center to send you to in the following order:

- First, an Anthem Blue Cross HMO contracting specialist or specialty care center which is associated with your Medical Group;
- Second, any Anthem Blue Cross HMO contracting specialist or specialty care center; and
- Last, any specialist or specialty care center;

that has the expertise to provide the care you need for your condition or disease.

After the referral is made, the specialist or specialty care center will be authorized to provide you health care services that are within the specialist's area of expertise and training in the same manner as your Primary Care Doctor, subject to the terms of the treatment Plan.

Remember: We only pay for the number of visits and the type of special care that your Primary Care Doctor OK's. Call your Doctor if you need more care. **If your care isn't approved ahead of time, you will have to pay for it (except for Emergency Services and Care.)**

If you receive covered non-Emergency Services and Care at an Anthem Blue Cross HMO Hospital or facility in California at which, or as a result of which, you receive services provided by a non-Anthem Blue Cross HMO Health Care Provider, you will pay no more than the same cost sharing that you would pay for the same covered services received from an Anthem Blue Cross HMO Health Care Provider.

Ready Access

There are two ways you may get special care without getting an OK from your Medical Group. These two ways are the "Direct Access" and "Speedy Referral." programs. **Not all Medical Groups take part in the Ready Access program. See your Anthem Blue Cross HMO Directory for those that do.**

Direct Access. You may be able to get some special care without an OK from your Primary Care Doctor. We have a program called "Direct Access", which lets you get special care, without an OK from your Primary Care Doctor for:

- Allergy
- Dermatology
- Ear/Nose/Throat

Ask your Anthem Blue Cross HMO coordinator if your Medical Group takes part in the "Direct Access" program. If your Medical Group participates in the Direct Access program, you must still get your care from a Doctor who works with your Medical Group. The Anthem Blue Cross HMO coordinator will give you a list of those Doctors.

Speedy Referral. If you need special care, your Primary Care Doctor may be able to refer you for it without getting an OK from your Medical Group first. The types of special care you can get through Speedy Referral depend on your Medical Group.

Obstetrical and Gynecological Care

Obstetrical and gynecological services may be received directly, without obtaining referral, from an obstetrician and gynecologist or family practice physician who is a Member of your Medical Group, or who has an arrangement with your Medical Group to provide care for its patients, and who has been identified by your Medical Group as available for providing obstetrical and gynecological care.

- A Doctor specializing in obstetrical or gynecological care may refer you to another Doctor or health care provider and order

related obstetrical and gynecological items and services if you need additional Medically Necessary care.

- The conditions for a referral from a Doctor specializing in obstetrical or gynecological care are the same conditions for a referral from your participating care Doctor. See **When You Need a Referral**.
- Ask your Anthem Blue Cross HMO coordinator for the list of OB-GYN health care providers you must choose from.

Reproductive or Sexual Health Care Services

Reproductive or sexual health care services may be received directly, without obtaining referral from your Primary Care Doctor or Medical Group.

Care for Mental Health or Substance Use Disorder and Autism Spectrum Disorders

You may get care for the treatment of Mental Health or Substance Use Disorder and autism spectrum disorders without getting an OK from your Medical Group. In order for this care to be covered, you must go to an Anthem Blue Cross HMO Health Care Provider. Some services require that we review and OK care in advance. Please see "Mental Health/Substance Use Disorder" in the section called "Your Benefits At Anthem Blue Cross HMO" and the section "Benefits for Autism Spectrum Disorders Services" for complete information.

You can get an Anthem Blue Cross Behavioral Health Network directory listing these providers from your Plan administrator (usually your employer) or from us as follows:

- You can call our Member Services Number shown on your Member ID card or you may write to us and ask us to send you a directory. Ask for the Behavioral Health Network directory.
- You can also search for an Anthem Blue Cross HMO Health Care Provider using the "Provider Finder" function on our website at **www.anthem.com/ca**. Be sure to select the "Behavioral Health Professionals" option on the next screen following your selection of Plan category.

In addition, if you are a new Member and you enrolled in this Plan because the employer changed health Plans, and you are getting care for an acute, serious, or chronic mental health or for substance use disorder from a Doctor or other health care provider who is not part of the Anthem Blue Cross HMO network, you may be able to continue your course of treatment with that Doctor or health care provider for a reasonable period of time before transferring to an Anthem Blue Cross HMO Health Care Provider. To ask for this continued care or to get a copy of our written policy for this continued care, please call our Member Services Number shown on your Member ID card.

Mental Health Parity and Addiction Equity Act

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

The Mental Health Parity and Addiction Equity Act also provides for parity in the application of nonquantitative treatment limitations (NQTL). An example of a nonquantitative treatment limitation is a precertification requirement.

Also, the Plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on Mental Health or Substance Use Disorder benefits that are more restrictive than Deductibles, Copayment, Coinsurance and out of pocket expenses applicable to substantially all other medical and surgical benefits in the same classification.

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

Gender Affirming Services

You may get coverage for services and supplies provided in connection with Gender Transition without getting an OK from your Medical Group. You must obtain our approval in advance for all gender affirming services in order for these services to be covered by this Plan (see "Medical Management Programs" for details). No benefits are payable for these services if our approval is not obtained. Please see "Gender Affirming Services" in the section called "Your Benefits At Anthem Blue Cross HMO" for complete information.

When You Want a Second Opinion

You may receive a second opinion about care you receive from:

- Your Primary Care Doctor, or
- A specialist to whom you were referred by your Primary Care Doctor.

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

- Questions about whether recommended surgical procedures are reasonable or necessary.
- Questions about the diagnosis or Plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including but not limited to a serious chronic condition.
- The clinical indications are not clear or are complex and confusing.
- A diagnosis is in doubt because of test results that do not agree.
- The first Doctor or health care provider is unable to diagnose the condition.
- The treatment Plan in progress is not improving your medical condition within an appropriate period of time.

- You have tried to follow the treatment Plan or you have talked with the Doctor or health care provider about serious concerns you have about your diagnosis or Plan of care.

To ask for a second opinion about care you received from your Primary Care Doctor if your Primary Care Doctor is part of a Medical Group, call your Primary Care Doctor or your Anthem Blue Cross HMO coordinator at your Medical Group. The second opinion will be provided by a qualified Doctor or health care provider of your choice who is part of your Medical Group.

To ask for a second opinion about care you received from:

- Your Primary Care Doctor if he or she is an independently contracting Primary Care Doctor (not part of a Medical Group), or
- Any specialist,

please call the Member Services Number shown on your ID card. The Member Services Representative will verify your Anthem Blue Cross HMO Membership, get preliminary information, and give your request to an RN Case Manager. The second opinion will be provided by a qualified Doctor or health care provider of your choice who is part of the Anthem Blue Cross HMO network. Please note that if your Primary Care Doctor is part of a Medical Group, the Doctor or health care provider who provides the second opinion may not necessarily be part of your Medical Group.

For any second opinion, if there is no appropriately qualified Doctor or health care provider in the Anthem Blue Cross HMO network, we will authorize a second opinion by another appropriately qualified Doctor or health care provider, taking into account your ability to travel.

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

When approved, your Primary Care Doctor or Case Manager helps you with selecting a Doctor or health care provider who will provide the second opinion within a reasonable travel distance and makes arrangements for your appointment at a time convenient for you and appropriate to your medical condition. If your medical condition is serious, your appointment will be scheduled within no more than seventy-two (72) hours. You must pay only your usual Copay for the second opinion.

An approval letter is sent to you and the Doctor or health care provider who will provide the second opinion. The letter includes the services approved and the date of your scheduled appointment. It also includes a telephone number to call if you have questions or need additional help. Approval is for the second opinion consultation only. It does not include any other services such as lab, x-ray, or additional treatment. You and your Primary Care Doctor or specialist will get a copy of the second opinion report, which includes any recommended diagnostic testing or procedures. When you get the report, you and your Primary Care Doctor or specialist should work together to determine your treatment options and develop a treatment Plan. Your Medical Group (or your Primary Care Doctor, if he or she is an independently contracting Primary Care Doctor) must authorize all follow-up care.

You may appeal a disapproval decision by following our complaint process. Procedures for filing a complaint are described later in this Evidence of Coverage (see "How to Make a Complaint") and in your denial letter.

If you have questions or need more information about this program, please contact your Anthem Blue Cross HMO coordinator at your Medical Group or call the Member Services Number shown on your Member ID card.

When You Need a Hospital Stay

There may be a time when your Primary Care Doctor says you need to go to the hospital. If it is not an emergency, the Medical Group or Anthem will look into whether or not it is Medically Necessary. If your Hospital stay is OK'd, you will need to go to a Hospital that works with your Medical Group.

When There is an Emergency

If you need Emergency Services and Care, get the medical care you need right away. In some areas, there is a 9-1-1 emergency response system that you may call for Emergency Services and Care (this system is to be used only when there is an emergency that requires an emergency response) . If you are experiencing a mental health crisis, you may also call 988 for assistance.

We provide coverage for emergency room medical care and follow-up healthcare treatment for a Member who is treated following a rape or sexual assault without Cost Sharing for the first nine months after the Member initiates treatment. Follow-up health care treatment includes medical or surgical services for the diagnosis, prevention or treatment of medical conditions arising from an instance of rape or sexual assault. We will only cover follow-up healthcare treatment by an non-[Anthem CaliforniaCare/Anthem Select/Anthem Select Plus/Anthem Priority Select/Anthem Vivity/Anthem Designed Access] HMO Health Care Provider in the case of Emergency Medical Condition and/or if no [Anthem CaliforniaCare/Anthem Select/Anthem Select Plus/Anthem Priority Select/Anthem Vivity/Anthem Designed Access] HMO Health Care Provider is available to ensure timely access.

Benefits are also available for services provided by a Community Paramedicine Program, Triage to Alternate Destination Program, or Mobile Integrated Health Program, and if you receive Covered Benefits from non-[Anthem CaliforniaCare/Anthem Select/Anthem Select Plus/Anthem Priority Select/Anthem Vivity/Anthem Designed Access] HMO Health Care Provider, you will pay no more than the same Cost Sharing that you would pay for the same Covered Benefits received from an [Anthem CaliforniaCare/Anthem Select/Anthem Select Plus/Anthem Priority Select/Anthem Vivity/Anthem Designed Access] HMO Health Care Provider.

Once you are stabilized, your Primary Care Doctor or Anthem must OK any care you need after that.

- Ask the Hospital or emergency room Doctor to call your Primary Care Doctor.

- Your Primary Care Doctor or Anthem will OK any other Medically Necessary care or will take over your care.

You may need to pay a Copay for emergency room services. A Copay is a set amount you must pay for services. We cover the rest.

If You Are In-Area. You are in-area if you are less than 15-miles or 30-minutes from your Medical Group or Primary Care Doctor's office.

If you need Emergency Services and Care, get the medical care you need right away. If you want, you may also call your Primary Care Doctor and follow his or her instructions.

Your Primary Care Doctor or Medical Group may:

- Ask you to come into their office;
- Give you the name of a Hospital or emergency room and tell you to go there;
- Order an ambulance for you;
- Give you the name of another Doctor or Medical Group and tell you to go there; or
- Tell you to call the 9-1-1 emergency response system.

If You're Out of Area. You can still get Emergency Services and Care if you are more than 15-miles or 30-minutes away from your Medical Group or Primary Care Doctor's office.

If you need Emergency Services and Care, get the medical care you need right away (follow the instructions above for When There is an Emergency). In some areas, there is a 9-1-1 emergency response system that you may call for Emergency Services and Care (this system is to be used only when there is an emergency that requires an emergency response). You must call us within 48 hours if you are admitted to a hospital.

Remember:

- We won't cover services that don't fit what we mean by Emergency Services and Care.
- Your Primary Care Doctor must OK care you get once you are stabilized, unless Anthem Blue Cross HMO OKs it.
- Once your Medical Group or Anthem Blue Cross HMO give an OK for Emergency Services and Care, they cannot withdraw it.

You Need Urgent Care

If You Are In-Area. You are in-area if you are 15-miles or 30-minutes or less from your Medical Group or Primary Care Doctor's office.

If you are in area, call your Primary Care Doctor or Medical Group. Follow their instructions.

Your Primary Care Doctor or Medical Group may:

- Ask you to come into their office;
- Give you the name of a Hospital or emergency room and tell you to go there;
- Order an ambulance for you;
- Give you the name of another Doctor or Medical Group and tell you to go there; or
- Tell you to call the 9-1-1 emergency response system.

Please note: In-area Urgent Care services are only covered if they are provided by your Primary Care Doctor or Medical Group. Urgent Care services received by any other provider while in-area will not be covered.

If You're Out of Area. You can get Urgent Care if you are more than 15-miles or 30-minutes away from your Primary Care Doctor or Medical Group.

For Urgent Care, if care can't wait until you get back to make an appointment with your Primary Care Doctor, get the medical care you need right away. You must call us within 48 hours if you are admitted to a hospital.

If you need a Hospital stay or long-term care, we'll check on your progress. When you are able to be moved, we'll help you return to your Primary Care Doctor's or Medical Group's area.

Remember:

- We won't cover services that don't fit what we mean by Urgent Care.
- Your Primary Care Doctor must OK care you get once you are stabilized, unless Anthem Blue Cross HMO OKs it.

Triage and Screening Services

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

Getting Care When You Are Outside of California

If you or your family Members will be away from home for more than 90 days, you may be able to get a guest Membership in a Medical Group in the city you are visiting.

- Before you leave home, call the Anthem Blue Cross HMO Member Services Number on your Member ID card.
- Ask for the Guest Membership Coordinator.
- We will send you forms to fill out.

- If there is a Medical Group taking part in the national network in the city you will be visiting, you'll be a guest Member while you're away from home.
- The benefits you will get may not be the same as the benefits you would get at home.

Even without a guest Membership, you can get Medically Necessary care (Urgent Care, Emergency Services and Care, or follow-up care) when you are away from home.

You can get Medically Necessary care (Urgent Care, Emergency Services and Care, or follow-up care) when you are away from home.

- **If you are traveling outside California,** and need health care because of a non-emergency illness or injury, call the BlueCard Access 800 number, 1-800-810-BLUE (2583).
- **The BlueCard Access Call Center will tell you if there are Doctors or hospitals in the area** that can give you care. They will give you the names and phone numbers of nearby Doctors and hospitals that you go to or call for an appointment.
- **If it's an emergency, get medical care right away.** You or a Member of your family must call us within 48 hours after first getting care.
- **The provider may bill you for these services**. Send these bills to us. We will make sure the services were Emergency Services and Care or Urgent Care. You may need to pay a copay.

Note: Providers available to you through the BlueCard Program have not entered into contracts with Anthem Blue Cross. If you have any questions or complaints about the BlueCard Program, please call us at the Member Services telephone number listed on your ID card.

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

Prior to travel outside the United States, call the Member Services Number listed on your Member ID card to find out if your Plan has

Blue Cross Blue Shield Global Core benefits. Your coverage outside the United States is limited and we recommend:

- Before you leave home, call the Member Services Number listed on your Member ID card for coverage details. **You have coverage for services and supplies furnished only in connection with Urgent Care or an emergency when travelling outside the United States.**
- Always carry your current Member ID card.
- In an emergency or if you need Urgent Care, seek medical treatment immediately.
- **The Blue Cross Blue Shield Global Core Service Center is available 24 hours a day, seven days a week toll-free at (800) 810-BLUE (2583) or by calling collect at (804) 673-1177.** An assistance coordinator, along with a medical professional, will arrange a Doctor appointment or hospitalization, if needed.
- If you are admitted to a hospital, you must call us within 48 hours at the Member Services Number listed on your Member ID card. This number is different than the phone numbers listed above for Blue Cross Blue Shield Global Core.

Call the Blue Cross Blue Shield Global Core Service Center in these non-emergent situations:

- **You need to find a Doctor or Hospital or need medical assistance services.** An assistance coordinator, along with a medical professional, will arrange a Doctor appointment or hospitalization, if needed.
- **You need to be hospitalized or need inpatient care.** After calling the Service Center, you must also call us at the Member Services Number listed on your Member ID card for pre-service review to determine whether the services are covered. Please note that this number is different than the phone numbers listed above for Blue Cross Blue Shield Global Core.

Payment Information.

- **Participating Blue Cross Blue Shield Global Core hospitals.** When you make arrangements for hospitalization through Blue Cross Blue Shield Global Core, you should not need to pay upfront for inpatient care at participating Blue Cross Blue Shield Global Core hospitals except for the out-of-pocket costs (noncovered services, deductible, copays and coinsurance) you normally pay. The Hospital will submit your claim on your behalf.

- **Doctors and/or non-participating hospitals.** You will need to pay upfront for outpatient services, care received from a Doctor, and inpatient care not arranged through the Blue Cross Blue Shield Global Core Service Center. Then you can complete a Blue Cross Blue Shield Global Core claim form and send it with the original bill(s) to the Blue Cross Blue Shield Global Core Service Center (the address is on the form).

Claim Filing.

- **The Hospital will file your claim** if the Blue Cross Blue Shield Global Core Service Center arranged your hospitalization. You will need to pay the Hospital for the out-of-pocket costs you normally pay.

- **You must file the claim** for outpatient and Doctor care, or inpatient care not arranged through the Blue Cross Blue Shield Global Core Service Center. You will need to pay the health care provider and subsequently send an international claim form with the original bills to Anthem.

Additional Information About Blue Cross Blue Shield Global Core Claims.

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

- Exchange rates are determined as follows:

  - For inpatient Hospital care, the rate is based on the date of admission.

- For outpatient and professional services, the rate is based on the date the service is provided.

Claim Forms.

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

  www.bcbsglobalcore.com.

  The address for submitting claims is on the form.

Revoking or Modifying a Referral or Authorization

A referral or authorization for services or care that was approved by your Medical Group, your Primary Care Doctor, or by us may be revoked or modified prior to the services being rendered for reasons including but not limited to the following:

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

If You and Your Doctor Don't Agree

If you think you need a certain kind of care, but your Doctor or Medical Group isn't recommending it, you have a right to the following:

- **Ask for a written notice** of being denied the care you felt you needed. You should get this notice within 48 hours.
- **Your Doctor should give you a written reason** and another choice of care within 48 hours.
- **You can make a formal appeal** to the Medical Group and to Anthem. See "How to Make a Complaint" on a later page.

We Want You to Have Good Health

Ask about our many programs to:

- Educate you about living a healthy life.
- Get a health screening.
- Learn about your health problem.

For more information, please call us at our Member Services Number shown on your Member ID card.

Mental Health or Substance Use Disorder Services

You have a right to receive timely and geographically accessible Mental Health/Substance Use Disorder (MH/SUD) services when you need them. If Anthem fails to arrange those services for you with an appropriate provider who is in the health Plan's network, the health Plan must cover and arrange needed services for you from a non-Anthem Blue Cross HMO Health Care Provider. If that happens, you do not have to pay anything other than your ordinary Anthem Blue Cross HMO Health Care Provider cost-sharing.

If you do not need the services urgently, your health Plan must offer an appointment for you that is no more than 10 business days from when you requested the services from the health Plan. If you urgently need the services, your health Plan must offer you an appointment within 48 hours of your request (if the health Plan does not require prior authorization for the appointment) or within 96 hours (if the health Plan does require prior authorization).

If your health Plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health Plan's network. To be covered by your health Plan, your first appointment with the provider must be within 90 calendar days of the date you first asked the Plan for the MH/SUD services.

If you have questions about how to obtain MH/SUD services or are having difficulty obtaining services you can: 1) call your health Plan at the telephone number on the back of your health Plan identification card; 2) call the California Department of Managed Care's Help Center at 1-888-466-2219; or 3) contact the California Department of Managed Health Care through

its website at www.healthhelp.ca.gov to request assistance in obtaining MH/SUD services.

Timely Access to Care

Anthem has contracted with health care providers to provide covered services in a manner appropriate for your condition, consistent with good professional practice. Anthem ensures that its contracted provider networks have the capacity and availability to offer appointments within the timeframes specified below. Where there is no Anthem Blue Cross HMO Health Care Provider available for a Medically Necessary covered service, an Authorized Referral for a non-Anthem Blue Cross HMO Health Care Provider may be provided at the Anthem Blue Cross HMO Health Care Provider cost share amounts (deductible, copayment, and/or coinsurance). If you receive prior authorization for a non-Anthem Blue Cross HMO Health Care Provider due to network adequacy issues, you will not be responsible for the difference between the provider's non-Anthem Blue Cross HMO Health Care Provider charge and the negotiated fee rate. Please contact Member Services at the telephone number on the back of your Identification Card for Authorized Referrals information or to request authorization.

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

For Mental Health /Substance Use Disorder care:

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

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

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

If you need the services of an interpreter, the services will be coordinated with scheduled appointments and will not result in a delay of an appointment with an Anthem Blue Cross HMO Health Care Provider.

Your Benefits at Anthem Blue Cross HMO

It's important to remember:

- The benefits of this Plan are given only for those services that the Medical Group or Anthem finds are Medically Necessary.
- Care must be received from your Primary Care Doctor or another Anthem Blue Cross HMO Health Care Provider to be a covered service under this Plan. If you use a non-Anthem Blue Cross HMO Health Care Provider, your entire claim will be denied unless:
  - The services are for emergency or out-of-area Urgent Care;
  - The services are approved in advance by us as an Authorized Referral; or
  - You receive covered non-Emergency Services and Care at an Anthem Blue Cross HMO Hospital or facility in California at which, or as a result of which, you receive services provided by a non-Anthem Blue Cross HMO Health Care Provider; in such case you will pay no more than the same cost sharing that you would pay for the same covered services received from an Anthem Blue Cross HMO Health Care Provider.
- Just because a Doctor orders a service, it doesn't mean that:
  - The service is Medically Necessary; or
  - This Plan covers it.
- If you have any questions about what services are covered, read this Evidence of Coverage, or give us a call at the number on your Member ID card.

- All benefits are subject to coordination with benefits available under certain other Plans.
- We have the right to be repaid by a third party for medical care we cover if your injury, disease or other health problem is their fault or responsibility.
- Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking Emergency Services and Care, out-of-area, Urgent Care services or an Authorized Referral in accordance with this Plan from non-Anthem Blue Cross HMO Health Care Provider could be balanced billed by the non-Anthem Blue Cross HMO Health Care Provider for those services that are determined to be not payable as a result of these review processes and meets the criteria set forth in any applicable state regulations adopted pursuant to state law. A claim may also be determined to be not payable due to a provider's failure to submit medical records with the claims that are under review in these processes.

What are Copays?

A Copay is a set amount you pay for each medical service or prescription drug. You need to pay a Copay for some services given under this Plan, but many other supplies and services do not need a copay. Usually, you must pay the Copay at the time you get the services. The copays you need to pay for services are shown in the next section.

If you do not pay your Copay within 31 days from the date it's due, we have the right to cancel your coverage under the Plan. To find out how your coverage is cancelled if you do not pay your copay, see "How Your Coverage Ends", in the section "What You Should Know about Your Coverage", (see Table of Contents).

Here are the Copay Limits

If you pay more than the Copay Limits shown below in one calendar year (January through December), you won't need to pay any more copays for the rest of the year.

Per Number of Members	Copay Limits

- One Member **$3,000**
- Family **$6,000***

  *But, not more than $3,000 for any one Member in a Family. For any given family Member, the Copay Limit is met either after he/she meets the amount for Member, or after the entire family Copay Limit is met. The family Copay Limit can be met by any combination of amounts from any family Member.

The following won't apply to the Copay Limits:

- For infertility, any Copay for diagnosis and testing for finding out about it.
- Amounts in excess of the Prescription Drug maximum allowed amount.

Crediting Prior Plan Coverage

If you were covered by your employer's prior Plan immediately before your employer signs up with us, with no lapse in coverage, then you will get credit for any accrued deductible and, if applicable and approved by us, any Copay Limit under the prior Plan. This does not apply to individuals who were not covered by the prior Plan on the day before your employer's coverage with us began, or who join your employer later.

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

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

If your employer offers coverage through other products or carriers in addition to ours, and you change products or carriers to enroll in this product with no break in coverage, you will get credit for any accrued deductible and any Copay Limit under this Plan.

This Section Does Not Apply To You If:

- Your employer moves to this Plan at the beginning of each year;
- You change from one of our individual policies to a group Plan;
- You change employers; or
- You are a new Member who joins after your employer initial enrollment with us.

Important Notice about Your Deductible and Copay Limit Accrual Balances

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

What We Cover

We list benefits for the services and supplies in this section. Any copays you must pay are shown next to the service or supply. We list things **we do NOT cover in the next section**.

Remember:

Your Primary Care Doctor and your Medical Group or Anthem must give or OK your care.

Doctor Care (or services of a Health Professional)	Copay

- Office visits for a covered illness, injury or health problem **$20**
- Behavioral health and wellness screenings for children and adolescents 8 to 18 years of age including for both depression and anxiety, injury or health problem **$20**
- Home visits, when approved by your Medical Group, at the Doctor's discretion **$20**
- Surgery in hospital, Ambulatory Surgery Center or Medical Group and surgical assistants ..... **No charge**
- Anesthesia services ..... **No charge**
- Doctor visits during a Hospital stay ..... **No charge**
- Visit to a specialist **$35**
- Medically Necessary acupuncture OK'd by your Primary Care Doctor **$20**
- Vision exams if OK'd by your Primary Care Doctor **$20**

Preventive Care Services	Copay

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 preventive care services are covered with no deductible (if applicable) or Copay when you use an Anthem Blue Cross HMO Health Care Provider. In addition, office visits associated with a preventive care service will be provided at no cost if the preventive care service is not billed separately, or is not tracked as an individual encounter separately, from the office visit and the primary purpose of the office visit is the delivery of the preventive care service.

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

Covered services fall under the following broad groups:

- Services with an "A" or "B" rating from the United States Preventive Services Task Force ..... **No charge**

  Examples of health screenings include:

  - breast cancer screenings,
  - cervical cancer screening tests,
  - colorectal cancer screenings, including preventive colonoscopy, anesthesia, polyp removal and pathology tests in connection with the preventive screening. This also includes a preventive screening following a positive non-invasive stool-based screening test or following a positive direct visualization test (i.e., flexible sigmoidoscopy, CT colonography),
  - screenings for high blood pressure,
  - type 2 diabetes mellitus,
  - cholesterol,

- child and adult obesity.

♦ Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ..... **No charge**

♦ Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration ..... **No charge**

♦ Preventive care and screening as listed in the guidelines supported by the Health Resources and Services Administration, including: ..... **No charge**

- All FDA-approved contraceptive drugs, devices, and other products, including over-the-counter FDA-approved contraceptive drugs, devices, and other products. This includes contraceptive drugs as well as other contraceptive medications such as injectable contraceptives patches, over-the-counter oral contraceptives (including emergency contraceptives) and male condoms and devices such as diaphragms, intrauterine devices (IUDs) and implants, as well as voluntary sterilization procedures, contraceptive education and counseling. It also includes follow-up services related to the drugs, devices, products and procedures, including but not limited to management of side effects, counseling for continued adherence, and device insertion and removal.

  At least one form of contraception in each of the methods identified in the FDA's Birth Control Guide will be covered as preventive care under this section. If there is only one form of contraception in a given method, or if a form of contraception is deemed not medically advisable by your Doctor, 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 drugs must be generic contraceptives. Brand Name Drugs

will be covered under your Plan's Prescription Drug benefits (see "Getting Prescription Drugs"), except as described below.

Some categories and classes of contraceptives do not have generic drugs commercially available in the market and, in each of these categories, at least one brand drug is available at $0 cost sharing when you receive it from an Anthem Blue Cross HMO Health Care Provider. If your provider determines that a Brand Name Drug with an available generic drug therapeutic equivalent commercially available in the market is Medically Necessary because a generic drug equivalent is not appropriate for you, you may obtain coverage of the Brand Name Drug with $0 cost sharing if your provider submits an exception request. Your Doctor must complete a contraceptive exception form and return it to us. You or your Doctor can find the form online at https://file.anthem.com/Anthem_ABC_BrandContraceptiveCopayWaiverForm.pdf or by calling the number listed on the back of your ID Card. If medical necessity has been determined by your provider, an exception will be granted and coverage of the drug will be provided at $0 cost sharing. Otherwise, Brand Name Drugs will be covered as a Preventive Care Services benefit when Medically Necessary according to your attending provider, otherwise they will be covered under "Getting Prescription Drugs."

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

The Plan will not impose any restrictions or delays on your coverage of FDA-approved contraceptive drugs, devices, and other products, including prior authorization requests, any utilization controls or any other form of medical management restrictions.

Note that a prescription will not be required to trigger coverage of over-the-counter FDA-approved contraceptive drugs, devices, and products; and point-of-sale coverage for

over-the-counter FDA-approved contraceptive drugs, devices, and products will be provided at Member Drugstores with no cost sharing or medical management restrictions.

- Breast feeding support, supplies, and counseling ordered by your Primary Care Doctor or Medical Group. One breast pumps will be covered per pregnancy under this benefit.
- Gestational diabetes screening.
- Preventive prenatal care.
- Home test kits for sexually transmitted diseases (STD), including any laboratory costs of processing the kits.
  - Must be deemed Medically Necessary or appropriate and ordered directly by a clinician or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs, when ordered by an Anthem Blue Cross HMO Health Care Provider; and
  - Must be a product used for a test recommended by the federal Centers for Disease Control and Prevention guidelines or the United States Preventive Services Task Force that has been CLIA waived, FDA cleared or approved, or developed by a laboratory in accordance with established regulations and quality standards, to allow individuals to self-collect specimens for STDs, including HIV, remotely at a location outside of a clinical setting.

- Preventive care services for smoking cessation and tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including:
  - Counseling
  - Prescription Drugs obtained at a Retail or Home Delivery (Mail Order) Pharmacy

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

♦ Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Doctor: ..... **No charge**

Includes the following:

- Aspirin
- Folic acid supplement
- Bowel preparations
- Preexposure prophylaxis (PrEP) for prevention of HIV infection.

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

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

Examples of preventive care covered services are provided below.

Well Baby and Well Child Preventive Care

- Office Visits.
- Routine physical exam including medically appropriate laboratory tests, procedures and radiology services in connection with the exam.
- Screenings including blood lead levels for children at risk for lead poisoning; vision (eye chart only); and hearing screening in connection with the routine physical exam.

- Immunizations including those recommended by the American Academy of Pediatrics and the Advisory Committee on Immunization Practices.
- Health education on pediatric wellness to prevent common sickness including, but not limited to, asthma.
- Hepatitis B and varicella zoster (chicken pox) injectable vaccines and other age appropriate injectable vaccinations as recommended by the American Academy of Pediatrics and the office visit associated with administering the injectable vaccination when ordered by your Doctor.
- Human papillomavirus (HPV) test for cervical cancer and HPV vaccine.

Adult Preventive Care

- Routine physical exams.
- Medically appropriate laboratory tests and procedures and radiology procedures in connection with the routine physical exam.
- Cholesterol, osteoporosis (periodic bone density screening for menopausal or post-menopausal women), vision (eye chart only), and hearing screenings in connection with the routine physical exam.
- Immunizations including those recommended by the U.S. Public Health Service and the Advisory Committee on Immunization Practices for Members age 19 and above.
- Health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided.
- Screening and counseling for Human Immunodeficiency Virus (HIV).
- Preventive counseling and risk factor reduction intervention services in connection with tobacco use and tobacco use-related diseases.

- FDA-approved cancer screenings including pap examinations; breast exams; mammography testing; appropriate screening for breast cancer; ovarian, colorectal and cervical cancer screening tests, including the human papillomavirus (HPV) test for cervical cancer and HPV vaccine; prostate cancer screenings, including digital rectal exam and prostate specific antigen (PSA) test; and the office visit related to these services.

COVID-19	**Copay**

♦ Coverage for tests, immunizations, and therapeutics ..... **No Charge**

Note: For COVID-19 diagnosis, screening, prevention, and therapeutics, your cost share for non-Anthem Blue Cross HMO Health Care Provider services starting six months after the expiration of the current Public Health Emergency will not be covered.

Diabetes	**Copay**

♦ Equipment and supplies used for the treatment of diabetes (see below) ..... **See "Medical Equipment"**

- Glucose monitors, including monitors designed to help the visually impaired, and blood glucose testing strips.
- Insulin pumps
- Pen delivery systems for insulin administration (non-disposable).
- Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin.

♦ Podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes-related complications ..... **See "Prosthetic Devices"**

- Diabetes education program services supervised by a Doctor which include: **$20**
  - Teaching you and your family Members about the disease process and how to take care of it; and
  - Training, education, and nutrition therapy to enable you to use the equipment, supplies, and medicines needed to manage the disease.
- The following items are covered under your drug benefits ..... **See "Getting Prescription Drugs"**
  - Insulin, glucagon, and other prescription drugs for the treatment of diabetes.
  - Insulin syringes, disposable pen delivery systems for insulin administration.
  - Testing strips, lancets, and alcohol swabs.

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

General Medical Care (In a Non-Hospital-Based Facility)	**Copay**

- Hemodialysis treatment, including treatment at home if OK'd by the Medical Group ..... **No charge**
- Medical social services ..... **No charge**
- Chemotherapy and radiation therapy ..... **No charge**
- Infusion therapy, including but not limited to Parenteral Therapy and Total Parenteral Nutrition (TPN) ..... **No charge**
- Allergy tests and care ..... **No charge**
- X-ray and laboratory tests:

- Advanced Imaging Procedures .....**$100** per test
- Genetic testing (not including Medically Necessary genetic testing of the fetus or newborn or BRCA testing) ..... **No charge**
- All other x-ray and laboratory tests ..... **No charge**

- Smoking cessation programs for nicotine dependency. ..... **No charge**

  Prescription Drugs to help you stop smoking or reduce your dependence on tobacco products, as well as over-the-counter nicotine replacement products (limited to nicotine patches and gum) are covered when obtained with a Doctor's prescription. These drugs and products will be covered as preventive care services. See "Getting Prescription Drugs".

Pregnancy or Maternity Care	**Copay**

Medical services for an enrolled Member are provided for pregnancy and maternity care, including the following services: Prenatal, postnatal, and postpartum care, ambulatory care services (including ultrasounds, fetal non-stress tests, Doctor 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.

Benefits include all abortion and abortion-related services, including pre-abortion and follow-up services. For outpatient abortion services, precertification is not required. Covered services are not subject to the deductible, if applicable, copayment, and/or coinsurance.

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

- Standard; combined prenatal and postpartum visits: Office visits, including maternal mental health screenings and postpartum screenings as required by law **$20**
- Doctor's services for normal delivery or cesarean section ..... **No charge**
- Hospital services:
  - Inpatient services ..... **No charge**
  - Outpatient covered services ..... **No charge**
- Genetic testing, when Medically Necessary ..... **No charge**
- Prenatal testing administered by the State Department of Public Health for the California Prenatal Screening Program ..... **No charge**
- Hospital services for routine nursery care of your newborn child if the newborn child's natural mother is an enrolled Member ..... **No charge**

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

Note: For inpatient Hospital services related to childbirth, we will provide at least 48 hours after a normal delivery or 96 hours after a cesarean section, unless the mother and her Doctor decide on an earlier discharge. Please see the section called "For Your Information" for a statement of your rights under federal law regarding these services.

Doula Services	Copay

Doula services if you are pregnant or were pregnant within the last twelve (12) months. Prenatal and postpartum services provided by a doula include the following:

- One initial visit,
- Up to eight one-hour visits that may be provided in any combination of prenatal and postpartum visits,
- Doula support services provided during or after a miscarriage,
- Support during labor and delivery.

♦ Prenatal Visit.....**$20**

♦ Postnatal Visit **$20**

♦ Prenatal and Postnatal Visit Benefit Maximum (Combined).....**9 visits per benefit year**

♦ Doula Support Services Provided During or After Miscarriage.....**$20**

♦ Labor/Delivery Support Provided by a Doula .....**See Copays that apply**

The following services that may be provided by doulas are not covered under your Plan:

- Clinical or medical services (such as taking blood pressure or temperature, fetal heart tone checks, vaginal examinations, or postpartum clinical care);
- Assistance with activities of daily living;
- Alternative or complementary modalities (such as aromatherapy, childbirth education, massage therapy, or placenta encapsulation);

- Yoga;
- Birthing ceremonies;
- Over-the-counter supplies or Drugs;
- Home birth.

Family Planning Services	**Copay**

Your Plan includes coverage for contraceptives, sterilization procedures and counseling. The Plan will not impose any restrictions or delays on your coverage of FDA-approved contraceptive drugs, devices, and other products, including prior authorization or step therapy. Please see the "Preventive Care Services" for additional information.

Family planning services **$20**

Covered services for all Members include:

- All FDA approved contraceptive drugs, devices, and other products, including all FDA-approved contraceptive drugs, devices, and products available over-the-counter. Generic FDA-approved contraceptive drugs, devices, and other products at $0 cost share when obtained from an Anthem Blue Cross HMO Health Care Provider, unless there is no generic drug equivalent, the generic drug is unavailable or the generic drug would be medically inappropriate as determined by your provider at which time the Brand Name Drug would be covered with no deductible, copayment or coinsurance when obtained from an Anthem Blue Cross HMO Health Care Provider. Some categories and classes of contraceptives do not have generic drugs available and, in each of these categories, at least one Brand Name Drug is available at a $0 cost share when you receive it from an Anthem Blue Cross HMO Health Care Provider. If your provider determines that a Brand Name Drug with an available generic drug therapeutic equivalent is necessary because a generic drug therapeutic equivalent drug is not appropriate for you, you may obtain coverage of the Brand Name Drug with a $0 cost share when obtained from an Anthem Blue Cross HMO Health Care Provider. If there is one

or more therapeutic equivalent of a contraceptive drug, device or product, the Plan will cover at least one, if available, at a $0 cost share when obtained from an Anthem Blue Cross HMO Health Care Provider. Certain contraceptives are covered under the "Preventive Care Services" benefits. Please see that section for more details.

- A Prescription will not be required for over-the-counter FDA-approved contraceptive drugs, devices, and products and
- Over-the-counter FDA-approved contraceptive drugs, devices, and products will be provided at no cost when obtained from Member Drugstores. The Plan will not impose any medical management restrictions and prior authorization is not required.

Infertility and Fertility Services	**Copay**

Covered Benefits include the diagnosis and treatment of infertility and fertility services, including a maximum of three completed oocyte retrievals with unlimited embryo transfers in accordance with the guidelines of the American Society of Reproductive Medicine (ASRM), using single embryo transfer when recommended and medically appropriate. These services are provided on the same basis, at the same cost shares, as any other medical condition.

"Infertility" is defined as a condition or status characterized by any of the following:

- A licensed physician's findings, based on the patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors. This definition shall not prevent testing and diagnosis of infertility before the 12-month or 6-month period to establish infertility.
- A person's inability to reproduce either as an individual or with their partner without medical intervention.

- The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse. "Regular, unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older. Pregnancy resulting in miscarriage does not restart the 12-month or 6-month time period to qualify as having infertility.]

Additionally, benefits include Standard Fertility Preservation Services to prevent iatrogenic infertility when Medically Necessary are covered. Iatrogenic infertility means infertility caused directly or indirectly, as a possible side effect, by surgery, chemotherapy, radiation, or other covered medical treatment. "Caused directly or indirectly" means medical treatment with a possible side effect of infertility, as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine. Note that this benefit covers Standard Fertility Preservation Services only, as described, and benefits are determined by place of service. Standard Fertility Preservation Services do not include testing or treatment of infertility.

♦ Infertility and Fertility Services ..... **See Copays that apply**

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

Mastectomy	**Copay**
♦ Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema	**See copays that apply**
♦ Reconstructive Surgery of both breasts performed to restore symmetry following a mastectomy	**See copays that apply**

Reconstructive Surgery	Copay

- 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 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 ..... **See copays that apply**

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

Rehabilitative Care	Copay

You may have **up to a 60 day period of care** after an illness or injury. The 60 day period of care starts with the first visit for rehabilitative care. The 60 day limit does not limit the number of visits or treatments you get within the 60 day period. If you need more than the 60 day period of care, your Primary Care Doctor must get the OK from your Medical Group or Anthem. It must be shown that more care is Medically Necessary. Your Medical Group or Anthem will OK the extra visits or treatments. While there is no limit on the length of the covered period of care or the number of covered visits for Medically Necessary rehabilitative care, your Medical Group or Anthem must OK the longer time period and extra visits in advance.

Rehabilitative care as described above is also provided for a Member who is being treated for a mental health or substance use

disorder or for autism spectrum disorders. This care is provided even though the Member may not have suffered an illness or injury. The limits for physical therapy, occupational therapy, and speech therapy will not apply if you get care as part of the "Mental Health /Substance Use Disorder" benefit.

The Benefit Maximums apply to office and outpatient facility visits combined. The limits for physical, occupational and speech therapy will not apply if you get care as part of the Mental Health or Substance Use Disorder benefit (based on the primary diagnosis on the claim form).

If physical, occupational or speech therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health or Substance Use Disorder benefits, as required by law.

- Visits for rehabilitation, such as physical therapy, chiropractic services, occupational therapy or speech therapy ..... **No charge**

Inpatient Hospital Services	**Copay**

- A Hospital room with two or more beds, or a private room only if Medically Necessary, ordered by your Primary Care Doctor and OK'd by your Medical Group or Anthem..... **No charge**
- Operating room and special treatment room..... **No charge**
- Intensive care ..... **No charge**
- Nursing care ..... **No charge**
- Blood transfusions. This includes the cost of blood, blood products or blood processing ..... **No charge**
- Laboratory, cardiology, pathology and radiology services..... **No charge**

- Physical therapy, occupational therapy, speech therapy, radiation therapy, chemotherapy and hemodialysis ..... **No charge**
- Drugs and medicines, and supplies you get during your stay. This includes oxygen ..... **No charge**
- Bariatric surgery..... **No charge**

Outpatient (In a Hospital or Ambulatory Surgery Center)	**Copay**

- Emergency room use, supplies, other services, drugs and medicines. This includes oxygen.....**$75***

  *You don't have to pay the **$75** if you are admitted as an inpatient.

- Care given when surgery is done. This includes operating room use, supplies, drugs and medicines, oxygen, and other services. ..... **No charge**

As described in the "Consolidated Appropriations Act of 2021 Notice" at the front of this Evidence of Coverage, non-Anthem Blue Cross HMO Health Care Providers may only bill you for any applicable Copayments, Deductible and Coinsurance and may not bill you for any charges over the Plan's Reasonable and Customary Value (or when applicable, the negotiated fee rate) until the treating non-Anthem Blue Cross HMO Health Care Provider has determined you are stable and followed the notice and consent process. Please refer to the notice at the beginning of this Evidence of Coverage for more details.

- X-ray and laboratory tests:
  - Advanced Imaging Procedures.....**$100** per test
  - All other x-ray and laboratory tests ..... **No charge**

Urgent Care	Copay

If you are more than 15-miles or 30-minutes away from your Primary Care Doctor or Medical Group and require Urgent Care, get it right away. Urgent Care is not an emergency. It is care that is needed right away to relieve pain, find out what is wrong, or treat the health problem. You must call us within 48 hours if you are admitted to a hospital.

- Doctor's office visit or Urgent Care facility use, supplies, other services, drugs and medicines. This includes oxygen.....**$20***

  *You don't have to pay the **$20** if you are admitted as an inpatient to a hospital.

- Care given when surgery is done. This includes operating room use, supplies, drugs and medicines, oxygen, and other services. ..... **No charge**

Skilled Nursing Facility Services	Copay

You can get these kinds of care in a Skilled Nursing Facility for **up to 100 days in a calendar year**.

- Services and supplies provided by a Skilled Nursing Facility ..... **No charge**
  - A room with two or more beds;
  - Special treatment rooms;
  - Regular nursing services;
  - Laboratory tests;
  - Physical therapy, occupational therapy, speech therapy, or respiratory therapy;
  - Drugs and medicines given during your stay. This includes oxygen;
  - Blood transfusions; and

- Needed medical supplies and appliances.

Home Health Care	**Copay**

Benefits are available for covered services performed by a Home Health Agency or other provider in your home. We will cover home health care furnished by a Home Health Agency (HHA).

♦ Home health care services provided by a Home Health Agency (including intermittent skilled nursing services)..... **No charge**

Home health care services include the following:

- Care from a registered nurse or licensed vocational nurse who works under a registered nurse or a Doctor
- Physical therapy, occupational therapy, speech therapy, or respiratory therapy
- Visits with a medical social service worker
- Care from a health aide who works under a registered nurse with the HHA (one visit equals two hours or less). Other organizations may give services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Agency or other provider as approved by us or your Medical Group.

♦ Medically Necessary supplies from the HHA..... **No charge**

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/Substance Use Disorder" section below.

Hospice Care	**Copay**

You are eligible for hospice care if your Doctor and the hospice medical director certify that you are terminally ill and likely have less than twelve (12) months to live. You may access hospice care

while participating in an Approved Clinical Trial or continuing disease modifying therapy, as ordered by your treating Doctor. Disease modifying therapy treats the underlying terminal illness.

We will cover hospice care services shown below for the palliative care of pain and other symptoms if you have an illness that may lead to death within one year or less. Palliative care is care that controls pain and relieves symptoms but is not intended to cure the illness. Covered services include:

- Interdisciplinary team care to develop and maintain a Plan of care ..... **No charge**
- Short-term inpatient Hospital care in periods of crisis or as respite care ..... **No charge**
- Physical therapy, occupational therapy, speech therapy and respiratory therapy ..... **No charge**
- Social services and counseling services ..... **No charge**
- Skilled nursing services given by or under the supervision of a registered nurse. ..... **No charge**
- Certified home health aide services and homemaker services given under the supervision of a registered nurse. ..... **No charge**
- Diet and nutrition advice; nutrition help such as intravenous feeding or hyperalimentation ..... **No charge**
- Volunteer services given by trained hospice volunteers directed by a hospice staff Member..... **No charge**
- Drugs and medicines prescribed by a Doctor ..... **No charge**
- Medical supplies, oxygen and respiratory therapy supplies ..... **No charge**
- Care which controls pain and relieves symptoms ..... **No charge**
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care Plan to meet

those needs, both before and after the Member's death. Bereavement services are available to the patient and those individuals who are closely linked to the patient, including the immediate family, the primary or designated care giver and individuals with significant personal ties, for one year after the Member's death..... **No charge**

Your Doctor must consent to your care by the hospice and must be consulted in the development of your treatment Plan. The hospice must submit a written treatment Plan to us every 30 days or upon request.

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

This Plan's hospice benefit will meet or exceed Medicare's hospice benefit. If you use a non-Anthem Blue Cross HMO Health Care Provider, that provider may also bill you for any charges over Medicare's hospice benefit unless your claim involves a surprise billing claim.

Dental Care	**Copay**

♦ Inpatient Hospital services ..... **No charge**

Inpatient Hospital services are limited to 3 days when the stay is:

- Needed for dental care because of other medical problems you may have.
- Ordered by a Doctor (M.D.) or a dentist (D.D.S. or D.M.D.)
- Approved by the Medical Group or Anthem.

♦ General anesthesia and facility services when dental care must be provided in an outpatient Hospital or Ambulatory Surgery Center .....**No charge**

These services are covered when:

- You are less than the age of 20;
- You are developmentally disabled; or
- Your health is compromised and general anesthesia is Medically Necessary.

Note: No benefits are provided for the dental procedure itself or for the professional services of a dentist to do the dental procedure.

♦ Emergency care for accidental injury to natural teeth..... **No charge**

- The care is not covered if you hurt your teeth while chewing or biting unless the chewing or biting results from a medical or mental condition.
- This Plan does not cover any other kind of dental care.

♦ 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..... **No charge**

♦ Medically Necessary dental or orthodontic services that are an integral part of Reconstructive Surgery for cleft palate procedures. ..... **No charge**

"Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

Important: If you decide to receive dental services that are not covered under this Plan, a dentist who participates in an Anthem Blue Cross network may charge you his or her usual and customary rate for those services. Prior to providing you with dental services that are not a Covered Benefit, the dentist should provide a treatment Plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about the dental services that are covered under this Plan, please call us at the Member Services Number on

your Member ID card. To fully understand your coverage under this Plan, please carefully review this Evidence of Coverage document.

Gender Affirming Services	**Copay**

Services and supplies provided in connection with Gender Transition when you have been diagnosed with gender identity disorder or gender dysphoria by a Doctor. 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, medical management, and exclusions for cosmetic services, except as specifically stated in this provision. Coverage includes, but is not limited to, Medically Necessary services identified in the most recent edition of the Standards of Care developed by the World Professional Association for Transgender Health (WPATH) related to Gender Transition such as gender affirming surgery, hormone therapy, psychotherapy, and vocal training.

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

You must obtain our approval in advance in order for gender affirming services to be covered. Please refer to "Medical Management Programs" for information on how to obtain the proper reviews.

We will also pay for certain travel expenses incurred in connection with an approved gender affirming surgery, when the Hospital at which the surgery is performed is 75 miles or more from your place of residence, provided the expenses are authorized in advance by us. We will provide benefits for lodging, transportation, and other reasonable expenses up to the current limits set forth in the Internal Revenue Code, not to exceed **$10,000** per gender affirming surgery, or series of surgeries (if

multiple surgical procedures are performed), for travel expenses listed below, incurred by you and one companion. This travel expense benefit is not available for non-surgical gender affirming services.

- 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.

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

You must obtain our approval in advance in order for travel expenses to be covered. Please refer to "Medical Management Programs" for information on how to obtain the proper reviews.

- Gender affirming services ..... **See copays that apply**
- Gender affirming travel expense ..... **No charge***

  *Our maximum payment will not exceed **$10,000** per gender affirming surgery, or series of surgeries (if multiple surgical procedures are performed).

Special Food Products	Copay

♦ Special food products and formulas that are part of a diet prescribed by a Doctor for the treatment of phenylketonuria (PKU)..... **No charge**

You can get most formulas used in the treatment of PKU from a Drugstore. These are covered under your Plan's benefits for Prescription Drugs (see "Getting Prescription Drugs"). Special food products that are not available from a Drugstore are covered as medical supplies under your Plan's medical benefits.

Medical Equipment	Copay

♦ Medical equipment and supplies..... **No charge**

You can get long-lasting medical equipment (called durable medical equipment) and supplies that are rented or bought for you if they are:

– Ordered by your Primary Care Doctor.

– Used only for the health problem.

– Used only by the person who needs the equipment or supplies.

– Made only for medical use.

Equipment and supplies are **not** covered if they are:

– Only for your comfort or hygiene.

– For exercise.

– Only for making the room or home comfortable, such as air conditioning or air filters.

The Plan's reimbursement for durable medical equipment and devices and supplies will be based on the negotiated fee rate for a standard item that is a covered service, serves the same purpose, and is Medically Necessary to meet your needs. If you choose to purchase an item with features that exceed what is Medically Necessary, benefits will be limited to the negotiated fee rate for the standard item, and you will be required to pay any costs that

exceed the negotiated fee rate amount. Please check with your Doctor or contact us if you have questions about the negotiated fee rate.

Donor Human Milk	**Copay**

- Medically Necessary pasteurized donor human milk obtained from a tissue bank licensed by the State Department of Public Health..... **No charge**

Pediatric Asthma Equipment and Supplies	**Copay**

- Nebulizers, including face masks and tubing..... **No charge**

  These items are not subject to any limits or maximums that apply to coverage for Medical Equipment.

- Inhaler spacers and peak flow meters .....**See "Getting Prescription Drugs"**

  These items are subject to the Copay for Brand Name Drugs.

- Pediatric asthma education program services to help you use the items listed above.....**$20**

Organ and Tissue Transplants	**Copay**

Services and supplies are given if:

– You are receiving the organ or tissue, or

– You are the organ or tissue donor, if the person who is receiving it is a Member of Anthem Blue Cross HMO. If you are not a Member, the benefits are lowered by any amounts paid by your own health Plan.

- Services given with an organ or tissue transplant..... **See copays that apply**

Clinical Trials	Copay

Routine patient costs, as described below, for

an Approved Clinical Trial ..... **See copays that apply**

Coverage is provided for routine patient care costs you receive as a qualified enrollee in an Approved Clinical Trial. A "qualified enrollee" means that you meet both of the following conditions:

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

b) Either of the following applies:
   i. The referring health care professional is an Anthem Blue Cross HMO Health Care Provider and has concluded that your participation in the clinical trial would be appropriate because you meet the conditions of subparagraph (a).

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

The services must be those that are listed as covered by this Plan for Members who are not enrolled in an Approved Clinical Trial.

Routine patient care costs include items, services, and drugs provided to you in connection with an Approved Clinical Trial that would otherwise be covered by the Plan, including:

- Drugs, items, devices, and services typically covered absent an Approved Clinical Trial;
- Drugs, items, devices, and services required solely for the provision of an investigational drug, item, device, or service;
- Drugs, items, devices, and services required for the clinically appropriate monitoring of the investigational drug, item, device, or service;

- Drugs, items, devices, and services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service;
- Drugs, items, devices, and services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including diagnosis and treatment of complications.

Cost sharing (copayments, coinsurance, and deductibles) for routine patient care costs will be the same as that applied to the same services not delivered in an Approved Clinical Trial, except that the Anthem Blue Cross HMO Health Care Provider cost sharing and Copay Limits will apply if the clinical trial is not offered or available through an Anthem Blue Cross HMO Health Care Provider.

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

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

  - The National Institutes of Health,
  - The Centers for Disease Control and Prevention,
  - The Agency for Health Care Research and Quality,
  - The Centers for Medicare and Medicaid Services,
  - A cooperative group or center of any of the four entities listed above or the Department of Defense or the Department of Veterans Affairs,
  - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants, or
  - 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:

  - The Department of Veterans Affairs,
  - The Department of Defense, or
  - The Department of Energy.

- Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration.
- 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 Primary Care Doctor after deciding it will help you. If the clinical trial is not provided by or through your Medical Group, your Primary Care Doctor will refer you to the Doctor or health care provider who provides the clinical trial. Please see "When You Need a Referral" in the section called "When You Need Care" for information about referrals. You will only have to pay your normal copays for the services you get.

If one or more Anthem Blue Cross HMO Health Care Providers is conducting an Approved Clinical Trial, your Plan may require you to use an Anthem Blue Cross HMO Health Care Provider to utilize or maximize your benefits if the Anthem Blue Cross HMO Health Care Provider accepts you as an Approved Clinical Trial participant. It may also require that an Approved Clinical Trial be located in California, unless the clinical trial is not offered or available through an Anthem Blue Cross HMO Health Care Provider in California.

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

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

- The investigational item, device, or service itself.
- 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.
- Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- 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 pay for costs of services that are not covered.

If you do not agree with the coverage or medical necessity of possible clinical trial services, please read the "Independent Medical Review of Complaints Involving a Disputed Health Care Service" (see Table of Contents).

Biomarker Testing Services	**Copay**

Your Plan provides coverage for Medically Necessary biomarker testing for the purpose of diagnosis, treatment, appropriate management, or ongoing monitoring of a Member's disease or condition to guide treatment decisions. Coverage includes biomarker tests that meet any of the following:

a) Labeled indications for a test that has been approved or cleared by the FDA;

b) Indicated tests for an FDA-approved drug;

c) National coverage determinations made by the federal Centers for Medicare and Medicaid Services;

d) Local coverage determinations made by a Medicare Administrative Contractor for California;

e) Evidence-based clinical practice guidelines, supported by peer-reviewed literature and peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or

f) Standards set by the National Academy of Medicine.

Coverage under this section is subject to precertification. Please see "Medical Management Programs" for details. Precertification however is not required for FDA-approved therapies for the following:

- Biomarker testing for a Member with advanced or metastatic stage 3 or 4 cancer.
- Biomarker testing for cancer progression or recurrence in the Member with advanced or metastatic stage 3 or 4 cancer.

Restrictions and denials in the use of biomarker testing for the purpose of diagnosis, treatment, or ongoing monitoring of any medical condition is subject to grievance and appeal processes under state and federal law, as well as the Independent Medical Review process stated in the "How to Make a Complaint" section.

Ambulance	**Copay**

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

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

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

For the covered services of non-Anthem Blue Cross HMO ground or air ambulance providers, you will pay no more than the same cost sharing that you would pay for the same covered services received from Anthem Blue Cross HMO ambulance providers. Non-Anthem Blue Cross HMO ambulance providers may not bill you for charges in excess of the Plan's reasonable and customary value.

Non-emergency ambulance services are subject to medical necessity reviews by us or your Medical Group. Emergency ground ambulance services do not require pre-service review.

When using a ground or air ambulance in a non-emergency situation, we or your Medical Group reserve the right to select the ambulance provider. Non-Anthem Blue Cross HMO ground or air ambulance services are covered in a non-emergency when precertification is obtained.

For air and ground ambulance services, non-Anthem Blue Cross HMO Health Care Providers cannot bill you for more than your applicable Anthem Blue Cross HMO Health Care Provider deductible, coinsurance, and/or copayment.

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 Doctor are not a covered service.

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

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

If provided through the 911 emergency response system or the 988 suicide and crisis lifeline, ambulance services are covered if you reasonably believed that a medical emergency existed even if you are not transported to a hospital.

Your copays for covered ambulance services are:

- Base charge and mileage ..... **No charge**
- Disposable supplies ..... **No charge**
- Monitoring, EKG's or ECG's, cardiac defibrillation, CPR, oxygen, and IV solutions ..... **No charge**

IN SOME AREAS A 911 EMERGENCY RESPONSE SYSTEM OR A 988 SUICIDE AND CRISIS LIFELINE HAS BEEN ESTABLISHED. THESE SYSTEMS ARE TO BE USED ONLY WHEN THERE IS AN EMERGENCY

MEDICAL CONDITION OR BEHAVIORAL HEALTH CRISIS THAT REQUIRES AN EMERGENCY RESPONSE.

IF YOU REASONABLY BELIEVE THAT YOU ARE EXPERIENCING AN EMERGENCY OR BEHAVIORAL HEALTH CRISIS, YOU SHOULD CALL 911 OR 988, OR GO DIRECTLY TO THE NEAREST HOSPITAL EMERGENCY ROOM.

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

Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such a Skilled Nursing Facility or a rehabilitation facility) unless air ambulance services are determined to be Medically Necessary. Additionally, air ambulance will not be covered if you are taken to a Doctor's office or to your home, unless you are transported to one of these locations for an emergency medical condition.

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

Prosthetic Devices	Copay

You can get devices to take the place of missing parts of your body.

- Surgical implants (including, but not limited to, cochlear implants) ..... **No charge**
- Artificial limbs or eyes ..... **No charge**
- The first pair of contact lenses or eye glasses when needed after a covered and Medically Necessary eye surgery ..... **No charge**
- Breast prostheses and surgical bras following a mastectomy ..... **No charge**
- Prosthetic devices to restore a method of speaking when required as a result of a laryngectomy ..... **No charge**
- Therapeutic shoes and inserts designed to treat foot complications due to diabetes ..... **No charge**
- Orthotics ..... **No charge**

  Benefits are available for Medically Necessary orthotics, limited to: (1) foot orthotics, orthopedic shoes, footwear or support items used for a systemic illness affecting the lower limbs, such as diabetes, (2) braces, (3) boots and (4) splints. Covered services include the initial purchase, fitting, adjustment and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

- Colostomy supplies ..... **No charge**
- Supplies needed to take care of these devices ..... **No charge**

The Plan's reimbursement for orthotics, prosthetics and devices and supplies will be based on the negotiated fee rate for a standard item that is a covered service, serves the same purpose, and is

Medically Necessary to meet your needs. If you choose to purchase an item with features that exceed what is Medically Necessary, benefits will be limited to the negotiated fee rate for the standard item, and you will be required to pay any costs that exceed the negotiated fee rate amount. Please check with your Doctor or contact us if you have questions about the negotiated fee rate.

Hearing Aid Services	**Copay**

♦ Covered hearing aids
(one per ear every 3 years)..... **No charge**

The following hearing aid services are covered when ordered by or purchased as a result of a written recommendation from:

- an otolaryngologist; or
- a state-certified audiologist.

Services include:

- 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 the Plan benefits for office visits to Doctors.

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

- Bone-anchored hearing aids.
- Visits for fitting, counseling, adjustments and repairs for a one year period after receiving the covered hearing aid.

No benefits will be provided for the following:

- Charges for a hearing aid which exceeds specifications prescribed for the correction of hearing loss;
- Charges for a hearing aid which is not determined to be Medically Necessary, or for more than one hearing aid per ear every 3 years.

Mental Healthor Substance Use Disorder	**Copay**

You can get services for the Medically Necessary treatment of Mental Health or Substance Use Disorder or to prevent the deterioration of chronic conditions. These services are provided according to the terms and conditions of this Plan that apply to all other medical conditions, except as specifically stated in this section. This coverage is not limited to short-term or acute treatment. These services do not include programs to stop smoking, or to help with nicotine or tobacco abuse.

Before you get services for facility-based care for the treatment of Mental Health or Substance Use Disorder, you must get our approval first. Read "Medical Management Programs" to find out how to get approvals.

♦ Inpatient facility-based care for the treatment of mental health and substance use disorder..... **No charge**

Inpatient benefits include the following:

- Inpatient psychiatric hospitalization, including room and board, drugs, and services of physicians and other providers who are licensed health care professionals acting within the scope of their license,
- Psychiatric observation for an acute psychiatric crisis,

- Detoxification — medical management of withdrawal symptoms, including room and board, physician services, drugs, dependency recovery services, education and counseling,
- Residential treatment which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:
  - Treatment in a crisis residential program:
    - Observation and assessment by a psychiatrist weekly or more often,
    - Rehabilitation and therapy.
- Transitional residential recovery services for substance use disorder (chemical dependency),
- Reconstructive Surgery for gender dysphoria, Reconstructive Surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which the Member identifies, in accordance with the standard of care as practiced by physicians specializing in Reconstructive Surgery who are competent to evaluate the specific clinical issues involved in the care requested.

♦ Inpatient Doctor visits during a stay for the treatment of mental health and substance use disorder..... **No charge**

♦ Outpatient facility-based care, including partial hospitalization programs and intensive outpatient programs, for the treatment of Mental Health or Substance Use Disorder..... **No charge**

Outpatient facility-based care benefits include the following:

- Partial hospitalization programs and intensive outpatient programs,
- Outpatient psychological and neuropsychological testing,
- Outpatient substance use disorder day treatment programs,

- Multidisciplinary treatment in an intensive outpatient psychiatric treatment program,
- Psychiatric health facility services, including structured outpatient services as described in state law,
- Electroconvulsive therapy,
- Behavioral health treatment for autism spectrum disorders delivered at home,
- Ambulatory care services, including but not limited to physical therapy, occupational therapy, speech therapy and infusion therapy,
- Diagnostic laboratory services, diagnostic and therapeutic radiologic services, and other diagnostic and therapeutic services,
- Drug testing,
- Preventive health care services,
- Transcranial magnetic stimulation.

♦ Office visits (including virtual visits) and intensive in-home behavioral health services (when available in your area), received from a Doctor for the treatment of Mental Health or Substance Use Disorder.....**$10**

Office visit benefits include the following:

- Individual and group mental health evaluation and treatment,
- Individual, family and group substance use and mental health counseling,
- Outpatient services to monitor drug therapy and medication management,
- Narcotic (opioid) treatment programs and methadone maintenance treatment,
- Outpatient Prescription Drugs prescribed for Mental Health or Substance Use Disorder pharmacotherapy, including office-based opioid treatment. For more information on

covered Prescription Drugs, please refer to the "Getting Prescription Drugs" section,

- Intensive in-home behavioral health program services,
- Intensive community-based treatment, including assertive community treatment and intensive case management,
- Behavioral health treatment for autism spectrum disorders delivered in an office setting,

- Urgent Care services rendered inside and outside Anthem's Service Area.

♦ Behavioral health treatment for autism spectrum disorders in an office.....**$10**

Inpatient services, outpatient items and services, and office visits, are covered under this section. See the section "Benefits for Autism Spectrum Disorders Services" for a description of the services that are covered. You must get our approval first for all behavioral health treatment services for the treatment of autism spectrum disorders in order for these services to be covered by this Plan. Read "Medical Management Programs" to find out how to get approvals. No benefits are payable for these services if our approval is not obtained.

♦ Other services covered under the Mental Health or Substance Use Disorder benefit include the following:

- Home health care service including but not limited to physical therapy, occupational therapy, and speech therapy,
- Intensive home-based treatment,
- Coordinated specialty care for the treatment of first episode psychosis,
- School site services for a Mental Health or Substance Use Disorder that are delivered to an enrollee at a school site pursuant to state law,
- For gender dysphoria, all health care benefits identified in the most recent edition of the Standards of Care developed by the World Professional Association for Transgender Health,

- Hospice care,
- Polysomnography.
- Prophylaxis, diagnosis, and treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS), including treatment with antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, immunomodulating medicines, plasma exchange, and intravenous immunoglobulin therapy. Coverage will not be subject to a Deductible, Copayment or Coinsurance that is less favorable than that applied to other coverage under your Plan.

Please refer to these services under "What We Cover" for further details on how benefits will be paid.

If services for the Medically Necessary treatment of a mental health or substance use disorder are not available with an Anthem Blue Cross HMO Health Care Provider within the geographic and timely access standards set by law or regulation, we will arrange coverage to ensure the delivery of these services, and any Medically Necessary follow-up care that, to the maximum extent possible, meet those geographic and timely access standards. You will pay no more than the same cost sharing that you would pay for the same covered services received from an Anthem Blue Cross HMO Health Care Provider.

Coverage is also provided for Emergency Services and Care for treatment of Mental Health or Substance Use Disorder, including ambulance and ambulance transportation services (including those provided through the 911 emergency response system and the 988 suicide and crisis lifeline) and Emergency Services and Care received outside Anthem's Service Area. Cost sharing for Emergency Services and Care received from non-Anthem Blue Cross HMO Health Care Providers will be the same as Anthem Blue Cross HMO Health Care Providers. Precertification is not required for the Medically Necessary treatment of a Mental Health or Substance Use Disorder provided by a 988 center, mobile crisis

team, or other provider of behavioral health crisis services. However, precertification may be required once you are stabilized.

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 Services" section.

Prescription Drugs Administered by a Medical Provider

Your Plan covers Prescription Drugs, including specialty drugs, that must be administered to you as part of a Doctor's visit, home care visit, or at an outpatient facility when they are covered services. This may include Prescription Drugs for infusion therapy, chemotherapy, blood products, certain injectables, and any Prescription Drugs that must be administered by a Doctor. This section applies when a Doctor orders the Prescription Drug and a medical Doctor administers it to you in a medical setting. Benefits for Prescription Drugs that you inject or get through your pharmacy benefits (i.e., self-administered drugs) are not covered under this section. Benefits for those Prescription Drugs are described in the "Getting Prescription Drugs" section.

Important Details About Prescription Drug Coverage

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

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

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

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

- Step therapy requiring one prescription drug, Prescription Drug regimen, or treatment be used prior to use of another prescription drug, Prescription Drug regimen, or treatment for

safety and/or cost-effectiveness when clinically similar results may be anticipated.

- Use of an Anthem Prescription Drug formulary which is a list of FDA-approved Prescription Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

If you or your prescribing Doctor disagree with our decision, you may file an exception request. Please see the subsection "Exception Request for a Quantity, Dose or Frequency Limitation, Step Therapy, or a Drug not on the Prescription Drug Formulary" under the section "Getting Prescription Drugs".

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

Precertification

Precertification may be required for certain Prescription Drugs to help make sure proper use and guidelines for Prescription Drug coverage are followed. Requests for precertification must be submitted by your Doctor using the required uniform prior authorization form. If you're requesting an exception to the step therapy process, your Doctor must use the same form.
Upon receiving the completed form, for either precertification or step therapy exceptions, we will review the request and give our decision to both you and your Doctor within the following time periods:

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

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

If precertification is denied you have the right to file a Grievance as outlined in the "How to Make a Complaint" section of this Evidence of Coverage.

Therapeutic Equivalents

Therapeutic equivalents is a program that tells you and your Doctors about alternatives to certain Prescription Drugs. We may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic equivalent is right for you. For questions or issues about therapeutic equivalents, please call the toll-free number on your Member ID card.

Benefits for Autism Spectrum Disorders Services

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

Behavioral health treatment services covered under this Plan are subject to the same deductibles, coinsurance, and copayments that apply to services provided for other covered medical conditions. Services provided by Qualified Autism Service Providers, Qualified Autism Service Professionals, and Qualified Autism Service Paraprofessionals (see the "Definitions" below) will be covered under Plan benefits that apply for outpatient office visits or other outpatient items and services. Services provided in a

facility, such as the outpatient department of a hospital, will be covered under Plan benefits that apply to such Facilities. See also the section Mental Health / Substance Use Disorder for more detail.

Behavioral Health Treatment

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

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

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

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

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

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

Our network of Anthem Blue Cross HMO Health Care Providers is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the Anthem Blue Cross HMO Health Care Provider is limited to licensed Qualified Autism Service Providers who contract with Anthem and who may supervise and employ Qualified Autism Service Professionals or Paraprofessionals who provide and administer behavioral health treatment.

For purposes of this section, the following definitions apply:

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

Intensive Behavioral Intervention means any form of Applied Behavioral Analysis that is comprehensive, designed to address all

domains of functioning, and provided in multiple settings, across all settings, depending on the individual's needs and progress. Interventions can be delivered in a one-to-one ratio or small group format, as appropriate.

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

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

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

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

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

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

Qualified Autism Service Provider is either of the following:

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

designs, supervises, or provides treatment for autism spectrum disorders, provided the services are within the experience and competence of the licensee.

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

Medical Management Programs

In order to be covered by this Plan, most services must be provided or coordinated by your Primary Care Doctor and OK'd by your Medical Group or Anthem. These services include scheduled non-emergency Hospital or Skilled Nursing Facility stays; non-emergency outpatient services or surgeries; transplant and bariatric services; visits for physical therapy, physical medicine, occupational therapy and chiropractic services; durable medical equipment; infusion or home therapy; home health care; and diagnostic and laboratory procedures.

Exceptions to this rule are explained in the section "When You Need Care" earlier in this Evidence of Coverage. You may get care for the treatment of certain conditions directly, without getting an OK from your Medical Group. Some of these services must however be reviewed and approved by us in advance, through our Medical Management Programs, which consist of the Utilization Review Program and the Authorization Program.

The services that need to be reviewed and approved by us are indicated as such in the "What We Cover" section. You're also welcome to call the Member Services Number on your Member ID card for a list of services that need to be reviewed.

We will provide benefits only if you are covered at the time you get services and our payment will follow the terms and requirements of this Plan.

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 "Definitions" section. 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 Doctor's office.
- A service may be denied at a Skilled Nursing Facility but may be approvable in a home setting.

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

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

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

- You must be eligible for benefits;
- The service or supply must be covered under your Plan;
- The service cannot be subject to an exclusion under your Plan (please see "What We Do Not Cover" for more information); and
- You must not have exceeded any applicable limits under your Plan.

Types of Reviews

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

    For admissions following emergency care, you, your authorized representative or Doctor must tell us of the admission as soon as possible.

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

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

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

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

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

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

- Inpatient and outpatient facility-based care for the treatment of mental health or substance use disorder (including detoxification, rehabilitation, and residential treatment);
- Behavioral health treatment for autism spectrum disorders;
- Partial hospitalization programs, intensive outpatient programs, and transcranial magnetic stimulation (TMS);
- Air-ambulance services for non-emergency Hospital to Hospital transfers;

- Certain non-emergency ground ambulance services;
- Gender affirming services, including gender affirming travel expense, as specified under the "Gender Affirming Services" provision of "What We Cover". A Doctor must diagnose you with Gender Identity Disorder or Gender Dysphoria; and
- Other specific procedures, wherever performed, as specified by us.

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

Who is Responsible for Precertification?

Typically, Anthem Blue Cross HMO Health Care Providers know which services need precertification and will get any precertification when needed. Your Medical Group or Primary Care Doctor and other Anthem Blue Cross HMO Health Care Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the Doctor or Hospital will get in touch with us to ask for a precertification. However, you may request a precertification or you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for precertification and under what circumstances.

Provider Network Status	Responsibility to Get Precertification	Comments
Anthem Blue Cross HMO Health Care Providers	Provider	Anthem Blue Cross HMO Health Care Providers must get precertification when required
Non-Anthem Blue Cross HMO Health Care Providers	Member	Member has no benefit coverage for a non-Anthem Blue Cross HMO Health Care Provider unless: • The Member gets approval to use a non-Anthem Blue Cross HMO Health Care Provider before the service is given, or; • The Member requires out-of-area Urgent Care or an emergency care admission (See note below.) If these are true, then • Member must get precertification by calling Member Services when required. For an emergency care admission, precertification is not required. However, you, your authorized representative, or

Provider Network Status	Responsibility to Get Precertification	Comments
		Doctor must tell us of the admission as soon as possible. • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and / or setting is found to not be Medically Necessary, or is not emergency care.
Blue Card Provider	Member **(Except for Inpatient Admissions)**	Member has no benefit coverage for a BlueCard provider unless: • The Member gets approval to use a BlueCard provider before the service is given, or; • The Member requires Urgent Care or an emergency care admission (See note below.) If these are true, then • The Member must call Member Services to get precertification when required. For

Provider Network Status	Responsibility to Get Precertification	Comments
		an emergency care admission, precertification is not required. However, you, your authorized representative, or Doctor must tell us of the admission as soon as possible. • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and / or setting is found to not be Medically Necessary, or is not an emergency. • **Blue Card providers must obtain precertification for all inpatient admissions.**
NOTE: For an emergency care admission, precertification is not required. However, you, your authorized representative or Doctor must tell us of the admission as soon as possible.		

How Decisions are Made

Our clinical coverage guidelines, such as medical policy, clinical guidelines and other applicable policies and procedures are used to help make medical necessity decisions. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time.

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

If you are not satisfied with the decision under this section of your benefits, please refer to the section entitled "How to Make a Complaint" to see what rights may be available to you.

Decision and Notice Requirements

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

Request Category	**Timeframe Requirement for Decision**
Urgent Pre-Service	72 hours from the receipt of the request
Non-Urgent Pre-Service	5 business days from the receipt of the request

Request Category	Timeframe Requirement for Decision
Urgent Continued Stay Review when hospitalized at the time of the request and no previous authorization exists	72 hours from the receipt of the request
Urgent Continued Stay Review when request is received at least 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Urgent Continued Stay Review when request is received less than 24 hours before the end of the previous authorization	72 hours from the receipt of the request
Non-Urgent Continued Stay Review	5 business days from the receipt of the request
Post-service Review	30 calendar days from the receipt of the request

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

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

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

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

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

Authorization Program

The authorization program provides prior approval for medical care or service by a non- Anthem Blue Cross HMO Health Care Provider. The service you receive must be a Covered Benefit of this Plan.

You must get approval before you get any non-emergency or non-urgent service from a non-Anthem Blue Cross HMO Health Care Provider for the following services:

- **Treatment of mental health or substance use disorder,**
- **Behavioral health treatment for autism spectrum disorders,**
- **Gender affirming services, including gender affirming travel expense, and**
- **Other specific procedures, wherever performed, as specified by us.**

The toll-free number to call for prior approval is on your Member ID card.

If you get any of these services, and do not follow the procedures set forth in this section, no benefits will be provided for that service.

If Anthem is unable to provide access to timely and geographical services for the treatment of Mental Health or Substance Use Disorders with an appropriate provider in the Plan's network, Anthem must cover and arrange needed services for you from an out-of-network provider. Please see the "Mental Health or Substance Use Disorder Services" notice under the Getting Started section for more information.

Authorized Referrals. In order for the benefits of this Plan to be provided, you must get approval **before** you get services from non-Anthem Blue Cross HMO Health Care Providers. When you get proper approvals, these services are called Authorized Referral services.

Effect on Benefits. If you receive Authorized Referral services from a non-Anthem Blue Cross HMO Health Care Provider, the applicable Anthem Blue Cross HMO Health Care Provider copays will apply. When you do not get a referral, **no benefits are provided** for services received from a non-Anthem Blue Cross HMO Health Care Provider.

If you receive covered non-Emergency Services and Care at an Anthem Blue Cross HMO Hospital or facility in California (State Surprise Billing Claims) at which, or as a result of which, you receive services provided by a non-Anthem Blue Cross HMO Health Care Provider, you will pay no more than the same cost sharing that you would pay for the same covered services received from an Anthem Blue Cross HMO Health Care Provider.

How to Get an Authorized Referral. You or your Doctor must call the toll-free telephone number on your Member ID card **before** scheduling an admission to, or before you get the services of, a non-Anthem Blue Cross HMO Health Care Provider.

When an Authorized Referral Will be Provided. Referrals to non-Anthem Blue Cross HMO Health Care Providers will be approved only when all of the following conditions are met:

- There is no Anthem Blue Cross HMO Health Care Provider who practices the specialty you need, provides the required services or has the necessary facilities; AND
- You are referred to the non-Anthem Blue Cross HMO Health Care Provider by a Doctor who is an Anthem Blue Cross HMO Health Care Provider; AND
- We authorize the services as Medically Necessary before you get the services.

Health Plan Individual Case Management

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

How Health Plan Individual Case Management Works

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

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

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached

through contact and team work with you and /or your chosen authorized representative, treating Doctors, and other providers.

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

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

EXCLUSIONS AND LIMITATIONS

The Plan does not cover the services or supplies listed below that are excluded from coverage or exceed limitations as described in this Evidence of Coverage (EOC).

These Exclusions and limitations do not apply to Medically Necessary basic health care services required to be covered under California or federal law, including but not limited to Medically Necessary treatment of a Mental Health or Substance Use Disorder, as well as preventive services required to be covered under California or federal law.

These Exclusions and limitations do not apply when covered by the Plan or required by law.

1. Acupuncture Services

This Plan does not cover acupuncture services, except [Standard; may be omitted per group request: as described in this EOC in under "What We Cover" or] as required by law.

2. Chiropractic Services

This Plan does not cover chiropractic services, except as described in this EOC under "What We Cover" or as required by law.

3. Clinical Trials

This Plan does not cover clinical trials, except Approved Clinical Trials as described in this EOC in "Clinical Trials" under "What We Cover" or as required by law.

Coverage of Approved Clinical Trials does not include the following:

- The investigational drug, item, or service itself.
- Drugs, items, devices, and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the Member.
- Drugs, items, devices, and services specifically excluded from coverage in this EOC, except for drugs, items, devices, and services required to be covered pursuant to state and federal law.
- Drugs, items, devices, and services customarily provided free of charge to a clinical trial participant by the research sponsor.

This Exclusion does not limit, prohibit, or modify a Member's rights to the Experimental Services or Investigational Services independent review process as described in this EOC in "Independent Medical Review of Denials of Experimental Services or Investigational Services", or to the Independent Medical Review (IMR) from the Department of Managed Health Care (DMHC) as described in this EOC in "Independent Medical Review of Complaints Involving a Disputed Health Care Service".

4. Cosmetic Services, Supplies, or Surgeries

This Plan does not cover cosmetic services, supplies, or surgeries that slow down or reverse the effects of aging, or alter or reshape

normal structures of the body in order to improve appearance rather than function except as described in this EOC in "What We Cover", "Prescription Drugs Administered by a Medical Provider" and/or "Your Prescription Drug Benefits", or as required by law. The Plan does not cover any services, supplies, or surgeries for the promotion, prevention, or other treatment of hair loss or hair growth except as described in this EOC in "What's Covered", or as required by law.

This Exclusion does not apply to the following:

- Medically Necessary treatment of complications resulting from cosmetic surgery, such as infections or hemorrhages.
- Reconstructive surgery as described in this EOC in "Reconstructive Surgery" under "What We Cover".
- For gender dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which a Member identifies, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested as described in this EOC in "Gender Affirming Services" under "What We Cover".

5. Custodial or Domiciliary Care

This Plan does not cover custodial care, which involves assistance with activities of daily living, including but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered, except as described in this EOC in "What We Cover" or as required by law.

This Exclusion does not apply to the following:

- Assistance with activities of daily living that requires the regular services of or is regularly provided by trained medical or health professionals.
- Assistance with activities of daily living that is provided as part of covered hospice, skilled nursing facility, or inpatient hospital care.

- Custodial care provided in a healthcare facility.

6. Dental Services

This Plan does not cover dental services or supplies, except as described in this EOC in "Dental Services" under "What We Cover" or as required by law.

7. Dietary or Nutritional Supplements

This Plan does not cover dietary or nutritional supplements, except as described in this EOC in "What We Cover" or as required by law.

8. Disposable Supplies for Home Use

This Plan does not cover disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, diapers, and incontinence supplies, except as described in this EOC in "What We Cover" or as required by law.

9. Experimental Services or Investigational Services

This Plan does not cover Experimental Services or Investigational Services, except as described in this EOC in "What We Cover" or as required by law.

Experimental Services means drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation.

Investigational Services means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but:

(1) Testing is not complete; and

(2) The efficacy and safety of such services in human subjects are not yet established; and

(3) The service is not in wide usage.

The determination that a service is an Experimental Service or Investigational Service is based on:

(1) Reference to relevant federal regulations, such as those contained in Title 42, Code of Federal Regulations, Chapter

IV (Health Care Financing Administration) and Title 21, Code of Federal Regulations, Chapter I (Food and Drug Administration);

(2) Consultation with provider organizations, academic and professional Specialists pertinent to the specific service;

(3) Reference to current medical literature.

However, if the Plan denies or delays coverage for your requested service on the basis that it is an Experimental Service or Investigational Service and you meet all the qualifications set out below, the Plan must provide an external, independent review.

Qualifications

1. You must have a Life-Threatening or Seriously Debilitating condition.
2. Your Health Care Provider must certify to the Plan that you have a Life-Threatening or Seriously Debilitating condition for which standard therapies have not been effective in improving your condition, or are otherwise medically inappropriate, or there is no more beneficial standard therapy covered by the Plan.
3. Either (a) your Health Care Provider, who has a contract with or is employed by the Plan, has recommended a Drug, device, procedure, or other therapy that the Health Care Provider certifies in writing is likely to be more beneficial to you than any available standard therapies, or (b) you or your Health Care Provider, who is a licensed, board-certified, or board-eligible physician qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that, based on two documents from acceptable medical and scientific evidence, is likely to be more beneficial for you than any available standard therapy.
4. You have been denied coverage by the Plan for the recommended or requested service.
5. If not for the Plan's determination that the recommended or requested service is an Experimental Service or Investigational Service, it would be covered.

External, Independent Review Process

If the Plan denies coverage of the recommended or requested therapy and you meet all of the qualifications, the Plan will notify you within five business days of its decision and your opportunity to request external review of the Plan's decision. If your Health Care Provider determines that the proposed service would be significantly less effective if not promptly initiated, you may request expedited review and the experts on the external review panel will render a decision within seven days of your request. If the external review panel recommends that the Plan cover the recommended or requested service, coverage for the services will be subject to the terms and conditions generally applicable to other benefits to which you are entitled.

DMHC's Independent Medical Review (IMR)

This Exclusion does not limit, prohibit, or modify a Member's rights to an IMR from the DMHC as described in this EOC in "Independent Medical Review Based Upon the Denial of Experimental Services or Investigational Services". In certain circumstances, you do not have to participate in the Plan's grievance or appeals process before requesting an IMR of denials for Experimental Services or Investigational Services. In such cases you may immediately contact the DMHC to request an IMR of this denial.

10. Vision Care

This Plan does not cover vision services, except as described in this EOC under "What We Cover" or as required by law.

11. Hearing Aids

This Plan does not cover hearing aids, except [Optional; Use if hearing aid rider included: as described in this EOC in "Hearing Aid Services" under "What We Cover" or] as required by law.

12. Immunizations

This Plan does not cover non-Medically Necessary or non-preventive immunizations solely for foreign travel or occupational purposes, except as required by law.

13. Non-licensed or Non-certified Providers

This Plan does not cover treatments or services rendered by a non-licensed or non-certified Health Care Provider, except as required by law.

This Exclusion does not apply to Medically Necessary treatment of a Mental Health or Substance Use Disorder furnished or delivered by, or under the direction of, a Health Care Provider acting within the scope of practice of the provider's license or certification under applicable state law.

14. Prescription Drugs / Outpatient Prescription Drugs

The Plan does not cover the following Prescription Drugs, except as described in this EOC in "Prescription Drugs Administered by a Medical Provider" and "Your Prescription Drug Benefits" under "What We Cover" or as required by law:

- When prescribed for cosmetic services. For purposes of this Exclusion, cosmetic means drugs solely prescribed for the purpose of altering or affecting normal structure of the body to improve appearance rather than function.
- When prescribed solely for the treatment of hair loss, sexual dysfunction, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. The Exclusion does not apply to drugs for mental performance when they are Medically Necessary to treat diagnosed mental illness or medical conditions affecting memory, including, but not limited to, treatment of the conditions or symptoms of dementia or Alzheimer's disease.
- When prescribed solely for the purpose of losing weight, except when Medically Necessary for the treatment of [The following will reflect the word "severe" as standard. Please note, the plan may only remove either Class III or severe if the removal of these qualifiers has been approved by the DMHC in accordance with Rule 1300.67.24(g): Class III or severe] obesity. Enrollment in a comprehensive weight loss program, if covered by the Plan, may be required for a reasonable period of time prior to or concurrent with receiving the Prescription Drug.

- When prescribed solely for the purpose of shortening the duration of the common cold.
- Prescription Drugs available over the counter or for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the Prescription Drug). This Exclusion does not apply to:
    - Insulin,
    - Over-the-counter drugs as covered under preventive services, e.g., over-the-counter FDA-approved contraceptive drugs),
    - Over-the-counter drugs for reversal of an opioid overdose, or
    - An entire class of Prescription Drugs when one drug within that class becomes available over the counter.
- Replacement of lost or stolen drugs.
- Drugs when prescribed by non-contracting providers for non-covered procedures and which are not authorized by a plan or a plan provider, except when coverage is otherwise required in the context of Emergency Services and Care.

15. Private Duty Nursing

This Plan does not cover private duty nursing in the home, hospital, or long-term care facility, except [as described in this EOC in "Home Health Care" under "What We Cover" or as required by law.

16. Personal or Comfort Items

This Plan does not cover personal or comfort items, such as internet, telephones, personal hygiene items, food delivery services, or services to help with personal care, except as required by law.

17. Reversal of Voluntary Sterilization

This Plan does not cover reversal of voluntary sterilization, except for Medically Necessary treatment of medical complications, except as described in this EOC in "Family Planning Services" under "What We Cover" or as required by law.

18. Surrogate Pregnancy

This Plan does not cover testing, services, or supplies for a person who is not covered under this Plan for a surrogate pregnancy, except as required by law.

19. Therapies

This Plan does not cover the following physical and occupational therapies, except as described in this EOC in "Therapy Services" under "What We Cover" or as required by law:

- Massage therapy, unless it is a component of a treatment plan;
- Training or therapy for the treatment of learning disabilities or behavioral problems;
- Social skills training or therapy; and
- Vocational, educational, recreational, art, dance, music, or reading therapy.

20. Routine Physical Examination

The Plan does not cover physical examinations for the sole purpose of travel, insurance, licensing, employment, school, camp, court-ordered examinations, pre-participation examination for athletic programs, or other non-preventive purpose, except as required by law.

21. Travel and Lodging

This Plan does not cover transportation, mileage, lodging, meals, and other Member-related travel costs, except for licensed ambulance or psychiatric transport as described in this EOC in "Ambulance Services" under "What's Covered", as otherwise described in this EOC in [Optional; use if group includes Travel Coverage Rider: "Travel Benefit" under the Schedule of Benefits" and] "Gender Affirming Services" under "What We Cover", or as required by law.

22. Weight Control Programs and Exercise Programs

This Plan does not cover weight control programs and exercise programs, except as required by law.

Getting Prescription Drugs

In addition to the drugs or medicines you may need while you are in the hospital, the Plan also cover drugs or medicines you buy from a Drugstore, through the home delivery program, or through the specialty drug program. The drug or medicine must:

- Be prescribed by a health care provider licensed to prescribe, and be given to you within one year of being prescribed. It must be a drug that may only be sold with a prescription under federal and state law.

  Note: Specified over-the-counter items are covered under this Plan only when obtained with a Doctor's prescription as specified under "Preventive Prescription Drugs and Other Items", subject to all terms of this Plan that apply to those benefits.

  - Smoking cessation and nicotine replacement products.
  - FDA-approved contraceptives.
  - Vitamins, supplements, and health aids.

- Be approved for general use by the Food and Drug Administration (FDA).

- Be for the direct care and treatment of your illness, injury, or health problem. Dietary supplements, health aids, or drugs for cosmetic purposes are not covered. However the following items are covered:

  - Formulas prescribed by a Doctor for the treatment of phenylketonuria.
  - Vitamins, supplements, and health aids specifically listed in this Plan as covered.
  - Drugs that may be prescribed for cosmetic purposes, but are Medically Necessary and prescribed for the treatment of a medical condition other than one that is cosmetic.

- Be dispensed from a licensed retail Drugstore, by the home delivery program or through the specialty pharmacy program.
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- **If it is a specified specialty drug, be obtained by using the specialty pharmacy program.** See "Getting Your Medicine Through the Specialty Pharmacy" for how to get your drugs by using the specialty pharmacy program. **You will have to pay the full cost of specialty drugs you get from a retail Drugstore that you should have obtained from the specialty pharmacy 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 pharmacy program for processing and will be processed according to specialty pharmacy program rules.**
- **Exceptions to specialty pharmacy program.** This requirement does not apply to:

  a. The first month's supply of a specified specialty pharmacy drug which is available through a Member Drugstore;

  b. Drugs, which due to medical necessity, must be obtained immediately; or

  c. A Member for whom, according to the Coordination of Benefit rules, this Plan is not the primary Plan.

  How to obtain an exception to the specialty pharmacy program. If you believe that you should not be required to get your medication through the specialty pharmacy program, for any of the reasons listed above, except for c., you must complete an Exception to Specialty Drug Program form to request an exception and send it to us. The form can be faxed or mailed to us. If you need a copy of the form, you may call us at 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 we have given you an exception, it will be good for a limited period of time. The exception period will be determined based on the reason for the exception. When the exception period ends, if you believe that you should still not be required to get your

medication through the specialty pharmacy program, you must again request an exception. If we deny your request for an exception, it will be in writing and will tell you why we did not approve the exception.

Urgent or emergency need of a specialty drug subject to the specialty pharmacy program. If you are out of a specialty drug which must be obtained through the specialty pharmacy program, the pharmacy benefits manager will authorize an override of the specialty pharmacy program requirement for 72-hours, or until the next business day following a holiday or weekend, to allow you to get an emergency supply of medication if your Doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copay shown in "What You Will Need to Pay" for the 72-hour supply of your drug.

- If you order your specialty pharmacy drug through the specialty pharmacy program and it does not arrive, if your Doctor decides that it is Medically Necessary for you to have the drug immediately, we will authorize an override of the specialty pharmacy program requirement for a 30-day supply or less, to allow you to get an emergency supply of medication from a Member drug store near you. A Dedicated Care Coordinator from the specialty pharmacy program will coordinate the exception and you will not be required to make an additional copay.

- Not be dispensed while you are an inpatient in any facility. It must not be dispensed in or administered by an outpatient facility. While not covered under this Prescription Drug benefit, if you need these drugs, they are covered as specified in "Inpatient Hospital Services," "Outpatient (In a Hospital or Ambulatory Surgery Center)," "Preventive Care Services," "Home Health Care," "Hospice Care" and "Skilled Nursing Facility Services," subject to all terms of this Plan that apply to those benefits.

- Not typically more than a 30-day supply if you get it at the Drugstore or the specialty pharmacy program. However, a Doctor can prescribe an additional 30-day supply of your

medication for you to receive at a retail Drugstore or specialty pharmacy. If you receive more than a 30-day supply of medication, you will have to pay the applicable Copay for each additional 30-day supply of medication you receive.

Note: FDA-approved, Self-Administered Hormonal Contraceptives must not exceed a 12-month supply when dispensed or furnished at one time by a provider or Pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies.

You can get a 60-day supply of drugs at the Drugstore for treating attention deficit disorder if they:

- Are FDA approved for treating attention deficit disorder;
- Are federally classified as Schedule II drugs; and
- Require a triplicate prescription form.

♦ Not be more than a 90-day supply if you get it from our home delivery program.

Note: FDA-approved, Self-Administered Hormonal Contraceptives must not exceed a 12-month supply when dispensed or furnished at one time by a provider or Pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies.

♦ If the Doctor prescribes a 60-day supply for drugs classified as Schedule II for the treatment of attention deficit disorders, you have to pay double the amount of Copay for retail Drugstores. If you get the drugs through our home delivery program, the Copay will be the same as for any other drug.

♦ FDA-approved smoking cessation products and over-the-counter nicotine replacement products are limited as specified under "Preventive Prescription Drugs and Other Items".

♦ 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 Doctor or health care provider and obtained from a Member Drugstore or through the home delivery program. This includes items that can be obtained over the counter for which a Doctor or health care provider 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 contraceptive drugs including drugs available over-the-counter, self-administered contraceptives, including oral contraceptive drugs, self-injectable contraceptive drugs, contraceptive patches, and contraceptive rings. Coverage is also provided for up to a 12-month supply of FDA-approved, Self-Administered Hormonal Contraceptives, when dispensed or furnished at one time by a provider or Pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies. Certain contraceptives are covered under the "Preventive Care Services" benefit. Please see that section for more details. If your Doctor determines that none of these contraceptive methods are appropriate for you based on your medical or personal history, coverage will be provided for at least one other prescription contraceptive method at $0 cost sharing that is approved by the Food and Drug Administration (FDA) and prescribed by your Doctor and obtained at a Member Drugstore.

  The Plan will not impose any restrictions or delays on your coverage of FDA-approved contraceptive drugs, devices, and other products, including prior authorization requests, any utilization controls or any other form of medical management restrictions.

  Note that a prescription will not be required to trigger coverage of over-the-counter FDA-approved contraceptive drugs, devices, and products and point-of-sale coverage for over-the-counter FDA-approved contraceptive drugs, devices, and

products will be provided at Member Drugstores and with no cost sharing or medical management restrictions.

- Vaccinations prescribed by a physician and obtained from a Member Drugstore.
- 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 Doctor's prescription and you are at least 18 years old.
- 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 Formulary

The fact that a drug is on this list doesn't guarantee that your Doctor will prescribe you that drug. This list, which includes both generic drugs and Brand Name Drugs, is updated quarterly so that the list includes drugs that are safe and effective in the treatment of disease.

Some drugs need to be approved - the Doctor or Drugstore will know which drugs they are. If you have a question regarding whether a particular drug is on our formulary drug list or requires prior authorization please call us at the number on the back of your ID Card. Information about the drugs on our formulary drug list is also available on our internet website www.anthem.com/ca.

As part of your drug benefit, you may be required to try an AB-rated generic equivalent, biosimilar (interchangeable biosimilar product) before receiving coverage for the equivalent Brand Name Drug.

Note: If there is a generic equivalent to a Brand Name Drug, the lowest cost sharing will be applied, whether or not both the generic equivalent and the Brand Name Drug are on the formulary.

Exception request for a Quantity, Dose or Frequency Limitation, Step Therapy, or a drug not on the Prescription Drug formulary. Your Prescription Drug benefit covers those drugs listed on our 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.

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

Your Doctor must complete an exception form and return it to us. You or your Doctor can get the form online at

www.anthem.com/ca or by calling the number listed on the back of your ID card.

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

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

When exigent circumstances do not exist, we will make a coverage decision within 72 hours of receiving your request. If we approve the exception request, coverage of the drug will be provided for the duration of the prescription order, including refills. If we deny the request, you have the right to request an external review by an Independent Review Organization (IRO). The IRO will make a coverage decision within 72 hours of receiving your request. If the IRO approves the request, coverage will be provided for the duration of the prescription order, including refills.

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

Requesting an exception or having an IRO review your request for an exception does not affect your right to submit a grievance or

request an Independent Medical Review. Please see the section entitled "GRIEVANCE PROCEDURES" for details.

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 and Step Therapy Exceptions.

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

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

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

- Specific clinical criteria and/or recommendations made by state or federal agencies (including, but not limited to, requirements regarding age, test result requirements, presence of a specific condition or disease, quantity, dose and/or frequency of administration);
- Specific provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies) as recommended by the FDA;
- Step therapy requiring one drug, drug regimen, or treatment be used prior to use of another drug, drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated;
- Use of a Prescription Drug 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 Doctor can get the list of the Prescription Drug that require prior authorization by calling the phone number on the back of your identification card or check our website at www.anthem.com. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under your Plan. Your Doctor may check with us to verify Prescription Drug coverage, to find out which Prescription Drug are covered under this section and if any drug edits apply.

In order for you to get a drug that needs to be approved and step therapy exceptions, your Doctor must send us a request in writing using the required uniform prior authorization request form. The request, for either prior authorization or step therapy exceptions, can be sent to us by mail, facsimile, or it may be submitted electronically. If your Doctor needs a copy of the request form, he or she may call us at 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.

Upon receiving the completed uniform prior authorization request form, we will review the request and respond to both you and your prescribing Doctor, or notify your prescribing Doctor that we need more information 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 we fail to notify the prescribing Doctor of our decision or that we need more information within these time periods from receipt of a prior authorization or step therapy exception request, the prior authorization or step therapy exception request will be deemed approved for the duration of the drug, including refills.

Your Doctor may submit a step therapy exception if they do not agree with the drug we are requiring. The prescribing Doctor should submit necessary justification and supporting clinical

documentation supporting their determination that the drug Anthem requires is inconsistent with good professional practice for providing Medically Necessary covered services, taking into consideration your needs and medical history, along with the professional judgment of your Doctor.

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

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

consideration while covered by their current or previous health coverage or Medicaid.

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

While we are reviewing the request, a 72-hour emergency supply of medication may be dispensed to you if your Doctor or Pharmacist decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copay shown for the 72-hour supply of your drug. If we approve 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 copay.

If we approve coverage for the drug originally prescribed, you will be provided the drug originally requested at the applicable cost share. (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, and you underwent a prior authorization process under the prior Plan which required you to take different drugs, we will not require you to try a drug other than the one you are currently taking.). If the drugs are approved you will be able to get them after you make the required Copay or coinsurance.

If you have any questions regarding whether a drug is on our Prescription Drug formulary, or needs to be approved or step therapy exception requests, please call us at the number on the back of your ID Card. Information about the drugs on our formulary drug list is also available on our internet website www.anthem.com/ca.

If we don't approve a request for a drug that is not part of our Prescription Drug formulary or step therapy exception requests, you or your Doctor can appeal the decision by calling us at the number on the back of your ID Card. If you are not happy with the result, please see the section called "How to Make a Complaint".

Revoking or modifying a prior authorization. A prior authorization or step therapy exception requests 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 agreement with the group 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 or step therapy exception requests 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 are to be included on the list of formulary drugs covered by the Plan and is decided by the Pharmacy and Therapeutics Process which is comprised of independent Doctors and Pharmacists. The Pharmacy and Therapeutics Process meets quarterly and decides on changes to make in the Prescription Drug formulary list based on our recommendations and a review of relevant information, including current medical literature.

Getting Your Medicine at a Drugstore

To get medicine your Doctor has prescribed:

- Go to a Member Drugstore.
- For help finding a Member Drugstore, call us at the number on the back of your ID Card.
- Show your Member ID card.

- ♦ Pay the Copay when you get the medicine. You must also pay for any medicine or supplies that are not covered under the Plan.

Please note that taking a prescription to a Drugstore or Pharmacist does not mean it is a claim for benefit coverage. If you take a prescription to a Member Drugstore, and the Member Drugstore:

- Says they cannot give you your medicine; or
- Must have an additional copay;

this is not considered an adverse claim decision. If you want your medicine now, you will have to pay the cost for it and submit a claim to Prescription Drug Program (see "Submitting a claim," below). (Please note that we contract with a pharmacy benefits manager to provide Prescription Drug benefits. Neither they nor their Member Drugstores are employees of Anthem. They are independent contractors.)

Important Note: If we determine that you may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of Member Drugstores may be limited. If this happens, we may require you to select a single Member Drugstore that will provide and coordinate all future pharmacy services. Benefits will only be paid if you use the single Member Drugstore. We will contact you if we determine that use of a single Member Drugstore is needed and give you options as to which Member Drugstore you may use. If you do not select one of the Member Drugstores we offer within 31 days, we will select a single Member Drugstore for you. If you disagree with our decision, you may ask us to reconsider it as described in the section called "How to Make a Complaint".

In addition, if we determine that you may be using controlled substance Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of Anthem Blue Cross HMO Health Care Providers for controlled substance prescriptions may be limited. If this happens, we may require you to select a single Anthem Blue Cross HMO Health Care Provider that will provide and coordinate all controlled substance

prescriptions. Benefits for controlled substance prescriptions will only be paid if you use the single Anthem Blue Cross HMO Health Care Provider. We will contact you if we determine that use of a single Anthem Blue Cross HMO Health Care Provider is needed and give you options as to which Anthem Blue Cross HMO Health Care Providers you may use. If you do not select one of the Anthem Blue Cross HMO Health Care Provider we offer within 31 days, we will select a single Anthem Blue Cross HMO Health Care Provider for you. If you disagree with our decision, you may ask us to reconsider it as outlined in the "How to Make a Complaint" section of this Plan.

Submitting a claim. If you believe you should get some Plan benefits for the medicine that you have paid the cost for, have the Pharmacist fill out a claim form and sign it. Send the claim form to us (within 90 days) to:

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

If the Member Drugstore doesn't have claims forms, or if you have questions, call the number on the back of your ID Card.

It will cost you more if you go to a non-member Drugstore.

- Take a claim form with you to the non-member Drugstore. If you need a claim form or if you have questions, call the number on the back of your ID Card.
- Have the Pharmacist fill out the form and sign it.
- Then send the claim form (within 90 days) to:

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

- When the pharmacy benefits manager first gets your claim, they take out:

- Costs for medicine or supplies not covered under the Plan,
- Then any cost more than the Prescription Drug maximum allowed amount we use for non-member Drugstore, except when the drugs are related to Urgent Care or Emergency Services and Care; and
- Then your copay.

The rest of the cost is covered.

If you are out of state, and you need medicine,

- Call the number on the back of your ID Card to find out where there is a Member Drugstore.
- If there is no Member Drugstore, pay for the drug and send the pharmacy benefits manager a claim form.

Getting Your Medicine Through the Mail

When you order medicines through the mail, here's what to do:

- **Get your prescription from your health care provider.** He or she should be sure to sign it. It must have the drug name, how much and how often to take it, how to use it, the provider's name and address and telephone number along with your name and address. You can have your Doctor send prescriptions electronically, via fax or phone call, or you can submit written prescriptions from your Doctor to the home delivery/mail service pharmacy.
- **Fill out the order form.** The **first time** you use the home delivery program, you must also send a filled out Patient Profile questionnaire about yourself**.** Order forms and a Patient Profile questionnaire can be obtained by contacting us at the number on the back of your ID Card to request one. The forms are also available on-line at www.anthem.com/ca.
- **Be sure to send the Copay** along with the prescription and the order form and the Patient Profile. You can pay by check, money order, or credit card.

- **There may be some medicines you cannot order through this program, for example, drugs to treat sexual dysfunction, are not available. Call the number on the back of your ID Card to find out if you can order your medicine through the Home Delivery Program.**
- Your Plan will only cover Prescription Drugs obtained by mail when you use the Mail Service/Home Delivery Pharmacy provided by Anthem's PBM. No benefits will be provided if you purchase Prescription Drugs from a mail order or home delivery pharmacy that is not provided by Anthem's Pharmacy Benefits Manager.

Getting Your Medicine Through the Specialty Pharmacy

Certain specified specialty drugs must be obtained through the specialty pharmacy program unless you are given an exception from the specialty drug program (see the introduction of this section, Getting Prescription Drugs). These specified specialty drugs that must be obtained through the Specialty Pharmacy Program are limited up to a 30-day supply. The Specialty Pharmacy Program will deliver your medication to you by mail or common carrier (you cannot pick up your medication from them).

You or your Doctor may order your specialty drug by calling the number on the back of your ID Card. When you call the Specialty Pharmacy 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 Pharmacy Program at the address shown below. Once you have met your deductible, if any, you will only have to pay your copay.

With few exceptions, most orally administered anti-cancer medications are considered specialty drugs. For orally administered anti-cancer medications, the Prescription Drug

deductible, if any, will not apply and the copayment will not exceed the lesser of the applicable copayment shown below or $250 for a 30-day supply for medications obtained at a retail Drugstore or $750 for a 90-day supply for medications obtained through home delivery.

The first time you get a prescription for a specialty drug you must also include a completed Intake Referral Form. The Intake Referral Form is to be completed by calling the toll-free number below. You need only enclose the prescription or refill notice, and the appropriate payment for any subsequent specialty drug prescriptions, or call the toll-free number. Copays 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 Pharmacy 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.

What You Will Need to Pay

You will need to pay the following copays for each prescription.

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

Member Drugstores	Copay

The following co-payments apply for a 30-day supply of medication. If you receive more than 30-day supply of medication

at a Drugstore, you will have to pay the applicable Copay shown below for each additional 30-day supply of medication.

Note: Specified specialty drugs must be obtained through the specialty pharmacy program. However, the first month supply of a specialty drug is obtained through a retail Drugstore, after which the drug is available only through the specialty pharmacy program unless an exception is made.

- Tier 1 drugs **$10**
- Diabetic Supplies **$10**
- Diabetic Supplies (disposable)..... **No-Copayment**
- Tier 2 drugs **$30**
- Tier 3 drugs **$60**
- Compound Medication..... **$60**
- Tier 4 drugs ..... **20%** of the prescription drug maximum allowed amount to a maximum co-payment of **$100**

Non-Member Drugstores (inside and outside California)	**Copay**

The following co-payment applies to a 30-day supply for any drug you receive from a non-member Drugstore.

- Tier 1 drugs ..... **$10** plus **50%** of the remaining Prescription Drug maximum allowed amount
- Tier 2 drugs ..... **$30** plus **50%** of the remaining Prescription Drug maximum allowed amount
- Tier 3 drugs ..... **$60** plus **50%** of the remaining Prescription Drug maximum allowed amount

Note: Specified specialty drugs must be obtained through the specialty pharmacy program. However, the first month supply of a specialty drug may be obtained through a retail Drugstore, after which the drug is available only through the specialty pharmacy program unless an exception is made.

Home Delivery Program: You need to pay the following co-pays for a 90-day supply of medication:

Home Delivery Prescriptions	Copay

- Tier 1 drugs **$20**
- Diabetic Supplies **$20**
- Diabetic Supplies (disposable)..... **No-Copayment**
- Tier 2 drugs **$60**
- Tier 3 drugs **$120**
- Tier 4 drugs ..... **20%** of the prescription drug maximum allowed amount to a maximum co-payment of **$100**

Exceptions to Prescription Drug Co-Payments

- "Preventive Prescription Drugs and Other Items" covered under Getting Prescription Drugs ..... **No charge**

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

- For a 30-day supply from a retail Drugstore..... **$250**
- For a 90-day supply through home delivery **$750**

Your costshare will be prorated for partial fills of prescribed oral, solid dosage forms of Schedule II controlled substances. A partial

fill means a part of a prescription filled that is of a quantity less than the entire prescription.

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

You will always have to pay for costs that this Plan does not cover.

PRESCRIPTION DRUG OUT-OF-POCKET AMOUNT
After you pay **$3,600** per Member, up to a maximum of **$7,200** per family, in copays for your drugs in one year, you will have reached the Prescription Drug Out-of-Pocket Amount and you will not need to pay any more copays for drugs the rest of the year.

After we determine that you have reached the Prescription Drug Out-of-Pocket Amount, we will let the Member Drugstores know that you do not need to pay copays for the rest of the calendar year for your drugs.

Preferred Generic Program

Prescription Drugs will always be dispensed by a Pharmacist as prescribed by your Doctor. Your Doctor may order a drug in a higher or lower drug Copay tier for you. You may request your Doctor to prescribe a drug in a higher Copay tier for you or you may request the Pharmacist to give you a drug in a higher Copay tier instead of a drug in a lower Copay tier. Under this Plan, if a drug in a lower Copay drug tier is available, and it is not determined that a higher Copay tier drug is Medically Necessary for you to have) see "Prescription Drug Formulary, Prior Authorization and Step Therapy Exceptions," above), you will have to pay the Copay for the lower Copay drug tier plus the difference in cost between the Prescription Drug maximum allowed amount for the lower Copay drug tier and the higher Copay drug tier, but, not more than 50% of our average cost for the tier that the drug is in. If your Doctor specifies "dispense as written," in lieu of paying the Copay for the lower Copay drug tier plus the difference, as previously stated, you will pay just the applicable Copay shown for the drug in the higher Copay tier you get. For certain higher cost generic drugs, we may make an

exception and not require you to pay the difference in cost between the generic drug and Brand Name Drug.

Special Programs

From time to time, we may initiate various programs to encourage you to utilize more cost-effective or clinically-effective drugs including, but, not limited to, generic drugs, home delivery drugs, over-the-counter drugs or preferred drug products. Such programs may involve reducing or waiving co-payments for those generic drugs, over-the counter drugs, or the preferred drug products for a limited time. If we initiate such a program, and we determine that you are taking a drug for a medical condition affected by the program, you will be notified in writing of the program and how to participate in it.

Split Fill Dispensing Program

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

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

Drug Cost Share Assistance Programs

If you qualify for and participate in certain drug cost share assistance programs offered by drug manufacturers or other third parties to reduce the deductible, copayment, or coinsurance you pay for certain specialty drugs, the reduced amount you pay will

be the amount we apply to your deductible and/or out-of-pocket limit**.**

Therapeutic Equivalents

Therapeutic equivalents is a program that tells you and your Doctors about alternatives to certain Prescription Drugs. We may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic equivalent is right for you. For questions or issues about therapeutic equivalents, please call the toll-free number on your Member ID card.

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "What You Will Need to Pay" and "Getting Prescription Drugs" sections of this Plan. In most cases, you must use a certain amount of your drugs before it can be refilled. In some cases we may let you get an early refill. For example, we may let you refill your drugs early if it is decided that you need a larger dose. We will work with the Drugstore to decide when this should happen.

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

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

Rebate Impact on Prescription Drugs You get at Member Drugstore or Home Delivery

Anthem and/or its pharmacy benefits manager may also, from time to time, enter into agreements that result in Anthem receiving rebates or other funds ("rebates") directly or indirectly from

Prescription Drug manufacturers, Prescription Drug distributors or others.

You will be able to take advantage of a portion of the cost savings anticipated by Anthem from rebates on Prescription Drugs purchased by you from a Member Drugstore, home delivery or specialty pharmacy under this section. If the Prescription Drug purchased by you is eligible for a rebate, most of the estimated value of that rebate will be used to reduce the maximum allowable amount for the prescription drug. Any deductible or coinsurance would be calculated using that reduced amount. The remaining value of that rebate will be used to reduce the cost of coverage for all Members enrolled in coverage of this type.

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

For your health and safety

For your health and safety, we check the medicines you are using. Some drugs may need our OK. If we see that too many drugs are being used, we will let your Doctor and the Drugstore know. We may also limit the benefits to prevent over-use.

We Cover These Drug Services and Supplies

- Drugs and medicines which need a prescription by law, except as specifically stated in this Evidence of Coverage. Formulas prescribed by a Doctor for the treatment of phenylketonuria. These formulas are subject to the Copay for Brand Name Drugs.
- Insulin.
- Syringes for use with insulin and other medicines you inject yourself.

- All FDA approved contraceptive drugs including drugs available over-the-counter, self-administered contraceptives, including oral contraceptive drugs, self-injectable contraceptive drugs, contraceptive patches, and contraceptive rings. Coverage is also provided for up to a 12-month supply of FDA-approved, Self-Administered Hormonal Contraceptives, when dispensed or furnished at one time by a provider or Pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies. Certain contraceptives are covered under the "Preventive Care Services" benefit. Please see that section for more details. If your Doctor determines that none of these contraceptive methods are appropriate for you based on your medical or personal history, coverage will be provided for at least one other prescription contraceptive method at $0 cost sharing that is approved by the Food and Drug Administration (FDA) and prescribed by your Doctor and obtained at a Member Drugstore.

  The Plan will not impose any restrictions or delays on your coverage of FDA-approved contraceptive drugs, devices, and other products, including prior authorization requests, any utilization controls or any other form of medical management restrictions.

  Note that a prescription will not be required to trigger coverage of over-the-counter FDA-approved contraceptive drugs, devices, and products and point-of-sale coverage for over-the-counter FDA-approved contraceptive drugs, devices, and products will be provided at Member Drugstores and with no cost sharing or medical management restrictions.

- Drugs with Food and Drug Administration (FDA) labeling for self-administration.

- AIDS vaccine (when approved by the federal Food and Drug Administration and that is recommended by the US Public Health Services).

- Disposable diabetic supplies (such as test strips and lancets).

- Prescription Drugs for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.

- Inhaler spacers and peak flow meters for the treatment of pediatric asthma. These items are subject to the Copay for Brand Name Drugs.
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These drugs will be covered as specified under "Preventive Prescription Drugs and Other Items", subject to all terms of this Plan that apply to those benefits.
- FDA-approved smoking cessation products and over-the-counter nicotine replacement products when obtained with a Doctor's prescription. These products will be covered as preventive care services when obtained from a Member Drugstore. Coverage is provided as specified under "Preventive Prescription Drugs and Other Items", subject to all terms of this Plan that apply to those benefits
- Preexposure prophylaxis and postexposure prophylaxis that has been furnished by a pharmacist and obtained at a Member Drugstore, as required by law, including the pharmacist's services and related testing ordered by the pharmacist.
- At least one FDA-approved Drug in each of the following categories without prior authorization, step therapy, or Utilization Review:
  - Medication for the reversal of opioid overdose;
  - Medication for the detoxification or maintenance treatment of a substance use disorder;
  - A long-acting buprenorphine product; and
  - A long-acting injectable naltrexone product.
- Prescription Drugs, vaccinations (including administration), vitamins, supplements, and certain over-the-counter items specifically listed in this Plan as covered under "Preventive Prescription Drugs and Other Items", subject to all terms of this Plan that apply to those benefits.

EXCLUSIONS AND LIMITATIONS

The Plan does not cover the services or supplies listed below that are excluded from coverage or exceed limitations as described in this Evidence of Coverage (EOC).

These Exclusions and limitations do not apply to Medically Necessary basic health care services required to be covered under California or federal law, including but not limited to Medically Necessary treatment of a Mental Health or Substance Use Disorder, as well as preventive services required to be covered under California or federal law.

These Exclusions and limitations do not apply when covered by the Plan or required by law.

The Plan does not cover the following Prescription Drugs, except as described in this EOC in "Prescription Drugs Administered by a Medical Provider" and "Getting Prescription Drugs", or as required by law:

- When prescribed for cosmetic services. For purposes of this Exclusion, cosmetic means drugs solely prescribed for the purpose of altering or affecting normal structure of the body to improve appearance rather than function.
- When prescribed solely for the treatment of hair loss, sexual dysfunction, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. The Exclusion does not apply to drugs for mental performance when they are Medically Necessary to treat diagnosed mental illness or medical conditions affecting memory, including, but not limited to, treatment of the conditions or symptoms of dementia or Alzheimer's disease.
- When prescribed solely for the purpose of losing weight, except when Medically Necessary for the treatment of [The following will reflect the word "severe" as standard. Please note, the Plan may only remove either Class III or severe if the removal of these qualifiers has been approved by the DMHC in accordance with Rule 1300.67.24(g): Class III or severe] obesity. Enrollment in a comprehensive weight loss program, if

covered by the Plan, may be required for a reasonable period of time prior to or concurrent with receiving the Prescription Drug.

- When prescribed solely for the purpose of shortening the duration of the common cold.
- Prescription Drugs available over the counter or for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the Prescription Drug). This Exclusion does not apply to:
  a. Insulin,
  b. Over-the-counter drugs as covered under preventive services, e.g., over-the-counter FDA-approved contraceptive drugs),
  c. Over-the-counter drugs for reversal of an opioid overdose, or
  d. An entire class of Prescription Drugs when one drug within that class becomes available over the counter.
- Replacement of lost or stolen drugs.
- Drugs when prescribed by non-contracting Health Care Providers for non-covered procedures and which are not authorized by a Plan or a Plan Health Care Provider, except when coverage is otherwise required in the context of Emergency Services and Care.]
- [Exclusion only for religious groups: Contraceptive Drugs, injectable contraceptive Drugs and patches unless we must cover them by law. This exclusion does not apply to sterilization services or procedures for purposes other than contraception. Benefits or services may be available at no cost through the California Reproductive Health Equity Program.]
- This Plan does not cover Drugs that have been prescribed for one or more uses that are different from the use for which the Drug is approved for marketing by the FDA (i.e., off-label use), if the conditions required by law are not met.]

What You Should Know about Your Coverage

How Coverage Begins

Persons who meet the eligibility requirements established by your employer can enroll in Anthem Blue Cross HMO. Please contact your Human Resources office for more information.

You can enroll the following family Members in Anthem Blue Cross HMO:

- Your spouse as recognized under state or federal law. This includes same sex spouses when legally married in a state that recognizes same-sex marriages.
- Your domestic partner, if you are in a legally registered and valid domestic partnership.

  If you're not in a legally registered and valid domestic partnership, you must meet these rules:

  - You have a common residence;
  - Neither of you is married to someone else nor a Member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity;
  - You are not related by blood so closely that you cannot be legally married in California or in the state or commonwealth you live in;
  - You are both 18 years of age or older;
  - You are both able to agree to be part of a domestic partnership; and
  - You must provide your employer with a signed, notarized, affidavit certifying you meet all of the rules shown above for your domestic partner to be a family Member.

  As used above, "have a common residence" means that both domestic partners share the same residence. It is not necessary that the legal right to possess the common residence be in both

of their names. Two people have a common residence even if one or both have additional residences. Domestic partners do not cease to have a common residence if one leaves the common residence but intends to return.

- Your natural children, step children, or legally adopted children (children for whom you may be a legal guardian are not eligible) who are:
  - Under 26 years old, or
  - 26 years old or more if they are not capable of getting a self-sustaining job due to a physical or mental condition, and
    - They are unmarried.
    - They must depend chiefly on you, your spouse, or domestic partner for support and maintenance. A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.
    - A Doctor certifies in writing that the child is incapable of getting a self-sustaining job due to a physical or mental condition. We must receive the certification, at no expense to us, within 60-days of the date you receive our request. We may request proof of continuing dependency and that a physical or mental condition still exists, but not more often than once each year after the initial certification.

    The child may remain covered under the Plan until he or she is no longer chiefly dependent on you, your spouse, or domestic partner for support and maintenance due to a continuing physical or mental condition.

You can't enroll as a spouse or domestic partner:

- If you are also covered as an employee under the same Plan.
- If you are now on active duty in the armed services.

You and your family Members must live or work in the Anthem Blue Cross HMO Service Area. You and your family Members must live in the United States to be covered under this Plan.

When Are You Covered?

You are eligible to enroll with this health Plan as determined by your employer. Please contact your Human Resources office for more information.

Your family Members are eligible to be covered:

- For all existing family Members, on the date you are covered; or
- For a new spouse and step child, if any, the first day of the month after the date your spouse and step child, if any, become a family Member(s) due to marriage;
- For a new domestic partner and his or her child, if any, the first day of the month after the date your domestic partner and his or her child, if any, become a family Member(s) due to the start of a domestic partnership;
- For an over age child, the first day of the month after the date your child again becomes a family Member; or
- The date a child becomes your family Member due to birth or adoption.

To enroll, you must give your employer a signed Enrollment Form within 31 days after the day you are eligible. We must get this form from your employer within 90 days. If not, you may not be covered.

- If you enroll before, on, or within 31 days after the date you were eligible, then your coverage will start on your eligibility date.
- If you do not enroll within 31 days of your eligibility date, you cannot enroll. Your next chance to enroll is your employer's next Open Enrollment. Sometimes, you may be able to enroll earlier. See "When You Can Enroll Without Waiting."

If you choose to leave this Plan, you will be eligible to enroll again during your employer's next Open Enrollment. You may be able to enroll earlier. See "When You Can Enroll Without Waiting."

Your employer must pay the subscription charges every month in order for you to be covered. Your employer may ask you to pay all or part of these charges. Talk to your employer about how much you must pay.

For you to get benefits we must have an agreement with your employer and you must be covered at the time you got the service. The benefits you get will be the benefits in effect at the time the services are provided. Your employer's health Plan agreement with us may change from time to time, or end, without your consent.

If You Want to Enroll a New Child

Here's how new children are enrolled if you are already covered:

- Any child born to you will be enrolled from the moment of birth for 31 days; and
- Any child being adopted by you will be covered for 31 days from the date:
  - You have financial responsibility for the child OR
  - You have the right to control the child's health care.

  You will need to give us legal papers or other proof for either one.

For the child's enrollment to continue beyond this 31-day period, you must submit a Membership change form to the group within this 31-day period. You will need to pay subscription charges, if any, for them from the date their coverage began.

When You Can Enroll Without Waiting

You may enroll without waiting for your employer's next open enrollment period if any of the following are true:

- **You meet all of the following requirements:**

- You were covered as an individual or dependent under either:

  ⇒ Another employer group health Plan or health insurance coverage, including coverage under a COBRA or CalCOBRA continuation; or

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

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

- Your coverage under the other health Plan wherein you were covered as an individual or dependent ended as follows:

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

  Loss of eligibility for coverage under an employer group health Plan or health insurance includes loss of eligibility due to termination of employment or change in employment status, reduction in the number of hours worked, loss of dependent status under the terms of the Plan, termination of the other Plan, legal separation, divorce, death of the person through whom you were

covered, no longer living or working in the Anthem Blue Cross HMO Service Area (whether or not by your choice), and any loss of eligibility for coverage after a period of time that is measured by reference to any of the foregoing.

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

♦ A court has ordered that your spouse, domestic partner or child be covered under your employee health Plan, and you give your employer a signed Enrollment Form within 31 days from the date the court order was issued.

♦ We don't have a written statement from your employer stating that before you chose not to enroll or not be enrolled you were given and signed a notice that told you:

- If you choose not to enroll for coverage within 31 days after you become eligible; or
- If you choose to cancel your coverage; and
- Later choose to enroll;

Your coverage may not begin until the first day of the month following the end of your employer's open enrollment.

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

- If you enroll following marriage or domestic partnership, you and your new spouse or domestic partner must enroll within 31 days of the date of marriage or domestic partnership. Your new spouse or domestic partner's children may also enroll, but your other children may not

enroll unless they qualify under another one of these conditions listed above.

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

♦ All of the following conditions are met:

- You finished the waiting period under the Plan, if any, but ceased to be eligible due to the end of your employment;
- You again become eligible based on your employer's eligibility rules; and
- You enroll within 31 days of your return to work.

♦ You met or went beyond a lifetime limit on all benefits of another health Plan. Your application must be made within 31 days of the date a claim or a portion of a claim is denied because you met or went beyond a lifetime limit on all benefits of another health Plan.

♦ You become eligible for assistance, with respect to the cost of coverage under the employer's group Plan, under a state Medicaid or SCHIP health Plan, including any waiver or demonstration project conducted under or in relation to these Plans. You must properly file a signed Enrollment Form with the group within 60 days after the date you are determined to be eligible for this assistance.

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

were covered under the Plan and whose coverage terminated when the employee's coverage terminated. Other dependents who were not covered may not enroll at this time unless they qualify under another of the circumstances listed above.

The effective date of coverage for enrollments during a special enrollment period as described above will be on the first day of the month following the date you file the signed Enrollment Form, except as specified below:

- If a court has ordered that coverage be provided for a dependent child, coverage will become effective for that child on the earlier of:
  - The first day of the month following the date you file the signed Enrollment Form; or
  - Within 30 days after we receive a copy of the court order or of a request from the district attorney, either parent or the person having custody of the child, the employer, or the group administrator.
- For reservists and their dependents applying for reinstatement of coverage following reemployment with the employer, coverage will be effective as of the date of reemployment.
- For enrollments following the birth, adoption, or placement for adoption of a child, coverage will be effective as of the date of birth, adoption, or placement for adoption.

Open Enrollment

If you are eligible to be covered, Open Enrollment is a time you can enroll yourself or your family Members. Your employer has this time once a year in the month of November.

You or your family Members will be covered on the first day of the Plan year following the end of the Open enrollment period. If you had another Plan, it would end when this one starts.

When We Cannot Cancel Your Coverage

We cannot cancel your coverage while:

- This Plan is in effect;
- You're eligible;
- Your subscription charges are paid;
- You live or work within a Medical Group's Service Area;
- You follow your Primary Care Doctor's advice and treatment and you work with the Medical Group; and
- You pay all copays within 31 days after you get a bill.

The benefits of this Plan are only for Medically Necessary services as decided by your Medical Group or Anthem.

We are not responsible for any costs you have to pay over the Plan's benefits.

Only Members may get benefits under this Plan. You cannot transfer the right to benefits to another person.

How Your Coverage Ends

We are not required to send you a notice that coverage is ending if you decide, or your employer decides, to end coverage. Coverage may end:

- **If our agreement with your employer ends.** Coverage ends on the date the agreement is terminated or cancelled. If we decide to end the coverage provided to you by your employer for any of the reasons shown in the agreement, we will give written notice of termination, cancellation or non-renewal to your employer. Your employer will send or give you a copy of the termination, cancellation or non-renewal notice at least seven days prior to the date coverage ends.
- **If the subscription charges are not paid**. If your employer fails to pay the subscription charges as they become due, we may terminate the agreement as of the last day of the Grace Period described below. Nevertheless, we will terminate the

agreement only upon first giving the employer a written Notice of Cancellation that is delivered to them at least 30-days prior to that cancellation (or any longer period of time required by applicable federal law, rule, or regulation).

- The Notice of Start of Grace Period shall state that the agreement shall not be terminated if the employer makes appropriate payment in full within 30-days after the date of the Notice of Start of Grace Period (or any longer period of time required by applicable federal law, rule, or regulation). The Notice of Start of Grace Period shall also inform the employer that, if the agreement is terminated for non-payment and the employer wishes to apply for reinstatement, the employer shall be required to submit a new application for coverage, and that Anthem either may decline to permit reinstatement or may permit reinstatement upon terms and conditions as it shall determine appropriate, as set forth in the agreement. Per the agreement, your employer will mail a copy of our notice to them to you. If you have any questions about your coverage ending, and how it will affect you, please call the Member Services phone number on your I.D. card.

Grace Period. For every Subscription Charge Due Date except the first, there is a 30-day grace period in which to pay subscription charges. The grace period begins the day the Notice of Start of Grace Period is dated. The agreement remains in force during the grace period, and coverage is maintained during the grace period. The employer is liable for payment of subscription charges covering any period of time that the agreement remains in force, including any grace period. If your employer fails to pay us the subscription charges due during the grace period, we will not end your coverage until the end of the grace period. You will not be required by us to pay the subscription charges for your employer nor will you be required to pay more than your Copay for any services received during the grace period.

If subscription charges due are not paid by the end of the grace period, the agreement will be canceled as described above.

- **If the agreement is changed at your employer's request to stop covering the class of employees to which you belong.** We will no longer cover you or your family Members on the date of that change.
- **If the agreement is changed at your employer's request to stop covering family Members.** We will no longer cover your family Members on the date of that change.
- **If you are no longer covered.** Your family Members will no longer be covered.
- **If you do not pay your copay.** If you do not pay your Copay to a provider within 31-days from the date that you are sent a bill by a provider to make your Copay payment, if requested in writing to us by the provider, Anthem will send you a written notice to let you know that you have not paid your copay. If you do not pay your Copay to the provider within 15-days from the date we sent our notice to you, we will terminate your coverage at 12:00 midnight on the fifteenth day following the date we sent notice to you telling you of this. If your coverage is terminated, Anthem will tell your employer not to pay any further subscription charges for you. Within 30-days, we will return the pro-rata portion of any monies paid to us by your employer for your coverage for the unexpired period for which payment has been received together with amounts due on claims, if any, less any amounts due us. Your employer will return your portion of the money returned to them to you.

  If your coverage was ended because you didn't pay your copay, and you have now paid it, you may have your coverage reinstated by re-enrolling as follows:

  - If you paid your Copay and re-enroll on, or within 31-days after the date your coverage was ended, then your coverage will be reinstated to the date your coverage ended. (There will be no lapse of coverage.)
  - If you do not pay your Copay within 31-days after your coverage would end due to failure to make the required copay, but subsequently paid your Copay and re-enroll within 31-days after you paid your copay, then your

coverage will start on the next subscription charge due date shown in the agreement under the same terms that apply to others in your classification. (There will be a lapse of coverage for the time period between when we ended your coverage and the date your employer again pays subscription charges for your coverage.)

- If you did not pay your Copay within 31-days after the date your coverage ended, and you do not re-enroll within 31-days of the date you paid your copay, you will be eligible to enroll again during your employer's next Open Enrollment.

♦ **If you decide to cancel at any time.** Your coverage ends on the next subscription charge due date after we receive written notice from your employer that you have ended your coverage. You must give your employer written notice to end your coverage.

♦ **If you or a family Member are no longer eligible**. Your coverage ends on the next subscription charge due date following the date you are no longer eligible for coverage, except in these cases:

- **Leave of Absence.** If your employer pays the subscription charges to us, you may be covered for up to three months while you take a short-term leave of absence that is approved by your employer. This time period may be extended if required by law.

- **Handicapped Children.** If your child has a physical or mental condition that prevents him or her from getting a self-sustaining job and reaches the upper age limit in this Plan for a child (26 years), your child can still qualify if he or she is:

  ⇒ Covered under this Plan.

  ⇒ Still chiefly dependent on you, your spouse or your domestic partner for support and maintenance.

  ⇒ Not able to get a job to self-support himself or herself because of the physical or mental condition.

A Doctor must certify in writing that your child is incapable of self-sustaining employment due to a physical or mental condition.

We will notify you that your child's coverage will end when your child reaches the Plan's upper age limit at least 90 days prior to the date the child reaches that age. You must send proof of the child's physical or mental condition within 60 days of the date you receive our request. If we do not complete our determination of your child's continuing eligibility by the date your child reaches the Plan's upper age limit, your child will remain covered pending our determination.

After two years have passed since you gave us the first certification, you may need to send us proof that your child is still chiefly dependent on you, your spouse or your domestic partner for support and maintenance and that a physical or mental condition still exists, but we will not ask for this proof more than once a year.

We will cover your child until he or she no longer has a physical or mental condition that prevents him or her from getting a job or he or she is no longer dependent on you, your spouse or your domestic partner for support and maintenance.

A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

- **Fraud or misrepresentation by you or a family Member.** Termination is effective upon the later of: (1) the date shown in the written notice to you; or (2) the date the written notice was mailed to you:

  - **Fraud or deception in the use of services or facilities.** You or a family Member may individually have your coverage terminated if any of you commits fraud or deception in the use of services or facilities. If you, as the employee, have your coverage terminated for such fraud or

deception, coverage for all other family Members will also end.

- **Intentional misrepresentation of material fact under the terms of the agreement**. If you or a family Member purposely gives us incorrect or incomplete material information, and we rely on such information in providing health care services to that Member, we may end coverage to that Member. If you, the employee, furnish incorrect or incomplete material information, you and all family Members may have your coverage ended. No statement made by you, unless it is fraudulent and in writing, will be used in any contest to end your coverage under this Plan. After your coverage under this Plan has been in force for 24 months, no statement made by you will be used to end your coverage.

Note: If your marriage or domestic partnership ends, you must give or send to your employer written notice that it has ended. Coverage for former spouses and domestic partners, and their dependent children, if any, ends according to the "What You Should Know about Your Coverage" provisions. If Anthem has a loss, because you fail to tell your employer your marriage or domestic partnership ended, Anthem may recover any actual loss from you. If you fail to give your employer notice in writing that your marriage or domestic partnership ended, it will not delay or prevent the end of your marriage or domestic partnership. If you notify your employer in writing to cancel coverage for a former spouse or domestic partner, and the children of the former spouse or domestic partner, if any, right away at the end of your marriage or domestic partnership, such notice will be considered compliance with the requirements of this provision.

You may be entitled to continued benefits under terms which are specified elsewhere under Keeping Anthem Blue Cross HMO After Your Coverage Status Changes, and Extension.

A Medical Group Can End its Services to You

- **If you move away from the area it serves.** You will need to ask to transfer to another Medical Group. If you move outside

the Anthem Blue Cross HMO Service Area, you won't be eligible for Anthem Blue Cross HMO.

- Call the Member Services Number on your Member ID card, or ask your employer for a Membership change form.
- The change in your Medical Group will happen on the first day of the month after we get your request.

♦ **If you refuse to follow a treatment** your Doctor recommends when there is no other better choice, your coverage may end with that Doctor and/or Medical Group. We will help you get coverage with another Doctor and/or Medical Group.

♦ **If your conduct threatens others.** If you act in a way that threatens the safety of Anthem employees, providers, other Plan Members, or other patients, or repeatedly behave in a manner that substantially impairs Anthem's ability to furnish or arrange services for you or other Members or substantially impairs a provider's ability to provide services to other patients, your Medical Group may ask us to move you to another Medical Group. You will have the opportunity to respond to any allegations that any such behavior has occurred.

If You Believe Your Coverage Has Been Improperly Cancelled, Rescinded, or Not Renewed

If you believe your coverage has been or will be improperly cancelled, rescinded, or not renewed, you may file a complaint with us according to the procedures described in the section called "How to Make a Complaint". You should file your complaint as soon as possible after you receive notice that your coverage will end. You may also send a complaint to the Director of the Department of Managed Health Care. If your coverage is still in effect when you file a complaint, we will continue to provide coverage to you under the terms of this Plan until a final determination of your complaint has been made, including any review by the Director of the Department of Managed Health Care (this does not apply if your coverage is cancelled because the subscription charges have not been paid). If your coverage is maintained in force pending the outcome of the review, subscription charges must still be paid to us on your behalf.

Keeping Anthem Blue Cross HMO After Your Coverage Status Changes

If your employer employs 20 or more people, you may be able to keep on being covered even after you no longer work for that employer. This is called COBRA. Ask your employer for more information.

You or Your Family Members May Choose COBRA

You can go on being covered by Anthem:

- When your job ends, for any reason other than gross misconduct.
- When you lose coverage under an employer's Plan because your work hours have reduced.
- When, as a retiree, your benefits are canceled or reduced because your former employer filed for Chapter 11 bankruptcy.

Your family Members, other than a domestic partner, or the child of a domestic partner, can go on being covered by Anthem even.

- If your job ends, for any reason other than gross misconduct.
- If you lose coverage under an employer's Plan because your work hours have reduced.
- If you were to die.
- If you are divorced or legally separated.
- If your child is no longer qualifies as a dependent. For example, your child reaches the upper age limit of the Plan.
- If you become entitled to Medicare.

COBRA does not apply to a domestic partner, or the child of a domestic partner, under this Plan.

Your employer will let you or your family Members know that you have a right to keep your health Plan under COBRA. If you marry or have a new child during this time, your new spouse

or child can be enrolled as a family Member. But only a child born to or placed for adoption with you will have the same rights as someone who was covered under the Plan just before COBRA was elected.

Your employer will notify you or your family Members if you can continue your coverage under COBRA when:

- You lose your job or your work hours are reduced.
- Your benefits as a retiree are canceled or reduced because your former employer filed for Chapter 11 bankruptcy.
- You die or become entitled to Medicare. Your employer will notify your family Members.

You must inform your employer if your family Members want COBRA coverage within 60 days from the date:

- You get a divorce or legal separation.
- Your child is no longer a dependent.

If You Want to Keep Your Health Plan

- Tell your employer within 60 days of the date you get your notice of your right to keep your health Plan.
- You can have coverage for all the Members of the family, or only some of them.
- If you don't choose COBRA during those 60 days, you cannot have it later.
- Your employer must send your payment and the COBRA forms to keep you covered within 45 days after you choose to keep it.

You may have to pay the whole cost. You should know that you may have to pay the whole cost of staying on the health Plan.

- You must send your payment to the employer every month.
- Your employer must send it to Anthem. This will keep your coverage going.

The subscription charge that applies to the employee will also apply to:

- A spouse, because of divorce, separation or death.
- A child, even if you or your spouse do not choose COBRA (if more than one child enrolls, subscription charges for the number enrolling will apply).

How Long You Can Be Covered

You can go on being covered until the first of the following events takes place:

- The end of eighteen months (18) if you lost your job or your hours were lowered. (Note: If your COBRA began on or after January 1, 2003 and ends after 18 months, you can keep your medical coverage only under CalCOBRA for up to another 18 months, making a total of 36 months under COBRA and CalCOBRA combined. You must completely use up your eligibility under COBRA first. Your CalCOBRA rights are explained later in this section.)
- The date our agreement with your employer ends.
- The date you stop paying the monthly charges.
- The date you first become covered under another group health Plan.
- The date you first become entitled to Medicare.

Your family Members can go on being covered until the first of the following events takes place:

- Eighteen months (18) if you lost your job, or your hours were lowered. However, this does not apply if coverage did not end when you became entitled to Medicare before you lost your job or your work hours were lowered. COBRA coverage ends 36 months from the date you became entitled to Medicare if entitlement occurred within the 18 months before the date your job ended or your work hours were lowered. (Note: If your COBRA began on or after January 1, 2003 and ends after 18 months, or some longer period if you became entitled to

Medicare before you lost your job or your work hours were lowered but sooner than 36 months, you can keep your medical coverage only under CalCOBRA for the balance of 36 months under COBRA and CalCOBRA combined. You must completely use up your eligibility under COBRA first. Your CalCOBRA rights are explained later in this section.)

- Thirty-six months (36) if there was a death, divorce, or legal separation.
- Thirty-six months (36) if the child is no longer dependent.
- Thirty-six months (36) from your entitlement to Medicare.
- The date our agreement with your employer ends.
- The date they first become eligible under another group health Plan.
- They stop paying monthly charges.
- They first become entitled to Medicare.

Your family Members may be able to get extended COBRA coverage if they experience another event described above. If a second event occurs, your family Members may extend COBRA up to 36 months from the date of the first event if:

- Your family Members were originally covered under the first event; and
- Your family Members were covered under the Plan when the second event occurred.

This period may not go beyond 36 months from the date of the first event.

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 "When You Can Enroll Without Waiting". Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Retirement and COBRA

If you are a retiree and your benefits are canceled or reduced because your former employer filed for Chapter 11 bankruptcy, you may be covered for the remainder of your life. Your covered family Members may continue coverage for 36 months after your death. Coverage ends when:

- Our agreement with your former employer ends.
- You or your family Member stops paying the monthly charges.
- You or your family Member first becomes covered under another group health Plan.

If You or a Family Member is Disabled

If you or a family Member is determined by Social Security to be disabled, your whole family may be able to be covered for up to 29 months. This is an additional 11 months following the 18 months of COBRA coverage due to your job loss or reduction of work hours. You may be covered for the additional 11 months if you or a family Member is determined to be disabled by Social Security before the job loss or reduction of work hours or during the first 60 days of COBRA continuation.

You must show your employer proof that the Social Security Administration (SSA) found that you or your family Member was disabled. You must show your employer this proof during the first 18 months of your COBRA continuation and no later than 60 days after the later of the following:

- The date of the Social Security Administration's finding of the disability.
- The date the original qualifying event happened.
- The date you lost coverage.
- The date you are told you must show your employer the disability notice.

For the 19th through 29th months that the disability goes on, the employer must send the monthly charges.

- This will be **150%** of the applicable rate for the length of time the disabled person is covered, depending on how many family Members are being covered.
- If the disabled person is not covered during this additional 11 months, the charge will stay at **102%** of the applicable rate.
- The employer must send the charges to us every month.
- You may have to pay the whole cost.

This coverage will last until the first of the following events takes place:

- The end of the month following a period of 30 days after the SSA finds that the family Member is no longer disabled.
- The end of 29 months. (Note: If your COBRA began on or after January 1, 2003 and ends after 29 months, you can keep your medical coverage only under CalCOBRA for up to another seven (7) months, making a total of 36 months under COBRA and CalCOBRA combined. You must completely use up your eligibility under COBRA first. Your CalCOBRA rights are explained later in this section.)
- You stop paying the monthly charges.
- The agreement with your employer ends.
- You get another health Plan that will cover the disability.
- The disabled person becomes entitled to Medicare.

You must let your employer know within 30 days that the SSA found that you or your family Member is no longer disabled.

If a second event occurs during this additional 11 months, COBRA may extend for up to 36 months from the date of the first event. The charge will be **150%** of the applicable rate for the 19th through 36th months if the disabled person is covered. This charge will be **102%** of the applicable rate for any periods of time the disabled person is not covered after the 18th month.

What About After COBRA?

After COBRA ends, you may be able to keep your coverage through another program called "CalCOBRA", which is explained in the next section.

CalCOBRA

If your coverage under federal COBRA started on or after January 1, 2003, you can keep on being covered under CalCOBRA if your federal COBRA ended:

- 18 months after your qualifying event, if your job ended or your work hours were reduced; or
- 29 months after your qualifying event if you qualified for the additional 11 months of federal COBRA because of a disability.

You must completely use up your eligibility under federal COBRA before you can get coverage under CalCOBRA. You are not eligible for CalCOBRA if:

- You have Medicare;
- You have or get coverage under another group Plan; or
- You are eligible for or covered under federal COBRA.

Coverage under CalCOBRA is for medical benefits only.

You will be told about your rights. Within 180 days before your federal COBRA ends, we will tell you that you have a right to keep your coverage under CalCOBRA. If you want to keep your

coverage, you must tell us in writing within 60 days before the date your federal COBRA ends or when you are told of your right to keep your coverage under CalCOBRA, whichever is later. If you don't tell us in writing during this time period you will not be able to keep your coverage.

You can add family Members to your CalCOBRA coverage. For dependents acquired while you are covered under CalCOBRA, coverage begins according to the enrollment provisions of this Plan.

You may have to pay the whole cost of your CalCOBRA coverage. This cost will be:

- 110% of the applicable rate if your coverage under federal COBRA ended after 18 months; or
- 150% of the applicable rate if your coverage under federal COBRA ended after 29 months.

We must receive your payment every month to keep your coverage going. You must send your payment to us, along with your enrollment form, within 45 days after you tell us you want to keep your coverage. You must send us the payment by first class mail or some other reliable means. Your payment must be enough to pay the amount required and the entire amount due. If we don't get the correct payment within this 45 day period, you won't be able to get coverage under CalCOBRA. After you make the first payment, all other payments are due on the first day of each following month.

If your payment of the subscription charge is not received when due, your coverage will be cancelled. We will cancel your coverage only after sending you written notice of cancellation at least 30 days before cancelling your coverage (or any longer period of time required by applicable federal law, rule, or regulation). If you make payment in full within this time period, your coverage will not be cancelled. If you do not make this payment in full within this time period, your coverage will be cancelled as of 12:00 midnight on the thirtieth day after the date the cancellation notice is sent (or any longer period of time required by applicable federal law, rule, or regulation) and will not be reinstated. Any payment

we get after this time period runs out will be refunded to you within 20 business days. You are still responsible for any unpaid subscription charges that you owe to us, including subscription charges that apply during any grace period.

We may change the amount of your payment as of any payment due date. If we do, we will tell you in writing at least 60 days before the increase takes effect.

You must give us current information. We will rely on the eligibility information you give us as correct without checking on it, but we maintain the right to check any information you give us.

Coverage through a prior Plan. If you were covered through CalCOBRA under the prior Plan, you can keep your coverage under this Plan for the rest of the continuation period. But your coverage will end if you don't follow the enrollment rules and make the payments within 30 days of being told your CalCOBRA coverage under the prior Plan will end.

When CalCOBRA starts. When you tell us in writing that you want to keep your coverage through CalCOBRA and pay the first payment, we will reinstate your coverage back to the date federal COBRA ended. If you enroll a family Member while you are covered through CalCOBRA, the family Member's coverage begins according to the enrollment provisions of this Plan.

When CalCOBRA ends. Your coverage under CalCOBRA will end when the first of the following events takes place:

- The end of 36 months after the date of your qualifying event under federal COBRA*.
- The date our agreement with your employer ends.
- The date your employer stops providing coverage to the class of Members you belong to.
- The date you stop paying the monthly charges. Your coverage will be cancelled after written notification, as explained above.
- The date you become covered under another group health Plan.
- The date you become entitled to Medicare.

- The date you become covered under federal COBRA.

CalCOBRA will also end if you move out of our Service Area or commit fraud.

* If your coverage under CalCOBRA started under a prior Plan, the 36 month period will be dated from the time of your qualifying event under that prior Plan.

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

Extension

If our agreement with your employer ends. Your coverage can be canceled or changed without us telling you.

But, if you or a family Member is Totally Disabled and getting the care of a Doctor, your benefits for treating the totally disabling condition will go on, if:

- The disabled person is staying in a Hospital or Skilled Nursing Facility as long as the stay is Medically Necessary. You will get your benefits until you are no longer staying in the hospital.
- If you are not now in a Hospital or nursing facility, you may still be able to get total disability benefits. Your Doctor must send us a written statement of your disability. It must be sent within 90 days and every 90 days after that.

If you get coverage under another health Plan that provides benefits, without limitation, for your disability, this extension of benefits is not available.

Your benefits will end when:

- You are no longer disabled.
- Your Plan has paid the most it can.
- You get another health Plan which will cover your disability.
- Twelve (12) months have passed.

How to Make a Complaint

While Anthem Blue Cross HMO helps you get the care you need, we don't actually give the care.

We contract with Medical Groups, Doctors, and other health care providers. They are not employees of Anthem. The hospitals, nursing facilities and other health agencies are independent contractors.

However, we want to help you get the care and service you need. Here's how:

- **Talk to your Anthem Blue Cross HMO coordinator.** If you have questions about your services, call your Anthem Blue Cross HMO coordinator. He or she may be able to help you right away. You may also call the Member Services Number on your Member ID card.
- **Filing a Complaint.** If you are still unhappy and wish to file a complaint, you should fill out a "Member Issue Form." You can get this form from your Anthem Blue Cross HMO coordinator or from us. Complete the form and mail it to us or you may call us at the Member Services Number on your Member ID card and ask one of our Member Services representatives to fill out the Member Issue Form for you. You may also file a complaint with us online or print the Member Issue Form through the Anthem Blue Cross website at **www.anthem.com/ca**.
- **If you believe your coverage has been cancelled, rescinded, or not renewed unfairly.** If you believe your coverage has

been or will be improperly cancelled, rescinded, or not renewed, you may also file a complaint with us.

In filing a complaint, you must:

- Include the following information from your Member ID Card:
  - Your group number.
  - Your Member identification number.
- Explain what happened or what you would like help with.

You must file your complaint with us no later than 180 days after the date of the notice that you allege to be improper.

When you mail in the Member Issue form or file your complaint online, you are starting the formal complaint process. If you have an acute or urgent condition, you have the right to ask for an expedited review of an appeal for service that has been denied by your Medical Group. Expedited appeals must be resolved within three days.

♦ **Get help from Anthem.** You may ask for a review from Anthem.

- Just call us at the Member Services Number shown on your Member ID card.
- Or write to us at the following address:

Anthem Blue Cross

Grievance and Appeal Management

P.O. Box 4310

Woodland Hills, CA 91365

- Tell us all about your complaint.
- Send this along with any bills or records.

Except for complaints that concern the Prescription Drug formulary, we will review and respond to your complaint with the following timeframes:

- 30 days after we get and look at the facts of your complaint, we will send you a letter to tell you how we have solved the problem.
- If your case is urgent and involves an imminent threat to your health, such as severe pain or the loss of life or limb or major bodily function, or you believe this Plan has been or will be improperly cancelled, rescinded, or not renewed, we'll expedite the review and resolve your complaint within three days.

- **We will meet with you.** For issues dealing with whether a service is Medically Necessary or appropriate, you may:
  - appear in person before the committee meeting to review your appeal;
  - send someone else to represent you before the committee; or
  - have a telephone conference call with the committee.

- **You have the right to review all documents that are part of your complaint file and to give evidence and testimony as part of the complaint process.**

- **If, after our denial, we consider, rely on or generate any new or additional evidence in connection with your claim, we will provide you with that new or additional evidence, free of charge.** We will not base our appeal decision on a new or additional rationale without first providing you (free of charge) with, and a reasonable opportunity to respond to, any such new or additional rationale. If we fail to follow the appeal procedures outlined under this section the appeals process may be deemed exhausted. However, the appeals process will not be deemed exhausted due to minor violations that do not cause, and are not likely to cause, prejudice or harm so long as the error was for good cause or due to matters beyond our control.

- **If you don't like what the committee decides or it does not decide what to do within 30 days (or within three days for urgent cases).** You may complain directly to the Department of Managed Health Care (see later page). If your case is urgent and involves an imminent threat to your health as described above, you do not have to go through this complaint process or wait 30 days to complain to the Department of Managed Health Care (DMHC). You may do so right away. You may also, at any time, use Binding Arbitration to resolve your dispute. (See "Binding Arbitration" on a later page.)

- **If your complaint is about the cancellation of your coverage,** you may also complain to the DMHC right away if the DMHC agrees that your complaint requires immediate review. If your coverage is still in effect when you file your complaint, we will continue to provide coverage to you under the terms of the Plan until a final determination of your request for review has been made, including any review by the Director of the Department of Managed Health Care (this does not apply if your coverage is cancelled because the subscription charges have not been paid). If your coverage is maintained in force pending the outcome of the review, subscription charges must still be paid to us on your behalf. If your coverage has already ended when you file the complaint, your coverage will not be maintained. If the Director of the Department of Managed Health Care determines that your coverage should not have been cancelled, we will reinstate your coverage back to the date it was cancelled. Subscription charges must be paid current to us on your behalf from the date coverage is reinstated.

- **Questions about your outpatient Prescription Drug coverage.** If you have questions or concerns about your outpatient Prescription Drug coverage, please call the Pharmacy Member Services phone number on your ID card. If you are not happy about how your concerns are taken care of, you may use the complaint process above.

Prescription Drug List Exceptions

You may submit a grievance under this section for denials of drugs related to the formulary, prior authorization, or step therapy exception requests.

Please refer to the "Prior Authorization and Step Therapy Exceptions" and "Exception Request for a Quantity, Dose or Frequency Limitation, Step Therapy, or a Drug not on the Prescription Drug Formulary" section in GETTING PRESCRIPTION DRUGS for the process to submit a prior authorization form for the prior authorization and step therapy exceptions or an exception request for drugs not on the Prescription Drug formulary.

Independent Medical Review of Denials of Experimental or Investigative Treatment

If coverage for a proposed treatment is denied because we or your Medical Group determine that the treatment is experimental or investigative, you may ask that the denial be reviewed by an external independent medical review organization which has a contract with the California Department of Managed Health Care ("DMHC"). Your request for this review may be sent to the DMHC. You pay no application or processing fees of any kind for this review. You have the right to provide information in support of your request for review. A decision not to participate in this review process may cause you to give up any statutory right to pursue legal action against us regarding the disputed health care service. We will send you an application form and an addressed envelope for you to use to ask for this review with any grievance disposition letter denying coverage for this reason. You may also request an application form by calling us at the telephone number listed on your identification card or write to us at Anthem Blue Cross Grievance and Appeals Management, P.O. Box 4310, Woodland Hills, CA 91365. To qualify for this review, all of the following conditions must be met:

- You have a Life Threatening or Seriously Debilitating condition. The condition meets either or both of the following descriptions:

- A Life Threatening condition or a disease is one where the likelihood of death is high unless the course of the disease is interrupted. A Life Threatening condition or disease can also be one with a potentially fatal outcome where the end point of clinical intervention is the patient's survival.
- A Seriously Debilitating condition or disease is one that causes major irreversible morbidity.

♦ Your Medical Group must certify that either (a) standard treatment has not been effective in improving your condition, (b) standard treatment is not medically appropriate, or (c) there is no more beneficial standard treatment covered by this Plan than the proposed treatment.

♦ The proposed treatment must either be:

- Recommended by an Anthem Blue Cross HMO Health Care Provider who certifies in writing that the treatment is likely to be more beneficial than standard treatments, or
- Requested by you or by a licensed board certified or board eligible Doctor qualified to treat your condition. The treatment requested must be likely to be more beneficial for you than standard treatments based on two documents of scientific and medical evidence from the following sources:
  - Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized standards;
  - Medical literature meeting the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database of Health Services Technology Assessment Research (HSTAR);
  - Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;

- Either of the following: (i) The American Hospital Formulary Service's Drug Information, or (ii) the American Dental Association Accepted Dental Therapeutics;
- Any of the following references, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: (i) the Elsevier Gold Standard's Clinical Pharmacology, (ii) the National Comprehensive Cancer Network Drug and Biologics Compendium, or (iii) the Thomson Micromedex DrugDex;
- Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and
- Peer reviewed abstracts accepted for presentation at major medical association meetings.

In all cases, the certification must include a statement of the evidence relied upon.

You must ask for this review within six months of the date you receive a denial notice from us in response to your grievance, or from the end of the 30 day or three day grievance period, whichever applies. This application deadline may be extended by the DMHC for good cause.

Within three business days of receiving notice from the DMHC of your request for review we will send the reviewing panel all relevant medical records and documents in our possession, as well as any additional information submitted by you or your Doctor. Any newly developed or discovered relevant medical records that

we or an Anthem Blue Cross HMO Health Care Provider identifies after the initial documents are sent will be immediately forwarded to the reviewing panel. The external independent review organization will complete its review and render its opinion within 30 days of its receipt of request for review (or within seven days if your Doctor determines that the proposed treatment would be significantly less effective if not provided promptly). This timeframe may be extended by up to three days for any delay in receiving necessary records.

Please note: If you have a terminal illness (an incurable or irreversible condition that has a high probability of causing death within one year or less) and proposed treatment is denied because the treatment is determined to be experimental, you may also meet with our review committee to discuss your case as part of the complaint process (see "How to Make a Complaint").

Independent Medical Review of Complaints Involving a Disputed Health Care Service

You may ask for an independent medical review ("IMR") of disputed health care services from the Department of Managed Health Care ("DMHC") if you think that we or your Medical Group have wrongly denied, changed, or delayed health care services. A "disputed health care service" is any health care service eligible for coverage and payment under your Plan that has been denied, changed, or delayed by us or your Medical Group, in whole or in part because the service is not Medically Necessary.

The IMR process is in addition to any other procedures or remedies that you may have. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. We must give you an IMR application form and an addressed envelope for you to use to ask for IMR with any complaint disposition letter that denies, changes, or delays health care services. A decision not to participate in the IMR process may cause you to lose any lawful right to pursue legal action against us about the disputed health care service.

Eligibility: The DMHC will look at your application for IMR to confirm that:

1. One or more of the following conditions have been met:

   (a) Your provider has recommended a health care service as Medically Necessary, or

   (b) You have had Urgent Care or Emergency Services and Care that a provider determined was Medically Necessary, or

   (c) You have been seen by an Anthem Blue Cross HMO Health Care Provider for the diagnosis or treatment of the medical condition for which you want independent review;

2. The disputed health care service has been denied, changed, or delayed by us or your Medical Group, based in whole or in part on a decision that the health care service is not Medically Necessary; and

3. You have filed a complaint with us or your Medical Group and the disputed decision is upheld or the complaint is not resolved after 30 days. If your complaint requires expedited review you need not participate in our complaint process for more than three days. The DMHC may waive the requirement that you follow our complaint process in extraordinary and compelling cases.

You must apply for IMR within six months of the date you receive a denial notice from us in response to your complaint or from the end of the 30 day or three day complaint period, whichever applies. This application deadline may be extended by the DMHC for good cause.

If your case is eligible for IMR, the dispute will be submitted to a medical specialist or specialists who will make an independent determination of whether or not the care is Medically Necessary. You will get a copy of the assessment made in your case. If the IMR determines the service is Medically Necessary, we will provide the health care service.

For non-urgent cases, the IMR organization designated by the DMHC must provide its determination within 30 days of getting your application and supporting documents. For urgent cases involving an imminent and serious threat to your health, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of your health, the IMR organization must provide its determination within 3 days.

For more information regarding the IMR process, or to ask for an application form, please call us at the Member Services Number on your Member ID card.

Department Of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service Plans. If you have a grievance against your health Plan, you should first telephone your health Plan at the **1-800-365-0609** or at the TDD line **1-866-333-4823** for the hearing and speech impaired and use your health Plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health Plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health Plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR applications forms and instructions online.

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 ARBITRATION provision applies.

ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS, INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE Plan OR ANY OTHER ISSUES RELATED TO THE Plan AND CLAIMS OF MEDICAL MALPRACTICE MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. California Health and Safety Code Section 1363.1 require specified disclosures in this regard: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. YOU AND ANTHEM BLUE CROSS AGREE TO BE BOUND BY THIS ARBITRATION PROVISION. YOU ACKNOWLEDGE THAT FOR DISPUTES THAT ARE SUBJECT TO

ARBITRATION UNDER STATE OR FEDERAL LAW THE RIGHT TO A JURY TRIAL, THE RIGHT TO A BENCH TRIAL UNDER CALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 17200, AND/OR THE RIGHT TO ASSERT AND/OR PARTICIPATE IN A CLASS ACTION ARE ALL WAIVED BY YOU. If your Plan is subject to 45 CFR 147.136, this agreement does not limit your rights to internal and external review of adverse benefit determinations as required by that law. Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law.

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

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

The arbitration is initiated by the Member making written demand on Anthem Blue Cross. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS"), according to its applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by agreement of the Member and Anthem Blue Cross, or by order of the court, if the Member and Anthem Blue Cross cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, Anthem Blue Cross will assume all or a portion of the Member's costs of the arbitration. Unless you and Anthem Blue Cross agree

otherwise, the arbitrator may not consolidate more than one person's claims and may not otherwise preside over any form of a representative or class proceeding. Anthem Blue Cross will provide Members, upon request, with an application, or information on how to obtain an application from the neutral arbitration entity, for relief of all or a portion of their share of the fees and expenses of the neutral arbitration entity. Approval or denial of an application in the case of extreme financial hardship will be determined by the neutral arbitration entity.

Please send all Binding Arbitration demands in writing to:

Anthem Blue Cross
21215 Burbank Blvd
Woodland Hills, CA 91367

Other Things You Should Know

Notice of Claim & Proof of Loss

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

- An Anthem Blue Cross HMO Health Care Provider will submit claims for you. They are responsible for ensuring that claims have the information we need to determine benefits. If the claim does not include enough information, we will ask them for more details, and they will be required to supply those details within certain timeframes.
- Non-Anthem Blue Cross HMO Health Care Provider claims can be submitted by the Doctor if the Doctor is willing to file on your behalf. However, if the Doctor is not submitting on your behalf, you will be required to submit the claim. Claim forms are usually available from the Doctor. If they do not have a claims form, you can send a written request to us, or contact Member Services and ask for a claims form to be sent to you. If you do not receive the claims form, you can still submit written notice of the claim without the claim form. The

same information that would be given on the claim form must be included in the written notice of claim, including:

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

Non-Anthem Blue Cross HMO Health Care 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.

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.

Time Benefits Payable

When using an [Anthem CaliforniaCare/Anthem Select/Anthem Select Plus/Anthem Priority Select/Anthem Vivity/Anthem Designed Access] HMO Health Care Provider, they will bill Anthem directly for services rendered to you. In order for the Health Care Provider to submit a claim on your behalf, you must give the Health Care Provider information necessary for the claim to be filed, such as your Anthem ID Card.

Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. We will pay all benefits within thirty (30) calendar days for clean claims. "Clean claim" means a

claim submitted by you or a Health Care Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment.

If we fail to pay or deny a clean claim in thirty (30) calendar days, and we subsequently pay the claim, we will pay interest to the Health Care Provider that submitted the claim, as required by law.

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.

Member's Cooperation

You will be expected to complete and submit to us all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If you fail to cooperate, you will be responsible for any charge for services.

Third Party Liability and Reimbursement

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

We will automatically have a lien upon any amount you receive from any, insurer, or other source of monetary compensation by

judgment, award, settlement or otherwise. Our lien will be in the amount of the benefits we pay for treatment of the illness, injury, disease, or condition for which a third party is alleged to be liable or financially responsible. Our lien will not exceed the amount we actually paid for those services if we paid the provider other than on a capitated basis. If we paid the provider on a capitated basis, our lien will not exceed 80% of the usual and customary charges for those services in the geographic area in which they were rendered.

We will be entitled to collect on the full amount of our lien, except that our recovery is limited to the lesser of:

- The total lien minus a pro rata reduction for reasonable attorney fees and costs, or
- One-third of the moneys due to the enrollee or insured under any final judgment, compromise or settlement agreement if you have an attorney, or
- One-half of the moneys due to the enrollee or insured under any final judgment, compromise, or settlement agreement if you do not have an attorney.

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

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

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

Coordination of Benefits

If you're covered by this group health Plan, and one or more other medical or dental Plans, total benefits may be limited as shown below. These provisions apply separately each calendar year to each person and are based mainly on California law.

Definitions

When used in this section, the following words and phrases have the meanings explained here.

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

The following are not Allowable Expense:

1. Use of a private Hospital room is not an Allowable Expense unless the patient's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practice, or one of the Plans routinely provides coverage for Hospital private rooms.
2. If you are covered by two Plans that calculate benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method, any amount in excess of the higher of the reasonable and customary amounts.

3. If a person is covered by two Plans that provide benefits or services on the basis of negotiated rates or fees, an amount in excess of the lower of the negotiated rates.

4. If a person is covered by one Plan that calculates its benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method and another Plan provides its benefits or services on the basis of negotiated rates or fees, any amount in excess of the negotiated rate.

5. The amount of any benefit reduction by the Principal Plan because you did not comply with the Plan's provisions is not an Allowable Expense. Examples of these types of provisions include second surgical opinions, utilization review requirements, and network provider arrangements.

6. If you advise us that all Plans covering you are high deductible health Plans as defined by Section 223 of the Internal Revenue Code, and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code, any amount that is subject to the primary high deductible health Plan's deductible.

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage;

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

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

4. Medicare, except when by law Medicare's benefits are secondary to those of any private insurance program or another non-governmental program.

Each contract or arrangement for coverage listed above will be considered a separate Plan. The rules of these provisions will

apply only when the other Plan has coordination of benefits provisions.

Primary Plan is the Plan which will have its benefits figured first.

This Plan is the part of this Plan that 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 primary Plan, then we will figure out its benefits first without taking into account any other Plan.
2. If This Plan isn't the primary Plan, then we may reduce its benefits so that the benefits of all the Plans aren't more than the allowed expense.
3. The benefits of This Plan will never be more than the benefits we would have paid if you were covered only under this Plan.

If This Plan isn't the primary Plan, you may be billed by a health care provider. If you receive a bill, you should submit it to your Medical Group.

Order of Benefits Determination

The following rules determine the order in which benefits will be paid:

1. A Plan with no coordination provision will pay its benefits first. This always includes Medicare except when by law This Plan must pay before Medicare.
2. A Plan which covers you through your employer pays before a Plan which covers you as a family Member. But if you have Medicare and are also a dependent of an active employee under another employer Plan, this rule might change. If Medicare's rules say that Medicare pays after the Plan that covers you as a dependent but before your employer's Plan, then the Plan that covers you as a dependent pays before a Plan which covers you

through your employer. This might happen if you are covered under This Plan as a retiree.

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 year. But if one Plan doesn't have a birthday rule provision, that Plan's provisions will determine the order of benefits.

   Exception to rule 3: If a dependent child's parents are divorced or separated, the following rules will be used instead of rule 3:

   a. The Plan of the parent who has custody, will pay first, unless he or she has remarried.

   b. If the parent with custody has remarried, then the order is 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. However, if there is a court decree which holds one parent responsible for that child's health care coverage, the Plan which covers that child as a dependent of the responsible parent pays first.

4. The Plan covering you as a laid-off or retired employee or as such employee's dependent pays after another Plan covering you. But if either Plan doesn't have a rule about laid-off or retired employees, rule 6 applies.

5. A Plan covering you under a state or federal continuation of coverage pays after another Plan. However, if the other Plan doesn't have this rule, this rule won't apply.

6. When the rules above don't apply, the Plan that has covered you longer pays first unless two of the Plans have the same effective date. In this case, allowed expense is split evenly between the two Plans.

Our Rights Under This Provision

Responsibility For Timely Notice. We aren't responsible for coordination of benefits unless we get information from the asking party.

Reasonable Cash Value. If you get benefits from another Plan in the form of services, the value of services in cash will be considered allowed expense and a benefit paid.

Facility of Payment. If another Plan pays benefits that this Plan should have paid, we will pay the other Plan an amount determined by us. This will be considered a benefit paid under this Plan, and will fully satisfy what we are responsible for.

Right of Recovery. If we pay benefits that are more than we should have paid under this provision, the Medical Group and we may make appropriate adjustment to claims or recover the extra amounts from one or more of the following:

- The persons to or for whom payments were made;
- Insurance companies or service Plans; or
- Other organizations.

In most instances such recovery or adjustment activity shall be limited to the calendar year in which the error is discovered.

If You Qualify for Medicare

Active Employees and Family Members Age 65 or Over Who Are Eligible for Medicare

If you are:

- Age 65 or over; AND
- An Employee who is not retired; OR
- A Dependent of the Employee above who is not retired; AND
- Eligible for Part A of Medicare; AND
- Eligible and enrolled under this Plan;

you will get the benefits of this Plan without taking into account Medicare unless you've chosen Medicare as your primary Plan. If you've chosen Medicare as your primary health Plan, you won't be able to get any benefits under this Plan.

Other Members Who are Eligible for Medicare

If you are:

- A retired employee age 65 or more and eligible for Part A of Medicare; OR
- The spouse of a retired employee and are age 65 or more; OR
- Getting treatment for end-stage renal disease after the first 30 months you are entitled to end-stage renal disease benefits under Medicare; OR
- Entitled to Medicare benefits as a disabled person, unless you have a current employment status (as determined by Medicare's rules) and are enrolled in this Plan through a group of 100 or more employees;

Medicare is your primary health Plan. You will get the benefits of this Plan if and only if you have actually enrolled in Medicare and completed any consents, assignments, releases, and other documents needed to get Medicare repayments for this Plan or its Medical Groups.

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

Except when federal law requires us to be the primary payer, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Part B. Where Medicare is the responsible payer, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to us, to the extent we have made payment for such services. 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.

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

If you are enrolled in Medicare, your Medicare coverage will not affect the services provided or covered under this Plan except as follows:

- Medicare must provide benefits first for any services covered both by Medicare and under this Plan.
- For services you receive that are covered both by Medicare and under this Plan, that are not prepaid by us, coverage under this Plan will apply only to Medicare deductibles, coinsurance, and other charges for covered services over and above what Medicare pays.
- For services you received that are covered both by Medicare and under this Plan, that are prepaid by us, we make no additional payment.
- For any given claim, the combination of benefits provided by Medicare and the benefits provided under this Plan will not be more than what is considered allowed expense for the covered services.

If you have questions about how your benefits will be coordinated with Medicare, please call our Member Services Number on your Member ID card.

Other Things You Should Know

Transition Assistance for New Members: Transition Assistance is a process that allows for completion of covered services for new Members receiving services from a Doctor who is not an Anthem Blue Cross HMO Health Care Provider. If you are a new Member, you may request Transition Assistance if any one of the following conditions applies:

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

- A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Anthem in consultation with you and the Doctor who is not an Anthem Blue Cross HMO Health Care Provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time you enroll with Anthem.

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

Call us at the Member Services Number listed on your ID card to ask for transition assistance or to get a copy of the written policy. Eligibility is based on your clinical condition and is not determined by diagnostic classifications. Transition assistance does not provide coverage for services not otherwise covered under the Plan.

We will notify you by telephone, and the provider by telephone and fax, as to whether or not your request for Transition Assistance is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the Plan. Financial arrangements with Doctors who are not Anthem

Blue Cross HMO Health Care Providers are negotiated on a case-by-case basis. We will ask that the Doctor agree to accept reimbursement and contractual requirements that apply to Anthem Blue Cross HMO Health Care Providers, including payment terms, who are not capitated. If the Doctor does not agree to accept said reimbursement and contractual requirements, we are not required to continue that Doctor's services. If you do not meet the criteria for Transition Assistance, you are afforded due process including having your request reviewed.

Continuation of Care after Termination of Medical Group: Subject to the terms and conditions set forth below, Anthem will provide benefits at the Anthem Blue Cross HMO Health Care Provider level for covered services (subject to applicable copayments, coinsurance, deductibles and other terms) received from a Medical Group at the time the Medical Group's contract with us terminates (unless the Medical Group's contract terminates for reasons of medical disciplinary cause or reason, fraud, or other criminal activity). If your Medical Group leaves our network for any reason other than termination of cause, retirement or death, 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 Anthem Blue Cross HMO Health Care Provider benefits.

You must be under the care of the Medical Group at the time the Medical Group's contract terminates. The terminated Medical Group must agree in writing to provide services to you in accordance with the terms and conditions of the agreement with Anthem prior to termination. The terminated Medical Group must also agree in writing to accept the terms and reimbursement rates that apply to Anthem Blue Cross HMO Health Care Providers who are not capitated. If the terminated Medical Group does not agree with these contractual terms and conditions, we are not required to continue the terminated Medical Group's services beyond the contract termination date.

Anthem will provide such benefits for the completion of covered services by a terminated Medical Group only for the following conditions:

- An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
- A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Anthem in consultation with you and the terminated Medical Group and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the date the Medical Group's contract terminates.
- A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy. For purposes of an individual who presents written documentation of being diagnosed with a maternal mental health condition from the individual's treating health care provider, completion of covered services for the maternal mental health condition shall not exceed twelve (12) months from the diagnosis or from the end of pregnancy, whichever occurs later. A Maternal Mental Health Condition is a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.
- A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.

- The care of a newborn child between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the date the Medical Group's contract terminates.
- Performance of a surgery or other procedure that is authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the date the Medical Group's contract terminates.

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

Please call us at the Member Services Number listed on your ID card to ask for continuity of care or to get a copy of the written policy. Eligibility is based on the Member's clinical condition and is not determined by diagnostic classifications. Continuity of care does not provide coverage for services not otherwise covered under the Plan.

We will notify you by telephone, and the Medical Group by telephone and fax, as to whether or not your request for continuity of care is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the Plan. Financial arrangements with terminated Medical Groups are negotiated on a case-by-case basis. We will ask that the terminated Medical Group agree to accept reimbursement and contractual requirements that apply to Anthem Blue Cross HMO Health Care Providers, including payment terms, who are not capitated. If the terminated Medical Group does not agree to accept the same reimbursement and contractual requirements, we are not required to continue that Medical Group's services. If you disagree with our determination regarding continuity of care, you may file a complaint with us by following the procedures described in the section called "How to Make a Complaint".

This provision also applies if the contractual or employment relationship between your Medical Group or us and the Primary Care Doctor or specialist from whom you are receiving care

terminates. In this situation, please request continuity of care through your Anthem Blue Cross HMO coordinator.

Transition Assistance and Continuity of Care may be revoked or modified prior to the services being rendered for reasons including but not limited to the following:

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

Payment of Benefits. You authorize us to make payments directly to providers for covered services. In no event, however, shall our right to make payments directly to a provider be deemed to suggest that any provider is a beneficiary with independent claims and appeal rights under the Plan. We reserve the right to make payments directly to you as opposed to any provider for covered services, except for claims for emergency care or Federal Surprise Billing Claims for ground or air ambulance services or non-Emergency Services and Care performed by non-Anthem Blue Cross HMO Health Care Providers at certain Anthem Blue Cross HMO Health Care Provider facilities, which will be paid directly to providers and facilities. In the event that payment is made directly to you, you have the responsibility to apply this payment to the claim from the non-Anthem Blue Cross HMO Health Care Provider. Payments and notice regarding the receipt and/or adjudication of claims may also be sent to, an Alternate Recipient (which is defined herein as any child of a Subscriber who is recognized, under a "Qualified Medical Child Support Order", as having a right to enrollment under the group's Plan), or that person's custodial parent or designated representative. Any payments made by us (whether to any provider for covered service or you) will discharge our obligation to pay for covered services. You cannot assign your right to receive payment to anyone, except

as required by a "Qualified Medical Child Support Order" as defined by, and if subject to, ERISA or any applicable state law.

If you receive services from an Anthem Blue Cross HMO Health Care Provider in California (State Surprise Billing Claims), at which or as a result of which, you receive non-emergency covered services provided by a non-Anthem Blue Cross HMO Health Care Provider HMO Health Care Provider, you will pay the non-Anthem Blue Cross HMO Health Care Provider no more than the same cost sharing that you would pay for the same covered services received from an Anthem Blue Cross HMO Health Care Provider. You will not have to pay the non-Anthem Blue Cross HMO Health Care Provider more than the Anthem Blue Cross HMO Health Care Provider cost sharing for such non-emergency covered services.

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

The coverage, rights, and benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above. This prohibition against assignment includes rights to receive payment, claim benefits under the Plan and/or law, sue or otherwise begin legal action, or request Plan documents or any other information that a participant or beneficiary may request under ERISA. Any assignment made without written consent from the Plan will be void and unenforceable.

Inter-Plan Arrangements

Out-of-Area Services

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

When you receive care outside of California, you will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some providers ("non-participating providers") do not contract with the Host Blue. We explain below how we pay both kinds of providers.

Anthem Blue Cross covers only limited healthcare services received outside of California. For example, emergency or Urgent Care obtained outside of California is always covered. Any other services will not be covered when processed through any Inter-Plan Arrangements, unless authorized by Anthem Blue Cross.

Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are Prescription Drugs that you obtain from a pharmacy and most dental or vision benefits.

A. BlueCard® Program

Under the BlueCard® Program, when you receive covered services within the geographic area served by a Host Blue, we will still fulfill our contractual obligations. But, the Host Blue is responsible for: (a) contracting with its providers; and (b) handling its interactions with those providers.

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

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

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

involve types of settlements, incentive payments and/or other credits or charges.

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

B. Negotiated (non–BlueCard Program) Arrangements

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

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

C. Special Cases: Value-Based Programs

BlueCard® Program

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

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

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

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

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

E. Non-participating Providers Outside California

1. Allowed Amounts and Member Liability Calculation

When covered services are provided outside of California by non-participating providers, we may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services as deductible or copayment will be based on that allowed amount. Also, you may be responsible for the difference between the amount that the non-participating provider bills and the payment we will make for the covered services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network Emergency Services and Care.

2. **Exceptions**

In certain situations, we may use other pricing methods, such as billed charges or the pricing we would use if the healthcare services had been obtained within California, or a special negotiated price to determine the amount we will pay for services provided by non-participating providers. In these situations, you may be liable for the difference between the amount that the non-participating provider bills and the payment we make for the covered services as set forth in this paragraph.

Member Services is also available to assist you in determining your allowed amount for a particular service from a non-participating providers the specific procedure code(s) and diagnosis code(s) for the services the provider will render. You will also need to know the provider's charges to calculate your out-of-pocket responsibility. Although Member Services can assist you with this information, the final allowed amount for your claim will be based on the actual claim submitted by the provider. You

may call Member Services toll free at the telephone number on the back of your Identification Card for their assistance.

F. Blue Cross Blue Shield Global Core® Program

If you Plan to travel outside the United States, call Member Services to find out your Blue Cross Blue Shield Global Core benefits. Benefits for services received outside of the United States may be different from services received in the United States. The Plan only covers emergency, including ambulance, and Urgent Care outside of the United States. Remember to take an up to date health ID card with you.

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

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

Please refer to the "Medical Management Programs" section in this Evidence of Coverage for further information. You can learn how to get pre-authorization when you need to be admitted to the Hospital for emergency or non-emergency care.

How Claims are Paid with Blue Cross Blue Shield Global Core

In most cases, when you arrange inpatient Hospital care with Blue Cross Blue Shield Global Core, claims will be filed for you. The only amounts that you may need to pay up front are any copayment or deductible amounts that may apply.

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

- Doctor services;
- Inpatient Hospital care not arranged through Blue Cross Blue Shield Global Core; and
- Outpatient services.

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

When you need Blue Cross Blue Shield Global Core claim forms you can get international claims forms in the following ways:

- Call the Blue Cross Blue Shield Global Core Service Center at the numbers above; or
- Online at www.bcbsglobalcore.com.

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

Financial Arrangements with Providers. Anthem (or an affiliate) contracts with certain health care providers and suppliers ("Providers"). They do this to provide and pay for health care services for you and others covered under individual certificates, evidence of coverages, and group policies, contracts, or agreements to which Anthem is a party. This applies to you and all persons covered under the agreement.

Anthem offers several products and programs. Under the above contracts between Providers and Anthem, the negotiated rates used for certain medical services provided may not be the same for all products and programs. In negotiating the terms of the agreement, your employer was aware that Anthem offered different types of products and programs and chose this Plan. You and the employer are entitled to receive only the benefits of those discounts, payments, settlements, incentives, adjustments and/or allowances specifically set forth in the agreement for this Plan.

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

When you can't get care. If there is an epidemic or public disaster and you can't get care for covered services, we'll refund

the unearned part of the subscription charge paid for you. We must receive a request for the refund in writing and along with proof of the need for care within 31 days. This payment meets our duty under this Plan.

Right of Recovery. Whenever payment has been made in error, or the reasonable cash value of benefits provided under this Plan exceeds the maximum amount for which we are liable, we and your Medical Group will have the right to make appropriate adjustment to claims or recover such payment or excess amount from you or, if applicable, the provider, in accordance with applicable laws and regulations. In the event we recover a payment made in error from the provider, except in cases of fraud or misrepresentation on the part of the provider, we will only recover such payment from the provider within 365 days of the date we made the payment on a claim submitted by the provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

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

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

We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses, and whether to settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by us or you if the recovery method makes providing such notice administratively burdensome. We reserve the right to deduct or offset, including cross Plan offsetting on In-Network claims and on Out-Of-Network claims where the

Out-Of-Network Provider agrees to cross Plan offsetting, any amounts paid in error from any pending or future claim.

Who takes care of your COBRA or ERISA coverage. Anthem is not the Plan administrator of your COBRA or ERISA coverage. Your employer, or someone your employer hires, most often takes care of administrating your employer's health Plan. The employer must let you know about any changes, give you notices, or let you know about the details of the health Plan.

Workers' Compensation. Our health Plan agreement with your employer doesn't change your coverage by the Workers' Compensation program. It doesn't take the place of Workers' Compensation.

Renewing our agreement with your employer. We can renew our agreement at certain times. We may change the subscription charges, or other terms of the Plan from time to time without your consent.

Terms of Coverage

- In order for you to be entitled to benefits, both the agreement and your coverage under it must be in effect on the date the expense giving rise to a claim for benefits is incurred.
- Your benefits will depend on what is covered on the date you get the service or supply for which the charge is made.
- The agreement can be amended, modified or terminated without your consent.

Nondiscrimination. No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information which includes reproductive or sexual health application information, disability, sexual orientation or identity, gender, age, race, color, national origin, ancestry, religion, sex, or marital status.

Consumer Relations Committee. We have a special committee made up of people who are covered by our Plan, health care providers taking part in Anthem Blue Cross HMO, and a Member of our Board of Directors. This committee reviews information

about finances and any complaints of Members among other things. It advises the Board of Directors about how to make sure Members are served well and with respect.

Confidentiality and Release of Information. Applicable state and federal law requires us to undertake efforts to safeguard your medical information which includes reproductive or sexual health application information.

For informational purposes only, please be advised that a statement describing our policies and procedures regarding the protection, use and disclosure of your medical information which includes reproductive or sexual health application information is available on our website and can be furnished to you upon request by contacting our Member Services department.

Obligations that arise under state and federal law and policies and procedures relating to privacy that are referenced but not included in this Evidence of Coverage are not part of the contract between the parties and do not give rise to contractual obligations.

Medical Policy and New Technology. Anthem reviews and evaluates new technology. It does this using criteria set by its medical directors. The criteria it uses helps it decide if:

- the new technology is still investigational; or
- has medical necessity.

A committee called Medical Policy and Technology Assessment Committee (MPTAC) gives Anthem guidance. They also validate Anthem's medical policy. MPTAC is made up of about 20 Doctors. They come from various medical specialties and geographic areas. They include Anthem's medical directors, Doctors in academic medicine and Doctors who practice managed care medicine. Anthem's conclusions, based on MPTAC guidance, are incorporated into Anthem's medical policy used to:

- form decision protocols for particular diseases and injuries; or
- treatments for particular disease or injuries; and
- determine what is Medically Necessary.

MEMBERS' RIGHTS AND RESPONSIBILITIES

As a Member, you have a right to:

- Receive information about your rights and responsibilities.
- Receive information about your Plan, the services your Plan offers you, and the Health Care Providers available to care for you.
- Make recommendations regarding the Plan's member rights and responsibilities policy.
- Receive information about all health care services available to you, including a clear explanation of how to obtain them and whether the Plan may impose certain limitations on those services.
- Know the costs for your care, and whether your deductible or out-of-pocket maximum have been met.
- Choose a Health Care Provider in your Plan's network, and change to another doctor in your Plan's network if you are not satisfied.
- Receive timely and geographically accessible health care.
- Have a timely appointment with a Health Care Provider in your Plan's network, including one with a specialist.
- Have an appointment with a Health Care Provider outside of your Plan's network when your Plan cannot provide timely access to care with an in-network Health Care Provider.
- Certain accommodations for your disability, including:
    - Equal access to medical services, which includes accessible examination rooms and medical equipment at a Health Care Provider's office or facility.
    - Full and equal access, as other members of the public, to medical facilities.
    - Extra time for visits if you need it.
    - Taking your service animal into exam rooms with you.

- Purchase health insurance or determine Medi-Cal eligibility through the California Health Benefit Exchange, Covered California.
- Receive considerate and courteous care and be treated with respect and dignity.
- Receive culturally competent care, including but not limited to:
    - Trans-Inclusive Health Care, which includes all Medically Necessary services to treat gender dysphoria or intersex conditions.
    - To be addressed by your preferred name and pronoun.
- Receive from your Health Care Provider, upon request, all appropriate information regarding your health problem or medical condition, treatment plan, and any proposed appropriate or Medically Necessary treatment alternatives. This information includes available expected outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.
- Participate with your Health Care Providers in making decisions about your health care, including giving informed consent when you receive treatment. To the extent permitted by law, you also have the right to refuse treatment.
- A discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
- Receive health care coverage even if you have a pre-existing condition.
- Receive Medically Necessary treatment of a Mental Health or Substance Use Disorder.
- Receive certain preventive health services, including many without a co-pay, co-insurance, or deductible.
- Have no annual or lifetime dollar limits on basic health care services.
- Keep eligible dependent(s) on your Plan.
- Be notified of an unreasonable rate increase or change, as applicable.

- Protection from illegal balance billing by a Health Care Provider.
- Request from your Plan a second opinion by an Appropriately Qualified Health Care Provider.
- Expect your Plan to keep your personal health information private by following its privacy policies, and state and federal laws.
- Ask most Health Care Providers for information regarding who has received your personal health information.
- Ask your Plan or your doctor to contact you only in certain ways or at certain locations.
- Have your medical information related to sensitive services protected.
- Get a copy of your records and add your own notes. You may ask your doctor or health plan to change information about you in your medical records if it is not correct or complete. Your doctor or health plan may deny your request. If this happens, you may add a statement to your file explaining the information.
- Have an interpreter who speaks your language at all points of contact when you receive health care services.
- Have an interpreter provided at no cost to you.
- Receive written materials in your preferred language where required by law.
- Have health information provided in a usable format if you are blind, deaf, or have low vision.
- Request continuity of care if your Health Care Provider or medical group leaves your Plan or you are a new Plan member.
- Have an Advanced Health Care Directive.
- Be fully informed about your Plan's grievances procedure and understand how to use it without fear of interruption to your health care.
- File a complaint, grievance, or appeal in your preferred language about:
    - Your Plan or Health Care Provider.
    - Any care you receive, or access to care you seek.
    - Any covered service or benefit decision that your Plan makes.

- Any improper charges or bills for care.
- Any allegations of discrimination on the basis of gender identity or gender expression, or for improper denials, delays, or modifications of Trans-Inclusive Health Care, including Medically Necessary services to treat gender dysphoria or intersex conditions.
- Not meeting your language needs.

- Know why your Plan denies a service or treatment.
- Contact the Department of Managed Health Care if you are having difficulty accessing health care services or have questions about your Plan.
- To ask for an Independent Medical Review if your Plan denied, modified, or delayed a health care service.

As a Plan Member, you have the responsibility to:

- Treat all Health Care Providers, Health Care Provider staff, and Plan staff with respect and dignity.
- Share the information needed with your Plan and Health Care Providers, to the extent possible, to help you get appropriate care.
- Participate in developing mutually agreed-upon treatment goals with your Health Care Providers and follow the treatment plans and instructions to the degree possible.
- To the extent possible, keep all scheduled appointments, and call your Health Care Provider if you may be late or need to cancel.
- Refrain from submitting false, fraudulent, or misleading claims or information to your Plan or Health Care Providers.
- Notify your Plan if you have any changes to your name, address, or family members covered under your Plan.
- Timely pay any premiums, copayments, and charges for non-covered services.

Notify your Plan as soon as reasonably possible if you are billed inappropriately.

Confidential Communications of Medical Information. Any Member, including an adult or a minor who can consent to a health

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

The confidential communication request will apply to all communications that disclose medical information, including reproductive or sexual health application information, or a provider's name and address related to the medical services received by the individual requesting the confidential communication.

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

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

Legal Actions. No attempt to recover on the Plan through legal or equity action may be made until at least 60 days after the written proof of loss has been furnished as required by this Plan. No such action may be started later than three years from the time written proof of loss is required to be furnished. If you bring a civil action under Section 502(a) of ERISA, you must bring it within one year of the grievance or appeal decision.

Circumstances Beyond the Control of the Plan. If circumstances arise that are beyond the control of the Plan, we will make a good-faith effort to ensure covered services are available to you. In the event of a declared state of emergency, access to Medically Necessary health care services will be available to

Members who have been impacted and/or displaced as outlined in the California Health and Safety Code, Section 1368.7. Circumstances that may occur, but are not within the control of the Plan, include but are not limited to, a major disaster, epidemic, war, when health care services covered under this Plan are delayed or rendered impractical, or other events beyond our control. Under such circumstances, we will not be responsible for any delay or failure to give services due to lack of available facilities or staff.

Conformity with Laws. Any provision of the agreement which, on its effective date, is in conflict with the laws of the governing jurisdiction, is hereby amended to conform to the minimum requirements of such laws.

Value-Added Programs. We may offer health or fitness related programs to our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not covered services under your Plan but are in addition to Plan benefits. As such, program features are not guaranteed under your health Plan contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Voluntary Clinical Quality Programs. We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from covered services under your Plan. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards or retailer coupons, which we encourage you to use for health and wellness related activities or items. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for

certain covered laboratory tests at home and mail it to the laboratory for processing. You may also be offered a home visit appointment to test for immediate results or collect such specimens and complete biometric screenings. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit or the home visit. If you have any questions about whether receipt of a gift card or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

Voluntary Wellness Incentive Programs. We may offer health or fitness related program options for purchase by your group to help you achieve your best health. These programs are not covered services under your Plan, but are separate components, which are not guaranteed under this Plan and could be discontinued at any time. If your group has selected one of these options to make available to all employees, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options a group may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact us at the Member Services Number on your ID card and we will work with you (and, if you wish, your Doctor) to find a wellness program with the same reward that is right for you in light of your health status. If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.

Payment Innovation Programs. We pay HMO network providers through various types of contractual arrangements. Some of these arrangements – Payment Innovation Programs (Program(s)) – may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner.

These Programs may vary in methodology and subject area of focus and may be modified by us from time to time, but they will be generally designed to tie a certain portion of an HMO network provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, HMO network providers may be required to make payment to us under the Program as a consequence of failing to meet these pre-defined standards.

The Programs are not intended to affect your access to health care. The Program payments are not made as payment for specific covered services provided to you, but instead, are based on the HMO network provider's achievement of these pre-defined standards. You are not responsible for any copayment or coinsurance amounts related to payments made by us or to us under the Program(s), and you do not share in any payments made by HMO network providers to us under the Program(s).

Policies, Procedures and Pilot Programs. We are able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules, and interpretations.

Under the terms of the agreement, we have the authority to introduce or terminate from time to time, pilot or test programs for disease management, care management, case management, clinical quality or wellness initiatives that may result in the payment of benefits not otherwise specified in this Evidence of Coverage. We reserve the right to discontinue a pilot or test program at any time.

Program Incentives. We may offer incentives from time to time in order to introduce you to new programs and services available under this Plan. We may also offer the ability for you to participate in certain voluntary health or condition-focused digital applications or use other technology based interactive tool, or receive educational information in order to help you stay engaged and motivated, manage your health, and assist in your overall health and well-being. The purpose of these programs and incentives include, but are not limited to, making you aware of cost

effective benefit options or services, helping you achieve your best health, and encouraging you to update Member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards and health-related merchandise. Acceptance of these incentives is voluntary as long as we offer the incentives program. Motivational rewards, awards or points for achieving certain milestones may be a feature of the program. We may discontinue a program or an incentive for a particular new service or program at any time. If you have any questions about whether receipt of an incentive or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

DEFINITIONS

Definitions

The meanings of key terms used in this Evidence of Coverage are shown below.

Advanced Imaging Procedures are 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.

For a complete list of Advanced Imaging Procedures or if you need more information, please contact your Medical Group.

Agreement is the Group Benefit Agreement between Anthem and the group (your employer). In it, we agree to what benefits will be given to you.

Ambulatory Surgery Center is a facility licensed as an Ambulatory Surgery Center as required by law that must satisfy our accreditation requirements and be approved by us.

Anthem Blue Cross (Anthem) is a health care service Plan, regulated by the California Department of Managed Health Care.

Anthem Blue Cross HMO coordinator is the person at your Medical Group who can help you with understanding your benefits and getting the care you need.

Anthem Blue Cross HMO Health Care Providers are licensed health care providers who have an agreement with Anthem to provide services to you.

Appropriately Qualified Health Care Provider means a Health Care Provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or another Life-Threatening disease or condition that meets at least one of the following:

- The study or investigation is approved or funded, which may include funding through in-kind donations, by one or more of the following:
    - The National Institutes of Health.
    - The federal Centers for Disease Control and Prevention.
    - The Agency for Healthcare Research and Quality.
    - The federal Centers for Medicare and Medicaid Services.
    - A cooperative group or center of the National Institutes of Health, the federal Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the federal Centers for Medicare and Medicaid Services, the Department of

Defense, or the United States Department of Veterans Affairs.
    - A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    - One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
        - The United States Department of Veterans Affairs.
        - The United States Department of Defense.
        - The United States Department of Energy.
- The study or investigation is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from an investigational new drug application reviewed by the United States Food and Drug Administration.

Authorized Referral occurs when you, because of your medical needs, require the services of a specialist who is a non-Anthem Blue Cross HMO Health Care Provider for the treatment of Mental Health or Substance Use Disorder, behavioral health treatment for autism spectrum disorders, or gender affirming services, or require special services or facilities not available at a contracting hospital, but only when the referral has been authorized by us before services are rendered and when the following conditions are met:

1. there is no Anthem Blue Cross HMO Health Care Provider who practices in the appropriate specialty, or there is no contracting Hospital which provides the required services or has the necessary facilities;

2. that meets the adequacy and accessibility requirements of state or federal law; and

3. the Member is referred to Hospital or Doctor that does not have an agreement with Anthem for a covered service by an Anthem Blue Cross HMO Health Care Provider

Binding Arbitration is a process used to resolve complaints. It is used instead of going to a court of law. In Binding Arbitration, you and Anthem agree to meet with an arbitrator and go by the decision of the arbitrator.

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 in terms of safety, purity, and potency.

Brand Name Drugs are Prescription Drugs that we classify as Brand Name Drugs or our pharmacy benefits manager has classified as Brand Name Drugs through use of an independent proprietary industry database.

COBRA is a special law that gives you a chance to keep your health Plan even if you lose your job, have a reduction in hours or a change in dependents status. You will usually have to pay the monthly charges to keep the Plan under COBRA.

Community Paramedicine Program means a program developed by a local EMS agency and approved by the Emergency Medical Services Authority to provide community paramedicine services consisting of one or more of the program specialties described below under the direction of medical protocols developed by the local EMS agency that are consistent with the minimum medical protocols established by the authority. Community paramedicine services may consist of the following program specialties:

- Providing directly observed therapy (DOT) to persons with tuberculosis in collaboration with a public health agency to ensure effective treatment of the tuberculosis and to prevent spread of the disease.

- Providing case management services to frequent Emergency Services and Care users in collaboration with, and by providing referral to, existing appropriate community resources.
- Providing short-term, post discharge follow-up for persons recently discharged from a Hospital due to a serious health condition, including collaboration with, and by providing referral to, home health services when eligible.

Compound Medication (Compound Drug) is a mixture of compound ingredients within a Compound Drug when a commercially available dosage form of a Medically Necessary medication is not available, the ingredients of the compound medication 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.

Consolidated Appropriations Act of 2021. Please refer to the "Consolidated Appropriations Act of 2021 Notice" at the front of this Evidence of Coverage for details.

Copay is the amount you pay to get a Medically Necessary service with an Anthem Blue Cross HMO Health Care Provider. Anthem or the Medical Group pays the provider the rest. It is also the amount you pay when you buy drugs or medicines from a Drugstore or through the home delivery program.

Copay Limit is the most you will have to pay in one calendar year in copays.

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.

Covered Benefits means those Medically Necessary services and supplies that you are entitled to receive under a group agreement and which are described in this Evidence of Coverage or under California health plan law.

Custodial Care is care for your personal needs. This includes help in walking, bathing or dressing. It also includes: preparing food or special diets; feeding by utensil, tube or gastrostomy; suctioning; and giving medicine which you usually do yourself, or any other care for which the services of a health care provider are not needed.

If Medically Necessary, benefits will be provided for feeding (by tube or gastrostomy) and suctioning.

Doctor means a Doctor of medicine (M.D.) or Doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is given.

Drugstore means a store where you get medicine from a licensed Pharmacist.

Drug Negotiated Rate is the rate that we have negotiated with Member Drugstores under a Participating Pharmacy Agreement for drug covered expense. Member Drugstores have agreed to charge Members no more than the Drug Negotiated Rate. It is also the rate which [Anthem] Prescription Drug Program - Mail Service accepts as payment in full for mail service Prescription Drugs.]

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

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services and Care means (1) medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician and surgeon, to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery, within the scope of that person's license, if necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility; and/or (2)

an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a Psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition within the capability of the facility.

Evidence of Coverage means any certificate, agreement, contract, brochure, or letter of entitlement issued to a Member setting forth the coverage to which the Member is entitled.

Experimental Services means drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation.**Facility** is a facility including but not limited to, a hospital, freestanding Ambulatory Surgery Center, Residential Treatment Center or Skilled Nursing Facility as defined in this Evidence of Coverage. The facility must be licensed as required by law, satisfy our accreditation requirements, and be approved by us.

Facility-Based Care is inpatient or outpatient care provided in a hospital, psychiatric health facility, or Residential Treatment Center for the treatment of mental health or substance use disorder.

Federal Surprise Billing Claims are claims that are subject to the No Surprises Act requirements with respect to non-Anthem Blue Cross HMO Health Care Provider air ambulance services. Federal Surprise Billing Claims are described in the "Consolidated Appropriations Act of 2021 Notice" at the beginning of this Evidence of Coverage. Please refer to that section for further details.

Formulary drug is a drug listed on the Prescription Drug Formulary.

Gender Dysphoria is a formal diagnosis used by psychologists and Doctors to describe people who experience significant

dysphoria (discontent) with the sex they were assigned at birth and/or the gender roles associated with that sex.

Gender Transition is the process of changing one's outward appearance, including physical sex characteristics, to accord with his or her actual gender identity.

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

Generic drug is the same as one or more Brand Name Drugs and is approved by the government. It must be as safe, pure, strong, and work as well as the Brand Name Drug.

Group refers to the business entity to which we have issued this agreement. The name of the group is THE AEROSPACE CORPORATION.

Guest Membership is a special way you can get care when you go out of town for more than 90 days. If you know ahead of time, you can apply for a guest Membership in a Medical Group in the city you are going to visit. Call the Anthem Blue Cross HMO Member Services Number on your Member ID card and ask for the Guest Membership Coordinator.

Health Care Provider means any professional person, medical group, independent practice association, organization, health care

facility, or other person or institution licensed or authorized by the state to deliver or furnish health services.

Home health agencies are providers, licensed when required by law and approved by us, that:

1. Gives skilled nursing and other services on a visiting basis in your home; and
2. Supervises the delivery of services under a Plan prescribed and approved in writing by the attending Doctor.

Hospice is an agency or organization that gives a specialized form of interdisciplinary care that controls pain and relieves symptoms and helps with the physical, emotional, social, and spiritual discomforts of a terminally ill person, as well as giving support to the primary caregiver and the patient's family. A hospice must be currently licensed as a hospice according to Health and Safety Code section 1747 or a licensed Home Health Agency with federal Medicare certification according to Health and Safety Code sections 1726 and 1747.1. You may ask for a list of hospices.

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

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

Independent Medical Review (IMR) means a review of your Plan's denial, modification, or delay of your request for health care services or treatment. The review is provided by the Department of Managed Health Care and conducted by independent medical experts. If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by your Plan related to medical necessity of a proposed service or

treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. Your Plan must pay for the services if an IMR decides you need it.

Independent practice association (IPA) is a Medical Group made up of a group of Doctors who practice in private offices. The IPA has an agreement with Anthem to provide health care.

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

Intensive Outpatient Program is a structured, multidisciplinary treatment for Mental Health or Substance Use Disorders that provides a combination of individual, group and family therapy to Members who require a type or frequency of treatment that is not available in a standard outpatient setting.

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 terms of safety. In addition to meeting the biosimilarity standard, it is expected to produce the same clinical result as the reference product in any given patient and may be substituted for the reference product without the intervention of the health care provider who prescribed the reference product.

Investigational Services means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but:

(1) Testing is not complete; and
(2) The efficacy and safety of such services in human subjects are not yet established; and
(3) The service is not in wide usage.

Medical Group is a group of Doctors with an agreement with Anthem to provide health care.

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 that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of care, including generally accepted standards of Mental Health or Substance Use Disorder care.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.

Not primarily for the economic benefit of the health care service plan and Members or for the convenience of the patient, treating physician, or other Health Care Provider.

Member means a subscriber, enrollee, enrolled employee, or dependent of a subscriber or an enrolled employee, who has enrolled in the Plan and for whom coverage is active or live.

Member Services Number is the 800-number you can call at Anthem to answer your questions about Anthem Blue Cross HMO. You will find the number on your Member ID card.

Membership Change Form is a form you need to make changes in your health Plan. You may need a new Medical Group, or to add a new family Member. Ask your employer for the form if you need it.

Member Drugstore means a Drugstore that has a contract and works with Anthem to give you services. Call your local Drugstore and ask if it works with Anthem. Or call the toll-free Member Services telephone number to find a Drugstore with Anthem.

Mental Health or Substance Use Disorder means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders

chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

Mobile Integrated Health Program means a team of licensed health care practitioners, operating within their scope of practice, who provide mobile health services to support the emergency medical services system.

Non-member Drugstores mean Drugstores that are not part of the Anthem network. Most of the time, you will have to pay more out of your pocket when you go to one of these Drugstores.

Open Enrollment is a period of time each year that you can change your Plan options. You can also add or drop eligible family Members if you need to. Talk to your employer about when Open Enrollment takes place.

Outpatient Prescription Drug means a self-administered Drug that is approved by the federal Food and Drug Administration for sale to the public through a retail or mail order pharmacy, requires a prescription, and has not been provided for use on an inpatient basis.

Partial Hospitalization Program is a structured, multidisciplinary treatment for Mental Health or Substance Use Disorders, including nursing care and active individual, group and family treatment for Members who require more care than is available in an intensive outpatient program.

Pharmacy and Therapeutics Process is a two-step process used to make determinations that will help you access quality, low-cost medicines within your Plan. This process first uses an independent P&T committee of Health Care Providers that evaluate the clinical evidence of each product under review. During the second step of the process, a committee composed of members with various expertise combines the clinical review with an in-depth analysis of market dynamics, Member impact and financial value to make determinations about the formulary. Our programs may include, but are not limited to, Prescription Drug utilization programs, prior

authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Prescription Drug profiling initiatives.

Pharmacy Benefits Manager (PBM) is a company that manages pharmacy benefits on Anthem's behalf. Anthem's PBM has a nationwide network of retail pharmacies, a home delivery pharmacy, and clinical services that include Prescription Drug list management.

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

Plan is the set of benefits talked about in this Evidence of Coverage. From time to time, there may be some changes in what is covered depending on the agreement we have with your employer. If changes are made to the Plan, you will get a new Evidence of Coverage or a copy of an amendment showing the changes that were made.

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

Prescription Drug or "Drug'' means a drug approved by the federal Food and Drug Administration (FDA) for sale to consumers that requires a prescription and is not provided for use on an inpatient basis. The term "drug'' or "Prescription Drug'' includes: (A) disposable devices that are Medically Necessary for the administration of a covered Prescription Drug, such as spacers and inhalers for the administration of aerosol outpatient Prescription Drugs; (B) syringes for self-injectable Prescription Drugs that are not dispensed in pre-filled syringes; (C) drug, devices, and FDA-approved products covered under the Prescription Drug benefit of the product pursuant to sections 1367.002, 1367.25, and 1367.51 of the Health and Safety Code, including any such over-the-counter drugs, devices, and FDA-approved products; and (D) at the option of the health Plan, any

vaccines or other health care benefits covered under the Plan's Prescription Drug benefit.

Prescription Drug Formulary is one which we have made of Prescription Drugs for outpatient use that may be cost-effective, therapeutic choices. Any drug store with Anthem can assist you in buying drugs listed on the Prescription Drug Formulary. 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.

Prescription Drug maximum allowed amount is the maximum amount we will allow for any drug. The amount is determined by us using Prescription Drug cost information provided to us by the pharmacy benefits manager. The amount is subject to change. You may find out the Prescription Drug maximum allowed amount of a particular drug by calling the number on the back of your ID Card.

Prescription Drug tiers are used to classify drugs for the purpose of setting their co-payment. Anthem will decide which drugs should be in each tier based on clinical decisions made by the Pharmacy and Therapeutics Process. Anthem retains the right at its discretion to determine coverage for dosage formulation in terms of covered dosage administration methods (for example, by mouth, injection, topical or inhaled) and may cover one form of administration and may exclude or place other forms of administration in another tier (if it is Medically Necessary for you to get a drug in an administrative form that is excluded will you need to get written prior authorization (see the subsection "Prior Authorization and Step Therapy Exceptions," in the section "Prescription Drug Formulary," above) to get that that 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 higher copayments 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 copayments 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 copayments 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, interchangeable biologic products or multi-source Brand Name Drugs.

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, and are to become effective in accordance with those laws, including but not limited to, the Patient Protection and Affordable Care Act (PPACA). Sources for determining which services are recommended include the following:

- Services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF);

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

- Preventive care and screenings for infants, children and adolescents as 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.

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

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

http://www.ahrq.gov

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

Primary Care Doctor is a Doctor who is a Member of the Medical Group you have chosen to give you health care. Primary Care Doctors include general and family practitioners, internists and pediatricians. Certain specialists as we may approve may also be designated Primary Care Doctors.

Prior Plan is a Plan sponsored by your employer which was replaced by this Plan within 60 days of when it ended. You are considered covered under the prior Plan if you:

- Were covered under the prior Plan on the date that Plan ended;
- Properly enrolled for coverage within 31 days of this Plan's effective date; and
- Had coverage terminate solely due to the prior Plan's ending.

Prosthetic devices take the place of a body part that does not work or is missing. These include orthotic devices, rigid or semi-supportive devices which may support the motion of a weak or diseased part of the body.

Psychiatric Emergency Medical Condition means a mental disorder that manifests itself by acute symptoms of sufficient severity that renders the patient as being either: an immediate danger to himself or herself or to others, or immediately unable to

provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

Psychiatric health facility is a 24-hour facility, that is:

- Licensed by the California Department of Health Services.
- Qualified to provide short-term inpatient treatment.
- Accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHCO).
- Staffed by a professional staff which includes a Doctor as medical director.

Qualifying Payment Amount is the median Plan contract rate we pay Anthem Blue Cross HMO Health Care Providers for the geographic area where the service is provided for the same or similar services.

Recognized Amount:

For Federal Surprise Billing Claims, the Recognized Amount is calculated as follows:

- For air ambulance services, the Recognized Amount is equal to the lesser of the qualifying payment amount as determined under applicable law (generally, the median Plan contract rate we pay Anthem Blue Cross HMO Health Care Providers for the geographic area where the service is provided for the same or similar services) or the amount billed by the non-Anthem Blue Cross HMO air ambulance service provider.
- For all other Federal Surprise Billing Claims, the Recognized Amount is the amount determined by a specified state law; the lesser of the qualifying payment amount or the amount billed by the non-Anthem Blue Cross HMO Health Care Provider or facility; or the amount approved under an applicable All-Payer Model Agreement under section 1115A of the Social Security Act.

Reconstructive Surgery is surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease

to do either of the following: (a) improve function; or (b) create a normal appearance, to the extent possible.

Reproductive or Sexual Health Care Services as described in California state law which are the following:

- Medical care related to the prevention or treatment of pregnancy.
- Medical care related to the diagnosis or treatment of an infectious, contagious, or communicable disease, if such disease is required for reporting to a local health officer, or is a related sexually-transmitted disease.
- Medical care related to the prevention of a sexually-transmitted disease.
- For alleged rape or sexual assault, medical care related to the diagnosis or treatment of the condition, and the collection of medical evidence after an alleged rape or sexual assault.
- HIV testing.

Please see the Reproductive or Sexual Health Care Services section under "When You Need Care" for more information.

Residential Treatment Center is an inpatient facility that provides multidisciplinary treatment for Mental Health or Substance Use Disorders conditions. The facility must be licensed as a Residential Treatment Center in the state in which it is located, satisfy our accreditation requirements and be approved by us. The facility must be fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

The term Residential Treatment Center/facility does not include a provider, or that part of a provider, used mainly for:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged

- Custodial Care
- Educational care.

Retired employee is a former employee of the group employer who meets the group employer's rules for retirement.

Self-Administered Hormonal Contraceptives are products with the following routes of administration:

- Oral;
- Transdermal;
- Vaginal;
- Depot Injection.

Seriously Debilitating means diseases or conditions that cause major irreversible morbidity.

Service Area means the geographic area designated by the Plan within which a Plan shall provide health care services.

Single source Brand Name Drugs are drugs with no generic substitute.

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

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, or a place for rest, educational, or similar services.

Standard Fertility Preservation Services means procedures consistent with the established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

State Surprise Billing Claims are services received from an Anthem Blue Cross HMO Health Care Provider facility in California, at which or as a result of which, you receive non-

emergency covered services provided by a non-Anthem Blue Cross HMO Health Care Provider.

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

Specialty care center means a center that is accredited or designated by an agency of the State of California or the federal government or by a voluntary national health organization having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

Specialty Pharmacy Drugs are 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. These Drugs often require special handling, such as temperature-controlled packaging and overnight delivery, and are often unavailable at retail Drugstores.

Standing referral means a referral by a Primary Care Doctor to a specialist for more than one visit to the specialist, as indicated in the treatment Plan, if any, without the Primary Care Doctor having to provide a specific referral for each visit.

Totally Disabled means because of illness or injury, you cannot work for income at any job that you are trained for and you are unemployed. For your family Members, it means they cannot do all the activities usual for persons of their age.

Trans-Inclusive Health Care means comprehensive health care that is consistent with the standards of care for individuals who identify as transgender, gender diverse, or intersex; honors an individual's personal bodily autonomy; does not make assumptions about an individual's gender; accepts gender fluidity and nontraditional gender presentation; and treats everyone with compassion, understanding, and respect.

Triage to Alternate Destination Program means a program developed by a local EMS agency and approved by the Emergency

Medical Services Authority to provide triage paramedic assessments consisting of one or more specialties described below operating under triage and assessment protocols developed by the local EMS agency that are consistent with the minimum triage and assessment protocols established by the authority. Triage paramedic assessments may consist of the following program specialties:

- Providing care and comfort services to hospice patients in their homes in response to 911 calls by providing for the patient's and the family's immediate care needs, including grief support in collaboration with the patient's Hospice agency until the Hospice nurse arrives to treat the patient. This paragraph does not impact or alter existing authorities applicable to a licensed paramedic operating under the medical control policies adopted by a local EMS agency medical director to treat and keep a hospice patient in the patient's current residence or otherwise require transport to an acute care Hospital in the absence of an approved triage to alternate destination Hospice program.
- Providing patients with advanced life support triage and assessment by a triage paramedic and transportation to an alternate destination Facility.
- Providing transport services for patients who identify as veterans and desire transport to a local veteran's administration emergency department for treatment, when appropriate.

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

For Your Information

We are here to provide high-quality benefits and service to our Members. Benefits and coverage for services given under the Plan are governed by the Evidence of Coverage and not by this Member Rights and Responsibilities statement.

Statement of Rights Under the Newborns and Mothers Health Protection Act

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

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

In addition, a plan or issuer may not, under federal law, require that a Doctor or other Health Care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

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 contact your Medical Group or call us at the Member Services telephone number listed on your ID card.

ORGAN DONATION

Each year, organ transplantation saves thousands of lives. The success rate for transplantation is rising but there are far more potential recipients than donors. More donations are urgently needed.

Organ donation is a singular opportunity to give the gift of life. Anyone age 18 or older and of sound mind can become a donor when he or she dies. Minors can become donors with parental or guardian consent.

Organ and tissue donations may be used for transplants and medical research. Today it is possible to transplant more than 25 different organs and tissues; this can save the lives of as many as eight people and improve the lives of another 50 people. Your decision to become a donor could someday save or prolong the life of someone you know, perhaps even a close friend or family Member.

If you decide to become a donor, please discuss it with your family. Let your physician know your intentions as well. You may register as a donor by obtaining a donor card from the Department of Motor Vehicles. Be sure to sign the donor card and keep it with your driver's license or identification card. In California, you may also register online at:

www.donatelifecalifornia.org/

While organ donation is a deeply personal decision, please consider making this profoundly meaningful and important gift.

ANTHEM BLUE CROSS WEB SITE

Information specific to your benefits and claims history are available by calling the 800 number on your identification card or on the Anthem Blue Cross web site at **www.anthem.com/ca**. To access benefit information, claims payment status, benefit maximum status, participating providers or to order an ID card, simply log on to the web site, select “Member”, and click the "Register" button on your first visit to establish a User ID and Password to access the personalized and secure MemberAccess Web site. Once registered, simply click the "Login" button and enter your User ID and Password to access the MemberAccess Web site. Our privacy statement can also be viewed on our website. You may also submit a grievance online or print the Plan Grievance form through the website.

LANGUAGE ASSISTANCE PROGRAM

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

The Language Assistance Program makes it possible for you to access oral interpretation services and certain written materials vital to understanding your health coverage in a timely manner. Interpretation services are offered to you at no cost, even if you are accompanied by a family Member or friend who can provide interpretation services.

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

Oral interpretation services are also available in these languages.

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

To requesting a written or oral translation, please contact Member Services by calling the phone number on your ID card to update your language preference to receive future translated documents or to request interpretation assistance. Translation of written materials about your benefits can also be requested by contacting Member Services. TTY/TDD services are also available by dialing 711. A special operator will get in touch with us to help with your needs.

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

STATEMENT OF RIGHTS UNDER THE NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

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

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

In addition, a Plan or issuer may not, under federal law, require that a Doctor or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

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 contact your Medical

Group or call us at the Member Services telephone number listed on your ID card.

CLAIMS DISCLOSURE NOTICE REQUIRED BY ERISA

The Evidence of Coverage Form contains information on reporting claims, including the time limitations on submitting a claim. Claim forms may be obtained from the Plan Administrator or Anthem. 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 Evidence of Coverage Form. This Claims Disclosure Notice Required by ERISA is not a part of your Evidence of Coverage and Disclosure (Evidence of Coverage) Form.

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

If your request for benefits is denied in whole or in part, you will receive a notice of the denial within 72-hours after Anthem's receipt of the request for benefits, or 48 hours after receipt of all the information they need to process your request for benefits if the information is received within the time frame noted above. The notice will explain the reason for the adverse benefit determination and the Plan provisions upon which the denial decision was based. You have 180-days to appeal their adverse benefit determination.

You may appeal their decision orally, by telephone, or in writing by facsimile or other fast means. Within 72-hours after they receive your appeal, they must notify you of their decision, except as otherwise noted below. They will notify you orally, by telephone, or in writing by facsimile or other fast means. If your request for benefits is no longer considered urgent, it will be handled in the same manner as a Non-Urgent Care Pre-Service or Post-service appeal, depending upon the circumstances.

Non-Urgent Care Pre-Service (when care has not yet been received). Anthem 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 Anthem is waiting for receipt of the necessary information is not counted toward the time frame in which Anthem must make the benefit determination.

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

Concurrent Care Decisions:

- **Reduction of Benefits –** If, after approving a request for benefits in connection with your illness or injury, Anthem decides to reduce or end the benefits they have approved for you, in whole or in part:
    - They must notify you sufficiently in advance of the reduction in benefits, or the end of benefits, to allow you the opportunity to appeal their decision before the reduction in benefits or end of benefits occurs. In their notice to you, Anthem must explain their reason for reducing or ending your benefits and the Plan provisions upon which the decision was made.
    - To keep the benefits you already have approved, you must successfully appeal Anthem'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 Anthem 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 Anthem denies your appeal of their decision to reduce or end your benefits, in whole or in part, they must explain the reason for their denial of benefits and the Plan provisions upon which the decision was made. You may further appeal the denial of benefits according to the rules for appeal of an Urgent Care denial of benefits (see the section "Urgent Care," above).
- **Extension of Benefits –** If, while you are undergoing a course of treatment in connection with your illness or injury, for

which benefits have been approved, you would like to request an extension of benefits for additional treatments:

- You must make a request to Anthem for the additional benefits at least 24-hours prior to the end of the initial course of treatment that had been previously approved for benefits. If you request additional benefits when there is less than 24-hours until the end of the initially prescribed course of treatment, your request will be handled as if it was a new request for benefits and not an extension and, depending on the circumstances, it may be handled as an Urgent or Non-Urgent Care Pre-service request for benefits.

- If Anthem 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 Anthem 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). Anthem 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 Anthem is waiting for receipt

of the necessary information is not counted toward the time frame in which Anthem 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 60-days after Anthem has all the information they need to process your claim, if the information is received within the time frame noted above. The written notice will explain the reason for the adverse benefit determination and the Plan provisions upon which the denial decision is based. You have 180-days to appeal their decision. Your appeal must be in writing. Within 60-days after they receive your appeal, they must notify you of their decision about it. Their notice to you or their decision will be in writing.

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

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

You may have representation throughout the appeal and review procedure.

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

Get help in your language

Language Assistance Services

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

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for Members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish
IMPORTANTE: ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

Arabic
مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم1-888-254-2721 (TTY/TDD:711).

MCASH4644CML 06/16 DMHC3 DMHCW

Armenian
ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

Chinese
重要事項：您能看懂這封信函嗎？如果您看不懂，我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助，請立即撥打1-888-254-2721。(TTY/TDD: 711)

Farsi
مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید.(TTY/TDD:711)

Hindi
महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

MCASH4644CML 06/16 DMHC3 DMHCW

Hmong
TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Japanese
重要：この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。1-888-254-2721 (TTY/TDD: 711)

Khmer
សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ
យើងអាចឲ្យនរណាម្នាក់អានវាជូនអ្នក។
អ្នកក៏អាចទទួលលិខិតនេះដោយសរសេរជាភាសារបស់អ្នកផងដែរ។
ដើម្បីទទួលជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅលេខ 1-888-254-2721។ (TTY/TDD: 711)

Korean
중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오. (TTY/TDD: 711)

Punjabi
ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵਥੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਫੌਰਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

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Russian
ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog
MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai
หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่
หากท่านไม่สามารถอ่านจดหมายฉบับนี้
เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้
ท่านยังอาจให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย
หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่หมายเลข 1-888-254-2721 (TTY/TDD: 711)

Vietnamese
QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (TTY/TDD: 711)

MCASH4644CML 06/16 DMHC3 DMHCW

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.