Combined Evidence of Coverage and Disclosure Form

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://eoc.anthem.com/eocdps/ca/82EGIND01012025. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call (833) 913-2232 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Primary Care. Specialist Visit. Preventive Care. Dental. Vision. For more information see below.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$3,000/person or $6,000/family for In-Network Providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com/find-care/?alphaprefix=JQO or call (833) 913-2232 for a list of network providers. Costs may vary by site of service and how the provider bills.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an Out-of-Network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an Out-of-Network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15/visit	Not covered	Virtual visits (Telehealth) benefits available.
	Specialist visit	$25/visit	Not covered	Virtual visits (Telehealth) benefits available.
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office $20/visit X-Ray – Office $40/visit	Lab – Office Not covered X-Ray – Office Not covered	--------none--------
	Imaging (CT/PET scans, MRIs)	$100/visit	Not covered	--------none--------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.anthem.com/pharmacyinformation/	Typically Generic (Tier 1)	$5/prescription, Prescription Drug deductible does not apply (retail) and $15/prescription, Prescription Drug deductible does not apply (home delivery)	Not covered (retail and home delivery)	Most home delivery is 90-day supply. For more information, refer to "CA Select IND Drug List" at http://www.anthem.com/pharmacyinformation/ *See Prescription Drug section of the plan or policy document (e.g. evidence of coverage or certificate).
	Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2)	$25/prescription, Prescription Drug deductible applies (retail) and $75/prescription, Prescription Drug deductible applies (home delivery)	Not covered (retail and home delivery)	
	Typically Non-Preferred Brand and Generic drugs (Tier 3)	$45/prescription, Prescription Drug deductible applies (retail) and $135/prescription, Prescription Drug deductible applies (home delivery)	Not covered (retail and home delivery)	
	Typically Preferred Specialty (brand and generic) (Tier 4)	15% coinsurance up to $150/prescription, Prescription Drug deductible applies (retail) and 15% coinsurance up to $450/prescription,	Not covered (retail and home delivery)	

* For more information about limitations and exceptions, see the plan or policy document at https://eoc.anthem.com/eocdps/ca/82EGIND01012025.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Prescription Drug deductible applies (home delivery)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	--------none--------
	Physician/surgeon fees	20% coinsurance	Not covered	--------none--------
If you need immediate medical attention	Emergency room care	$150/visit	Covered as In-Network	Copayment waived if admitted. No charge for Emergency Room Physician Fee.
	Emergency medical transportation	$75/trip	Covered as In-Network	Non-emergency Out-of-Network Ambulance Services are limited to $50,000 per occurrence.
	Urgent care	$15/visit	Covered as In-Network	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	--------none--------
	Physician/surgeon fees	30% coinsurance	Not covered	20% coinsurance for Inpatient Anesthesia and Inpatient Physician for In-Network Providers.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit $15/visit Other Outpatient 20% coinsurance	Office Visit Not covered Other Outpatient Not covered	Office Visit 988 lifeline/mobile crisis team covered as In-Network. Virtual visits (Telehealth) benefits available. Other Outpatient --------none--------
	Inpatient services	20% coinsurance	Not covered	20% coinsurance for Inpatient Physician Fee In-Network Providers. No Coverage for Inpatient Physician Fee Out-of-Network Providers.
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services. $15/visit for Postnatal In-Network Providers. In-Network preventative prenatal and postnatal services are covered at 100%. Maternity care may include tests and
	Childbirth/delivery professional services	20% coinsurance	Not covered	
	Childbirth/delivery facility services	20% coinsurance	Not covered	

* For more information about limitations and exceptions, see the plan or policy document at https://eoc.anthem.com/eocdps/ca/82EGIND01012025.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				services described elsewhere in the SBC (i.e., ultrasound). *Coverage includes fertility preservation services, see Fertility Preservation section.
If you need help recovering or have other special health needs	Home health care	$15/visit	Not covered	100 visits/benefit period for Home Health and Private Duty Nursing combined for In-Network Providers.
	Rehabilitation services	$15/visit	Not covered	*See Therapy Services section.
	Habilitation services	$15/visit	Not covered	
	Skilled nursing care	20% coinsurance	Not covered	100 days/benefit period for skilled nursing services for In-Network Providers.
	Durable medical equipment	15% coinsurance	Not covered	*See Durable Medical Equipment section.
	Hospice services	No charge	Not covered	--------none--------
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	*See Vision Services section.
	Children's glasses	No charge	Not covered	
	Children's dental check-up	No charge	Not covered	*See Dental Services section.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Chiropractic care
- Hearing aids
- Routine eye care (Adult)
- Cosmetic surgery
- Long-term care
- Routine foot care unless medically necessary
- Dental care (Adult)
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion (including Non-Hyde Abortion Services)
- Infertility treatment
- Acupuncture
- Private-duty nursing 100 visits/benefit period combined with Home Health
- Bariatric surgery

* For more information about limitations and exceptions, see the plan or policy document at https://eoc.anthem.com/eocdps/ca/82EGIND01012025.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) 466-2219, https://www.dmhc.ca.gov/, or contact Anthem at the number on the back of your ID card. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 4310, Woodland Hills, CA 91365-4310

Department of Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) 466-2219, https://www.dmhc.ca.gov/

Additionally, a consumer assistance program can help you file your appeal. Contact California Consumer Assistance Program, Operated by the California Department of Managed Health Care, 980 9th Street, Suite 500, Sacramento, CA 95814, (888) 466-2219, https://www.dmhc.ca.gov/

Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Not Applicable.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$25
Hospital (facility) coinsurance	20%
Other copayment	$20

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,660**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$25
Hospital (facility) coinsurance	20%
Other copayment	$20

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$25
Hospital (facility) coinsurance	20%
Other copayment	$20

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$550**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi 1-888-254-2721

Amharic (አማርኛ): ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር 1-888-254-2721 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على 1-888-254-2721 .

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ 1-888-254-2721:

Bassa (Bǎsɔ́ɔ̀ Wùdù): Mˋ dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nìà kɛ dyí ní, ɔ mɔ̀ nì dyí-bɛ̀dɛ̀ìn-dɛ̀ bɛ́ m̀ ké gbo-kpá-kpá kè bɔ̌ kpɔ̃ dé m̀ bídí-wùdùŭn bó pídyi. Bé m̀ ké wudu-zììn-nyɔ̀ dò gbo wùdù kɛ, dá 1-888-254-2721.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য 1-888-254-2721 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အခွင့်အလမ်းများနှင့် အကူအညီကို အခမဲ့ကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် 1-888-254-2721 သို့ ခေါ်ဆိုပါ။

Chinese (中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電1-888-254-2721。

Dinka (Dinka): Na nɔŋ thiëëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl 1-888-254-2721.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u 1-888-254-2721.

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره 1-888-254-2721 تماس بگیرید.

Language Access Services:

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le 1-888-254-2721.

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie 1-888-254-2721.

Greek (Ελληνικά) Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο 1-888-254-2721.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો 1-888-254-2721.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele 1-888-254-2721.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें 1-888-254-2721 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau 1-888-254-2721.

Igbo (Igbo): Ọ bụr ụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ 1-888-254-2721.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti 1-888-254-2721.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi 1-888-254-2721.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero 1-888-254-2721

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには 1-888-254-2721 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ1-888-254-2721 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura 1-888-254-2721.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면1-888-254-2721 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄຳຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໂອ້ລົມກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ 1-888-254-2721.

Navajo (Diné): Díí naaltsoos bikáʼígíí łahgo bínaʼídiłkidgo ná bohónéedzą́ dóó bee ahóótʼiʼ tʼáá ni nizaad kʼehjí bee nił hodoonih tʼáadoo bą́ą́h ílínígóó. Ataʼ halneʼígíí łaʼ bichʼį́ʼ hadeesdzih nínízingo kojį́ʼ hodíilnih 1-888-254-2721.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ। दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् 1-888-254-2721

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, 1-888-254-2721 bilbilla.

Pennsylvania Dutch (Deitsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Helfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff 1-888-254-2721 aa.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-888-254-2721.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para 1-888-254-2721.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ।

Language Access Services:

Romanian (Română): Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic 1-888-254-2721.

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. 1-888-254-2721.

Samoan (Samoa): Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou ‘aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili 1-888-254-2721.

Serbian (Srpski): Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite 1-888-254-2721.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al 1-888-254-2721.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang 1-888-254-2721.

Thai (ไทย): หากท่านมีคำถามใดๆ เกียวกับเอกสารฉบับนี ท่านมีสิทธิ์ทีจะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร 1-888-254-2721 เพือพูดคุยกับล่าม

Ukrainian (Українська): якщо у вас виникають запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зателефонуйте за номером: 1-888-254-2721.

Urdu (اردو): اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لئے، 1-888-254-2721 پر کال کریں۔

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi 1-888-254-2721.

(Yiddish) (אידיש): אויב איר האט שאלות וועגן דעם דאקומענט, האט איר די רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהן קיין פרייז. צו רעדן צו אן איבערזעצער, רופט 1-888-254-2721 .

Yoruba (Yorùbá): Tí o bá ní èyíkéyìí ìbèrè nípa àkọsílẹ̀ yìí, o ní ẹ̀tọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ lọ́fẹ̀ẹ́. Bá wa ògbùfọ̀ kan sọ̀rọ̀, pe 1-888-254-2721.

Language Access Services:

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.

Summary of Benefits and Coverage

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.

Combined Evidence of Coverage and Disclosure Form

Anthem Silver 87 HMO

82EG

A Health Maintenance Organization (HMO) Plan

Anthem Blue Cross
P.O. Box 659960
San Antonio, TX 78265-9146
833-913-2232

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Welcome to Anthem!

We are pleased that You have become a Member of Our health Plan, where it is Our mission to improve the health of the people We serve. We have designed this Evidence of Coverage and Disclosure Form (also called Agreement or Plan) to give a clear description of Your benefits, as well as Our rules and procedures.

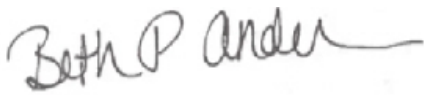
This Agreement explains many of the rights and duties between You and Us. It also describes how to get healthcare, what services are covered and what part of the costs You will need to pay. Many parts of this Agreement are related. Therefore, reading just one (1) or two (2) sections may not give You a full understanding of Your coverage. You should read the whole Agreement to know the terms of Your coverage.

You have the right to view this Agreement prior to enrollment. You have thirty (30) days from the date of delivery to examine this Agreement. If You are not satisfied, for any reason with the terms of this Agreement, You may return it to Us within those thirty (30) days. You, consistent with California law, will be required to pay for any services Anthem Blue Cross paid on Your behalf during the thirty (30) day period and We will refund any Premium paid by You, less Your medical and pharmacy expenses that We paid. If no services were rendered, You will be entitled to receive a full refund of any Premium paid. This Agreement will then be null and void.

This Evidence of Coverage and Disclosure Form, the application and any endorsements attached shall constitute the entire Agreement under which Covered Services and supplies are provided by Us.

Many words used in the Agreement have special meanings (e.g., Covered Services and Medical Necessity). These words are capitalized and are defined in the “Definitions” section. See these definitions for the best understanding of what is being stated. Throughout this Agreement, You will also see references to “We,” “Us,” “Our,” “You” and “Your.” The words “We,” “Us,” and “Our” mean Anthem Blue Cross (Anthem) or any of Our subsidiaries, affiliates, subcontractors, or designees. The words “You” and “Your” mean the Member, Subscriber and each covered Dependent.

Should You have a complaint, problem or question about Your health Plan or any services received, a Member Services representative will assist You. Contact Member Services by calling the number on the back of Your Member Identification Card. Also be sure to check Our website, www.anthem.com/ca for details on how to find a Provider, get answers to questions and access valuable health and wellness tips. Thank You again for enrolling!



Beth P. Andersen
President
Anthem Blue Cross

Contact Information

Contact Covered California at 800-300-1506 or visit CoveredCA.com to:

- Update Your address and contact information
- Report any changes to Your income
- Update information such as citizenship and proof of residency
- Make changes to Your health coverage
- Ask questions about financial assistance
- Cancel Your coverage
- Request a copy of Your health insurance related tax documents from the IRS, and when applicable, the State of California

Contact Anthem at 833-913-2232, visit www.anthem.com/ca, or write Us at P.O. Box 659960, San Antonio, TX 78265-9146 to:

- Make a payment or ask a question about billing and payments
- Request a new membership ID Card
- Learn more about benefits and eligibility
- Get help finding doctors or other Providers
- Find out how claims for services were paid
- Change Primary Care Physician (PCP)

Conformity with Law

Anthem shall comply with applicable Federal, State, or local laws, rules, or regulations. In the event Anthem is subject to a newly enacted or amended law, rule, or regulation that conflicts with the requirements of the endnotes to Covered California's patient-centered benefit plan designs, Anthem shall comply with the law, rule, or regulation and any applicable guidance from its regulatory authority. Where the endnotes to Covered California's patient-centered benefit plan designs exceed requirements imposed by law, Anthem shall comply with the requirements of the endnotes to Covered California's patient-centered benefit plan designs.

This coverage is a Health Maintenance Organization (HMO) Plan regulated by the California Department of Managed Health Care pursuant to the Health and Safety Code.

Acknowledgement of Understanding

Subscriber hereby expressly acknowledges their understanding that this Agreement constitutes a contract solely between Subscriber and Anthem Blue Cross, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Anthem Blue Cross to use the Blue Cross Service Mark in the State of California, and that Anthem Blue Cross is not contracting as the agent of the Association. Subscriber further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than Anthem Blue Cross and that no person, entity or organization other than Anthem Blue Cross shall be held accountable or liable to Subscriber for any of Anthem Blue Cross's obligations to Subscriber created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of Anthem Blue Cross other than those obligations created under other provisions of this Agreement.

Delivery of Documents

We will provide an Identification Card (ID Card) for each person enrolled in this Agreement and Evidence of Coverage and Disclosure Form for the Subscriber.

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician

We allow the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in Our network and who is available to accept You or Your family members. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of Your Identification Card or refer to Our website, www.anthem.com/ca. For children, You may designate a pediatrician as the PCP.

Access to Obstetrical and Gynecological (OB/GYN) Care

You do not need prior authorization from Us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a healthcare professional in Our network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, or procedures for making Referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of Your Identification Card or refer to Our website, www.anthem.com/ca.

Notice Required by State Law

Some Hospitals and other Providers do not provide one or more of the following services that may be covered under Your Plan contract and that You or Your 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 the health plan at 833-913-2232 to ensure that You can obtain the healthcare services that You need.

Transition Assistance

Transition assistance is a process that allows for continuity of care for new Members whose prior health plan withdrew their health benefit plan from the market, ceased to provide coverage in the individual market, or whose Providers have been terminated from Our Network. If this applies to You, please see the detailed information in the subsection “Continuity of Care” under the section “How Your Coverage Works.” You may call Member Services at the phone number on Your ID Card to request transition assistance.

Confidential Communications of Medical Information

Any Member, including an adult or a minor who can consent to a healthcare 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 the steps at the www.anthem.com/ca website. Members may also call Us at the phone number on the back of their ID Card.

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.

Telehealth Provider Visits

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

- Your plan covers the telehealth visit just like an office visit with a Provider in Your Plan's network.
- Any out-of-pocket costs You have from the telehealth visit count toward Your Plan's Deductible and Out of Pocket Maximum, just like any other care You receive.
- You have the 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 Provider as permitted by State and federal law, unless You tell Us not to share them.

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

It Is Important We Treat You Fairly

Notice of Non-Discrimination Required by Federal Law

That is why We follow federal civil rights laws in Our health programs and activities. We do not 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 is not 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 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 800-368-1019 (TDD: 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 .

Notice of Non-Discrimination Required by California Law

Anthem does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. Appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats are 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.

The California Department of Managed Health Care (DMHC) is responsible for regulating healthcare service plans. If You have grievance against Anthem, You should first call Anthem at 800-365-0609 (TDD: 866-333-4823) or the number on Your Identification Card and use Anthem's grievance process before contacting the DMHC. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to You. If You need help filing a grievance, call Anthem Member Services at 800-365-0609 or the number on Your Identification Card.

If You need help with a grievance involving an Emergency, a grievance not satisfactorily resolved by Anthem, or a grievance unresolved for more than thirty (30) days, call the DMHC for assistance. The DMHC also has a toll-free number (888-466-2219) and a TDD line (877-688-9891) for the hearing and speech impaired. The DMHC's internet website www.dmhc.ca.gov has complaint forms online.

Consolidated Appropriations Act of 2021 Notice

Consolidated Appropriations Act of 2021 (CAA)

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

The provisions within this CAA Notice shall apply unless State law or any other provisions within this Agreement are more advantageous to You.

Surprise Billing Claims

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

- Emergency Services provided by Out of Network Providers,
- Covered Services provided by an Out of Network Provider at an In Network Facility, and
- Out of Network air ambulance services.

No Surprises Act Requirements

Emergency Services

As required by the CAA, Emergency Services are covered under Your Agreement:

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

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

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

Out of Network Services Provided at an In Network Facility

When You receive Covered Services from an Out of Network Provider at an In Network Facility, Your claims will not be covered if the Out of Network Provider gives You proper notice of its charges, and You give written consent to such charges. This means You will be responsible for all Out of Network charges for those services. This requirement does not apply to ancillary services. Ancillary services are one of the following services: (A) Emergency Services; (B) anesthesiology; (C) laboratory and pathology services; (D) radiology; (E) neonatology; (F) diagnostic services; (G) assistant surgeons; (H) hospitalists; (I) intensivists; and (J) any services set out by the U.S. Department of Health & Human Services.

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

1. By obtaining Your written consent not later than seventy-two (72) hours prior to the delivery of services or
2. If the notice and consent is given on the date of the service, if You make an appointment within seventy-two (72) hours of the services being delivered.

How Cost Shares Are Calculated

Your Cost Shares for Emergency Services or for Covered Services received by an Out of Network Provider at an In Network Facility, will be calculated using the median plan In Network contract rate that We pay In Network Providers for the geographic area where the Covered Service is provided. Any out-of-pocket Cost Shares You pay to an Out of Network Provider for either Emergency Services or for Covered Services provided by an Out of Network Provider at an In Network Facility will be applied to

Your In Network Out of Pocket Maximum.

Appeals

If You receive Emergency Services from an Out of Network Provider, Covered Services from an Out of Network Provider at an In Network Facility, or Out of Network Air Ambulance Services and believe those services are covered by the No Surprises Act, You have the right to appeal that claim. If Your Appeal of a Surprise Billing Claim is denied, then You have a right to appeal the adverse decision to an Independent Review Organization as set out in the "If You Have a Complaint or an Appeal" section of this Agreement.

Provider Directories

Anthem is required to confirm the list of In Network Providers in its provider directory every ninety (90) days. If You can show that You received inaccurate information from Anthem that a Provider was In Network on a particular claim, then You will only be liable for In Network Cost Shares (i.e., Copayments, Deductibles, and/or Coinsurance) for that claim. Your In Network Cost Shares will be calculated based upon the Negotiated Fee Rate.

Transparency Requirements

Anthem provides the following information on its website at www.anthem.com/ca:

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

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

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

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

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

Mental Health and Substance Use Disorder (Chemical Dependency) 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. 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.

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LANGUAGE ASSISTANCE SERVICES

Get Help in Your Language

Language Assistance Services

Curious to know what all this says? We would be too. Here is 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 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 Member Services at 833-913-2232.

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 (TY/TDD:711T).

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.(Y/TDD:711TT)

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 लिखिवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

Hmong

TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Japanese

重要:この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。1-888-254-2721 (TTY/TDD: 711)

Khmer

សំខាន់ៈ 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 ਵਬੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਫੌਰਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian

ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

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)

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)

How to Obtain Language Assistance

Anthem Blue Cross (Anthem) is committed to communicating with Our Members about their health Plan, no matter what their language is. Interpretation services are available through all of Our Member Services call centers. Simply call the Member Services phone number on the back of Your Identification

Card and a representative will be able to help You. Interpretation services are offered at no cost, including when Our Member is accompanied by a family member or friend who can provide interpretation services. Translation of written materials about Your benefits can also be asked for by contacting Member Services.

Teletypewriter/Telecommunications Device for the Deaf (TTY/TDD) services are also available by dialing 711. A special operator will get in touch with Us to help with Your needs.

You may provide Your preferred written and spoken language directly to Anthem and directly to Your Provider. If You provide Your language preferences to Anthem, this information will be maintained by Anthem and will be shared with Your Provider when the Provider calls to check eligibility or upon request. If Your preferred written language is one of Your health plan's threshold languages, You may receive some Plan information in Your preferred written language. You may update Your preferred written and spoken languages to Your health plan by calling 833-913-2232.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente.

(If You need Spanish-language assistance to understand this document, You may request it at no additional cost by calling the Member Services number.)

Auxiliary aids and services are also available for Members with disabilities as well as information in alternate formats. These aids and services are free of charge and will be provided in a timely manner when they are necessary to ensure an equal opportunity for Members with disabilities to effectively communicate with Us.

SCHEDULE OF COST SHARE AND BENEFITS

Anthem Silver 87 HMO
82EG
A Health Maintenance Organization (HMO) Plan

This Schedule of Cost Share and Benefits sets forth the applicable Cost Shares for benefits available under this Agreement. Such benefits shall be consistent with those set forth under Federal and California laws and regulations. The term Cost Shares means the applicable Deductibles, Copayments, Coinsurance and Out of Pocket Maximums that You must pay for Covered Services You receive under this Agreement. This Schedule does not list all specific services available under this Agreement, their Cost Shares, or explain benefits, exclusions or limitations. For a complete explanation of the benefits available under this Agreement and any limitations and exclusions, please read the entire Agreement including "What is Covered," "What is Not Covered (Exclusions)," "How Your Claims are Paid" and "Requesting Approval for Benefits."

All benefits are subject to the conditions, exclusions, limitations and terms of this Agreement including any endorsements.

Benefits for Covered Services are based on the Negotiated Fee Rate, which is the most Anthem will allow for a Covered Service.

Services will only be Covered Services if rendered by In Network Providers unless:

- The services are for Emergency Care, ambulance services related to an Emergency for transportation to a Hospital, or Urgent Care services received at an Urgent Care Center or
- The services are approved in advance by Anthem. **Please be sure to contact Us if You are not sure if We have pre-approved a service as an Authorized Service.**

Services from an Out of Network Provider are not covered, and You may be responsible for the total amount billed by an Out of Network Provider, except for an Emergency, Urgent Care received at an Urgent Care Center, or for a service pre-approved as an Authorized Service, or, in certain circumstances, when You receive Covered Services at an In Network Facility from an Out of Network Provider. Please read "How Your Claims are Paid" for more details.

Benefits for Emergency and Urgent Care from an Out of Network Provider are based on the Reasonable and Customary Value, which is the most Anthem will allow for Emergency Care. Please read "What is Covered" for more details. **When You receive Emergency Services (except water ambulance services) from an Out of Network Provider within California, You will not be responsible for amounts in excess of the Reasonable and Customary Value. Out of Network Providers cannot bill You for more than Your applicable Cost Shares for nonemergency air or ground ambulance services if you have a Precertification. Please see the subsection "Ambulance Services (Air, Ground and Water)" in "What is Covered" for more detailed information.**

Deductibles and Coinsurance are calculated based upon the Negotiated Fee Rate, not the Provider's billed charges.

Medical Deductible	In Network You Pay	Out of Network You Pay
Individual Plan	$0 per Benefit Period	Not Covered
Family Plan	$0 per Benefit Period	Not Covered
Prescription Drug Deductible		
Individual Plan	$0 per Benefit Period	Not Covered
Family Plan	$0 per Benefit Period	Not Covered

Out of Pocket Maximums	In Network You Pay	Out of Network You Pay
Individual Plan	$3,000 per Benefit Period	Not Covered
Family Plan	$6,000 per Benefit Period	Not Covered

The Out of Pocket Maximums include all Cost Shares You pay during a Benefit Period for all Essential Health Benefits, medical services, child dental and vision services and Prescription Drug services combined. It does not include charges over the Reasonable and Customary Value or amounts You pay for non-Covered Services.

Once the applicable Out of Pocket Maximum is satisfied, You will not have to pay any additional Cost Shares for the rest of the Benefit Period. If the Agreement covers only one (1) individual Member, the Member will have no further Cost Shares after the applicable individual Out of Pocket Maximum is satisfied. If an Agreement covers two (2) or more Members, an individual Member will have no further Cost Shares once they have satisfied the applicable individual Out of Pocket Maximum. No one (1) individual Member can contribute more than their individual Out of Pocket Maximum. Once the applicable Family Out of Pocket Maximum is satisfied, all other Members of the family will not be subject to further Cost Shares for the Benefit Period. All Cost Share amounts paid for Covered Services by each individual Member in a family during a Benefit Period contribute to the applicable Out of Pocket Maximum.

Unless stated otherwise, all amounts You pay for Covered Services during a Benefit Period for Cost Shares apply to the Out of Pocket Maximum.

Charges over the Reasonable and Customary Value that are Your responsibility and amounts You pay for non-Covered Services do not apply to these Out of Pocket Maximums. Deductibles and Coinsurance are calculated based upon the Negotiated Fee Rate, not the Provider's billed charges.

Cost Shares paid for Out of Network Emergency Care, including Emergency medical transportation (ambulance) and Emergency Hospital care, will apply to the In Network Out of Pocket Maximum.

See "Out of Pocket Maximums" under "How Your Claims are Paid" for a detailed description of how Your Out of Pocket Maximums work.

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

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

Copayments and Coinsurance

The following lists the Copayments and Coinsurance for benefits under this Agreement. The following does not list all services or the locations where a service may be received. If a service is available in another setting, You may determine the applicable Cost Share by referring to that setting. For example, You might get physical therapy in a doctor's office, an Outpatient Facility or during an Inpatient Hospital stay. For services in the office, look up "Doctor (Physician) Visits." For services involving behavioral health treatment for autism spectrum disorder, Mental Health or Substance Use Disorder look up "Autism Spectrum Disorder Services" or "Mental Health and Substance Use Disorder (Chemical Dependency) Services." For services in the Outpatient department of a Hospital, look up "Outpatient Hospital Care." For services during an Inpatient stay, look up "Inpatient Hospital Care."

Cost Sharing for services with Copayments is the lesser of the Copayment amount or Negotiated Fee Rate.

IMPORTANT: You are responsible for confirming that the Provider You are seeing or have been referred to see is an In Network Provider for this Agreement. It is important to understand that Anthem has many contracting Providers who may not be part of the network of Providers to provide services under this Agreement. Any claims incurred with an Anthem contracted Provider who is not an In Network Provider under this Agreement will be paid at the Out of Network level of benefits, even if You have been referred by another Anthem contracted Provider, except for services received by an Out of Network Provider as a result of a Medical Emergency or Urgent Care services received at an Urgent Care Center. Additionally, if You receive Covered Services from an In Network Facility in California at which, or as a result of which, You receive services from an Out of Network Provider, You will pay no more than the same Cost Sharing that You would pay for the same Covered Services from an In Network Provider.

Anthem can help You find an In Network Provider specific to Your Agreement if You call Member Services at the phone number on Your ID Card or access Our website at www.anthem.com/ca.

Some services listed below require Precertification prior to receiving the service. See "Requesting Approval for Benefits" for more information.

Medical Services

Benefit	You Pay Copayment / Coinsurance	
	In Network	**Out of Network**
Acupuncture	$15 Copayment	Not Covered
Ambulance Services (Water) • Precertification is required for ambulance services except in a Medical Emergency (see “Requesting Approval for Benefits” for details) • Out of Network ambulance services covered only in case of Emergency or if Precertified by Us • If Precertified by Us, Out of Network nonemergency ambulance services are subject to the same Cost Shares as In Network services up to $50,000 per trip • Out of Network ambulance Providers may bill You for any charges that exceed the Reasonable and Customary Value	$75 Copayment	**Emergency:** $75 Copayment plus all charges in excess of the Reasonable and Customary Value **Nonemergency:** Not Covered
Ambulance Services (Ground and Air) • Precertification is required for ambulance services except in a Medical Emergency (see "Requesting Approval for Benefits” for details) • Out of Network ambulance services covered only in case of Emergency or nonemergency if Precertified by Us • If Precertified by Us, Out of Network nonemergency ambulance services are subject to the same Cost Shares as In Network services • Your payment responsibility to ground and air ambulance Providers will be at the In Network Cost Share. You will not owe a ground or air ambulance Provider more than the In Network Cost Sharing amount	$75 Copayment	**Emergency:** $75 Copayment **Nonemergency:** $75 Copayment
Autism Spectrum Disorder Services • Precertification is required for autism spectrum disorder services (see “Requesting Approval for Benefits” for details)		
Outpatient Office Visits	$15 Copayment	Not Covered
Other Outpatient Items and Services	20% Coinsurance up to $15	Not Covered

Benefit	You Pay Copayment / Coinsurance	
	In Network	Out of Network
Inpatient Services	20% Coinsurance	Not Covered
Inpatient Doctor/Surgeon Fee	20% Coinsurance	Not Covered
COVID-19		
Coverage for immunizations	No charge	50% Coinsurance
Coverage for tests and therapeutics	No charge	50% Coinsurance
Diagnostic Services • Precertification is required for certain diagnostic procedures and tests (see "Requesting Approval for Benefits" for details) • If You receive diagnostic testing, the Cost Share for those services are in addition to the applicable office visit (PCP or SCP), Outpatient surgery services or Urgent Care Coinsurance or Copayments		
Diagnostic Laboratory and Pathology Services	$20 Copayment	Not Covered
Diagnostic Imaging Services and Electronic Diagnostic Tests	$40 Copayment	Not Covered
Advanced Imaging Services	$100 Copayment	Not Covered
Doctor (Physician) Visits • Additional services received during an office visit may be subject to additional Coinsurance or Copayments • For preventive care visits, please see "Preventive Care Services" below		
Primary Care Physician (PCP) Visit, including Office, Online, and Telehealth	$15 Copayment	Not Covered
Specialty Care Physician (SCP) Visit, including Office, Online, and Telehealth	$25 Copayment	Not Covered
Other Practitioner Office Visit	$15 Copayment	Not Covered
Retail Health Clinic Visit, includes all Covered Services received at a Retail Health Clinic	$15 Copayment	Not Covered
Preferred Online and Telehealth PCP Visit, including Mental Health and Substance Use Disorder (Chemical Dependency) Services	$0 Copayment	Not Covered

Benefit	You Pay Copayment / Coinsurance	
	In Network	Out of Network
Emergency Care Services (Emergency Room) • Additional services received in an Emergency Room may be subject to additional Coinsurance or Copayments • Out of Network covered in case of Emergency only		
Emergency Room Facility Fee	$150 Copayment per Emergency Room Visit Cost Share is waived if admitted into the Hospital from the Emergency room	$150 Copayment per Emergency Room Visit Cost Share is waived if admitted into the Hospital from the Emergency room
Emergency Room Doctor Fee	No Charge	No Charge
Home Care Services • Precertification is required for home care services (see "Requesting Approval for Benefits" for details) • In Network home care services are limited to one-hundred (100) visits per Benefit Period	$15 Copayment per Home Health Care Visit	Not Covered
Hospice Care • Precertification is required for hospice care (see "Requesting Approval for Benefits" for details)	No Charge	Not Covered
Hospital Services		
Inpatient Facility • Precertification is required for Inpatient services (see "Requesting Approval for Benefits" for details) • Precertification is not required for Emergency admissions and Inpatient stays for the delivery of a child or mastectomy surgery, including the length of stays associated with mastectomy and/or breast reconstruction surgery for breast cancer • For Emergency admissions, You, Your authorized representative or doctor must tell Us as soon as possible (see "Requesting Approval for Benefits" for details) • Out of Network Inpatient services are covered in case of Medical Emergency only. If You receive Covered Services from an In Network Facility in California at which, or as a result of which, You receive services from an Out of Network Provider, You will pay no more than the same Cost Sharing that You would pay for the same Covered Services from an In Network Provider		

Benefit	You Pay Copayment / Coinsurance	
	In Network	**Out of Network**
Inpatient Facility Fee	20% Coinsurance	**Emergency:** 20% Coinsurance **Nonemergency:** Not Covered
Residential Treatment Center Facility Fee	20% Coinsurance	Not Covered
Inpatient Doctor/Surgeon Fee	20% Coinsurance	**Emergency:** 20% Coinsurance **Nonemergency:** Not Covered
Outpatient Facility • Precertification is required for surgical procedures (see "Requesting Approval for Benefits" for details) • Additional services received in an Outpatient surgery Hospital or Facility may be subject to additional Coinsurance or Copayments		
Outpatient Hospital or Facility Fee	20% Coinsurance	Not Covered
Ambulatory Surgical Center	20% Coinsurance	Not Covered
Outpatient Visit	20% Coinsurance	Not Covered
Outpatient Doctor/Surgeon Fee	20% Coinsurance	Not Covered
Maternity Services		
Preconception, Prenatal Care and First Postpartum Check-Up	No Charge	Not Covered
Postnatal Care	$15 Copayment	Not Covered
Medical Supplies, Durable Medical Equipment and Appliances • Precertification is required for certain prosthesis and assistive devices (see "Requesting Approval for Benefits" for details)	15% Coinsurance	Not Covered
Mental Health and Substance Use Disorder (Chemical Dependency) Services • Precertification is required for certain Mental Health and Substance Use Disorder services except in an Emergency (see "Requesting Approval for Benefits" for details)		

Benefit	You Pay Copayment / Coinsurance	
	In Network	Out of Network
Outpatient Office Visits	$15 Copayment	Not Covered
Other Outpatient Items and Services	20% Coinsurance up to $15	Not Covered
Inpatient Services	20% Coinsurance	Not Covered
Inpatient Doctor/Surgeon Fee	20% Coinsurance	Not Covered
Outpatient Habilitative Services • Limits for Habilitative and Rehabilitative Services shall not be combined. Anthem does not have limits on Habilitative or Rehabilitative Services	$15 Copayment	Not Covered
Outpatient Rehabilitative Services • Limits for Habilitative and Rehabilitative Services shall not be combined. Anthem does not have limits on Habilitative or Rehabilitative Services	$15 Copayment	Not Covered
Preventive Care Services	No Charge	Not Covered
Skilled Nursing Facility • Precertification is required for a Skilled Nursing Facility (see “Requesting Approval for Benefits” for details) • Skilled Nursing Facility is limited to one-hundred (100) days per Benefit Period. A Benefit Period begins on the date You are admitted to a Hospital or Skilled Nursing Facility at a skilled level of care. A Benefit Period ends on the date You have not been an Inpatient in a Hospital or Skilled Nursing Facility, receiving a skilled level of care, for sixty (60) consecutive days. A new Benefit Period can begin only after any existing Benefit Period ends. A prior three (3) day stay in an acute care Hospital is not required. This limit does not apply to Mental Health and Substance Use Disorder services or autism spectrum disorder services	20% Coinsurance	Not Covered
Urgent Care Center • Additional services received in an Urgent Care Center may be subject to additional Coinsurance or Copayments	$15 Copayment per Urgent Care Center visit	$15 Copayment per Urgent Care Center visit

Prescription Drugs

Prescription Drug benefits accumulate toward the applicable Out of Pocket Maximum.

Anthem uses a Prescription Drug List (formulary) that includes a select number of medications in therapeutic categories and classes. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Each Prescription Drug will be subject to Cost Shares as described below.

If Your Prescription Drug order includes more than one (1) Prescription Drug, a separate Cost Share will apply to each Prescription Drug.

If the retail or home delivery price for a covered Prescription and/or refill is less than the applicable Cost Share amount, You will not be required to pay more than that price. The retail or home delivery price paid will constitute the applicable Cost Sharing and will apply toward the Deductible and Out of Pocket Maximum in the same manner as any Cost Share.

Day Supply Limitations. Prescription Drugs will be subject to various day supply and quantity limits. Certain Prescription Drugs may have a lower than thirty (30) day supply limit due to other Agreement requirements such as prior authorization, quantity limits and/or age limits and utilization guidelines including clinical criteria and recommendations of State and federal agencies. If the quantity of the drug dispensed is reduced due to clinical criteria and/or recommendations of governmental agencies, the Prescription is considered complete.

IMPORTANT NOTES:

- Benefits for Covered Services are based on the Negotiated Fee Rate, which is the most Anthem will allow for a Covered Service. Please read “What is Covered” and “How Your Claims are Paid” for more details.
- Oral chemotherapy drugs are subject to a maximum Cost Share not to exceed $200 for a thirty (30) day supply.
- Prescription Drugs that We are required to cover by federal and State law under the “Preventive Care Services” benefit will be covered with no Cost Shares when You use an In Network Provider.

See “What is Covered” and “What is Not Covered (Exclusions)” for descriptions of Covered Services, limitations and exclusions. In cases where Your doctor prescribes a medication that is not on the Anthem Prescription Drug List (formulary), it may be necessary to obtain prior authorization in order for the Prescription to be a covered benefit. Doctors and Members are informed of the prior authorization process through the Subscriber’s Agreement, Anthem’s website, www.anthem.com/ca and the Provider’s manual.

Prescription Drug Deductible • retail and home delivery combined	**In Network You Pay**	**Out of Network You Pay**
Individual Plan	$0 per Benefit Period	Not Covered
Family Plan	$0 per Benefit Period	Not Covered

Benefit	**You Pay** **Copayment / Coinsurance**	
	In Network	**Out of Network**
Retail Prescription • Retail Pharmacy is limited to up to a thirty (30) day supply per Prescription • Specialty Drugs must be purchased from the Pharmacy Benefit Manager's Specialty Pharmacy • For FDA-approved, Self-Administered hormonal contraceptives, up to a twelve (12) month supply is covered when dispensed or furnished at one (1) time by a Provider or pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies		
Tier 1	$5 Copayment	Not Covered
Tier 2	$25 Copayment	Not Covered
Tier 3	$45 Copayment	Not Covered
Tier 4	15% Coinsurance up to $150 per 30-day supply	Not Covered

Benefit	You Pay Copayment / Coinsurance	
	In Network	Out of Network
Home Delivery Prescription • Home Delivery is limited to up to a ninety (90) day supply per Prescription • Specialty Drugs must be purchased from the Pharmacy Benefit Manager's Specialty Pharmacy and are limited to a thirty (30) day supply • For FDA-approved, Self-Administered hormonal contraceptives, up to a twelve (12) month supply is covered when dispensed or furnished at one (1) time by a Provider or pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies		
Tier 1	$15 Copayment	Not Covered
Tier 2	$75 Copayment	Not Covered
Tier 3	$135 Copayment	Not Covered
Tier 4	15% Coinsurance up to $450 per 90-day supply	Not Covered

Child Dental Care

The following child Dental Services are covered for Members until the end of the month in which they turn nineteen (19).

Covered Dental Services, unless otherwise stated below, are subject to the same Benefit Period Out of Pocket Maximum as medical and amounts can be found earlier in this Schedule of Cost Share and Benefits.

Please see “Child Dental Care” in the “What is Covered” section for more information on child Dental Services.

Benefit		You Pay Coinsurance	
CDT Code	Benefit Description • Limitation	In Network	Out of Network
Diagnostic Services		No Charge	Not Covered
D0120	Periodic oral evaluation - established patient • Once per six months		
D0140	Limited oral evaluation - problem focused		
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver		
D0150	Comprehensive oral evaluation - new or established patient		
D0160	Detailed and extensive oral evaluation - problem focused, by report		
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit) • Covered six times per three months for temporomandibular joint conditions • Covered twelve times per twelve months		
D0171	Re-evaluation – post-operative office visit		
D0180	Comprehensive periodontal evaluation - new or established patient		
D0210	Intraoral - comprehensive series of radiographic images • Once per thirty-six months		
D0220	Intraoral - periapical first radiographic image • Twenty images per twelve months; includes D0230		
D0230	Intraoral - periapical each additional radiographic image • Twenty images per twelve months; includes D0220		
D0240	Intraoral - occlusal radiographic image • Two images per six months		
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector • One image per day		

Benefit		You Pay Coinsurance	
CDT Code	Benefit Description • Limitation	In Network	Out of Network
D0251	Extra-oral posterior dental radiographic image • Four images per day		
D0270	Bitewing - single radiographic image • One image per day		
D0272	Bitewings - two radiographic images • One image per six months		
D0273	Bitewings - three radiographic images • One image per six months • For Members ages 10 and older		
D0274	Bitewings - four radiographic images • One image per six months • For Members ages 10 and older		
D0277	Vertical bitewings - seven to eight radiographic images • Billed as four bitewings		
D0310	Sialography		
D0320	Temporomandibular joint arthrogram, including injection • Three times per day		
D0322	Tomographic survey • Twice per twelve months		
D0330	Panoramic radiographic image • One image per thirty-six months		
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis • Twice per twelve months		
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally • Four images per day		
D0396	3D printing of a 3D dental surface scan		
D0460	Pulp vitality tests		
D0470	Diagnostic casts • Covered as part of orthodontic care		
D0502	Other oral pathology procedures, by report		
D0601	Caries risk assessment and documentation, with a finding of low risk		
D0602	Caries risk assessment and documentation, with a finding of moderate risk		
D0603	Caries risk assessment and documentation, with a finding of high risk		
D0701	Panoramic radiographic image – image capture only • One image per thirty-six months		
D0702	2-D cephalometric radiographic image – image capture only • Two images per twelve months		

Benefit		You Pay Coinsurance	
CDT Code	Benefit Description • Limitation	In Network	Out of Network
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only • Four images per day		
D0705	Extra-oral posterior dental radiographic image – image capture only • Four images per day		
D0706	Intraoral – occlusal radiographic image – image capture only • Two images per six months		
D0707	Intraoral – periapical radiographic image – image capture only • Twenty images per twelve months; includes D0230		
D0708	Intraoral - bitewing radiographic image – image capture only • One image per day		
D0709	Intraoral – comprehensive series of radiographic images – image capture only • One image per thirty-six months		
D0801	3D dental surface scan - direct		
D0802	3D dental surface scan - indirect		
D0803	3D facial surface scan - direct		
D0804	3D facial surface scan - indirect		
D0999	Unspecified diagnostic procedure, by report		
D9311	Consultation with a medical health professional		
D9997	Dental case management - patients with special health care needs		
D9999	Unspecified adjunctive procedure, by report		
Preventive Services		No Charge	Not Covered
D1110	Prophylaxis - adult • Once per six months; includes D1120		
D1120	Prophylaxis - child • Once per six months; includes D1110		
D1206	Topical application of fluoride varnish • Once per six months; includes D1208		
D1208	Topical application of fluoride – excluding varnish • Once per six months; includes D1206		
D1310	Nutritional counseling for control of dental disease		
D1320	Tobacco counseling for the control and prevention of oral disease		

Benefit		You Pay Coinsurance	
CDT Code	Benefit Description • Limitation	In Network	Out of Network
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use		
D1330	Oral hygiene instructions		
D1351	Sealant - per tooth for first, second and third molars only • Once per tooth per thirty-six months		
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth • Once per tooth per thirty-six months		
D1353	Sealant repair – per tooth		
D1354	Interim caries arresting medicament application - per tooth		
D1355	Caries preventive medicament application – per tooth		
D1510	Space maintainer - fixed - unilateral - per quadrant • Once per quadrant • For Members up to age 18		
D1516	Space maintainer – fixed – bilateral, maxillary • Once per arch • For Members up to age 18		
D1517	Space maintainer – fixed – bilateral, mandibular • Once per arch • For Members up to age 18		
D1520	Space maintainer - removable - unilateral - per quadrant • Once per quadrant • For Members up to age 18		
D1526	Space maintainer – removable – bilateral, maxillary • Once per arch • For Members up to age 18		
D1527	Space maintainer – removable – bilateral, mandibular • Once per arch • For Members up to age 18		
D1551	Re-cement or re-bond bilateral space maintainer - maxillary		
D1552	Re-cement or re-bond bilateral space maintainer - mandibular		
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant		
D1556	Removal of fixed unilateral space maintainer - per quadrant • Covered; only by Provider who did not initially place the space maintainer		
D1557	Removal of fixed bilateral space maintainer - maxillary • Covered; only by Provider who did not initially place the space maintainer		

Benefit		You Pay Coinsurance	
CDT Code	Benefit Description • Limitation	In Network	Out of Network
D1558	Removal of fixed bilateral space maintainer - mandibular • Covered; only by Provider who did not initially place the space maintainer		
D1575	Distal shoe space maintainer – fixed, unilateral - per quadrant		
D9995	Teledentistry - synchronous; real-time encounter		
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review		
Basic Services		20% Coinsurance	Not Covered
D2140	Amalgam - one surface, primary or permanent • Once per tooth per twelve months primary teeth • Once per tooth per thirty-six months permanent teeth		
D2150	Amalgam - two surfaces, primary or permanent • Once per tooth per twelve months primary teeth • Once per tooth per thirty-six months permanent teeth		
D2160	Amalgam - three surfaces, primary or permanent • Once per tooth per twelve months primary teeth • Once per tooth per thirty-six months permanent teeth		
D2161	Amalgam - four or more surfaces, primary or permanent • Once per tooth per twelve months primary teeth • Once per tooth per thirty-six months permanent teeth		
D2330	Resin-based composite - one surface, anterior • Once per tooth per twelve months primary teeth • Once per tooth per thirty-six months permanent teeth		
D2331	Resin-based composite - two surfaces, anterior • Once per tooth per twelve months primary teeth • Once per tooth per thirty-six months permanent teeth		
D2332	Resin-based composite - three surfaces, anterior • Once per tooth per twelve months primary teeth • Once per tooth per thirty-six months permanent teeth		
D2335	Resin-based composite - four or more surfaces (anterior) • Once per tooth per twelve months primary teeth • Once per tooth per thirty-six months permanent teeth		
D2390	Resin-based composite crown, anterior • Once per tooth per twelve months primary teeth • Once per tooth per thirty-six months permanent teeth		

Benefit		You Pay Coinsurance	
CDT Code	Benefit Description • Limitation	In Network	Out of Network
D2391	Resin-based composite - one surface, posterior • Once per tooth per twelve months primary teeth • Once per tooth per thirty-six months permanent teeth		
D2392	Resin-based composite - two surfaces, posterior • Once per tooth per twelve months primary teeth • Once per tooth per thirty-six months permanent teeth		
D2393	Resin-based composite - three surfaces, posterior • Once per tooth per twelve months primary teeth • Once per tooth per thirty-six months permanent teeth		
D2394	Resin-based composite - four or more surfaces, posterior • Once per tooth per twelve months primary teeth • Once per tooth per thirty-six months permanent teeth		
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration • Once per twelve months		
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core		
D2920	Re-cement or re-bond crown • Covered twelve months after initial placement of the crown by the same Provider		
D2921	Reattachment of tooth fragment, incisal edge or cusp		
D2928	Prefabricated porcelain/ceramic crown – permanent tooth • Once per thirty-six months		
D2929	Prefabricated porcelain/ceramic crown – primary tooth • Once per twelve months		
D2930	Prefabricated stainless steel crown - primary tooth • Once per twelve months		
D2931	Prefabricated stainless steel crown - permanent tooth • Once per thirty-six months		
D2932	Prefabricated resin crown • Once per tooth per twelve months primary teeth • Once per tooth per thirty-six months permanent teeth		
D2933	Prefabricated stainless steel crown with resin window • Once per tooth per twelve months primary teeth • Once per tooth per thirty-six months permanent teeth		
D2940	Protective restoration • Once per six months		
D2941	Interim therapeutic restoration – primary dentition		
D2949	Restorative foundation for an indirect restoration		

Benefit		You Pay Coinsurance	
CDT Code	Benefit Description • Limitation	In Network	Out of Network
D2950	Core buildup, including any pins when required		
D2951	Pin retention - per tooth, in addition to restoration • Once per tooth		
D2952	Post and core in addition to crown, indirectly fabricated • Once per tooth		
D2953	Each additional indirectly fabricated post - same tooth		
D2955	Post removal		
D2957	Each additional prefabricated post - same tooth		
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework		
D2980	Crown repair necessitated by restorative material failure • Covered twelve months after initial placement or repair of crown by same Provider		
D2999	Unspecified restorative procedure, by report		
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant • Once per quadrant per thirty-six months • For Members ages 13 and up		
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant • Once per quadrant per thirty-six months • For Members ages 13 and up		
D4910	Periodontal maintenance • Four times per twelve months • Up to twenty-four months following scaling and root-planing - includes D1110/D1120		
D9110	Palliative treatment of dental pain – per visit • Once per day		
D9210	Local anesthesia not in conjunction with operative or surgical procedures		
D9211	Regional block anesthesia		
D9212	Trigeminal division block anesthesia		
D9215	Local anesthesia in conjunction with operative or surgical procedures		
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia		
D9248	Non-intravenous conscious sedations • May be used for Members under age 13 when they are uncooperative		

Benefit		You Pay Coinsurance	
CDT Code	Benefit Description • Limitation	In Network	Out of Network
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician		
D9410	House/extended care facility call • Once per day		
D9420	Hospital or ambulatory surgical center call • Units are in hours		
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed • Once per day		
D9440	Office visit - after regularly scheduled hours • Once per day		
D9610	Therapeutic parenteral drug, single administration • Four times per day		
D9612	Therapeutic parenteral drugs, two or more administrations, different medications • Alternates to D9610, which equals four per day		
D9910	Application of desensitizing medicament • Once per twelve months		
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report • Once per day, within thirty days of extraction		
Endodontic Services		50% Coinsurance	Not Covered
D2989	Excavation of a tooth resulting in the determination of non-restorability		
D3110	Pulp cap - direct (excluding final restoration)		
D3120	Pulp cap - indirect (excluding final restoration)		
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament • Once per tooth		
D3221	Pulpal debridement, primary and permanent teeth • Once per tooth		
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development • Once per tooth		
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) • Once per tooth		
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) • Once per tooth		
D3310	Endodontic therapy, anterior tooth (excluding final restoration) • Once per tooth on permanent teeth only		

Benefit		You Pay Coinsurance	
CDT Code	Benefit Description • Limitation	In Network	Out of Network
D3320	Endodontic therapy, premolar tooth (excluding final restoration) • Once per tooth on permanent teeth only		
D3330	Endodontic therapy, molar tooth (excluding final restoration) • Once per tooth on permanent teeth only		
D3331	Treatment of root canal obstruction; non-surgical access		
D3333	Internal root repair of perforation defects		
D3346	Retreatment of previous root canal therapy - anterior • Once per permanent tooth, twelve months after initial root canal by same Provider		
D3347	Retreatment of previous root canal therapy - premolar • Once per permanent tooth, twelve months after initial root canal by same Provider		
D3348	Retreatment of previous root canal therapy - molar • Once per permanent tooth, twelve months after initial root canal by same Provider		
D3351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.) • Once per tooth		
D3352	Apexification/recalcification – interim medication replacement • Once per tooth		
D3410	Apicoectomy - anterior • Ninety days after root canal therapy by same Provider • Twenty-four months after apicoetomy/periradicular surgery by same Provider		
D3421	Apicoectomy - premolar (first root) • Ninety days after root canal therapy by same Provider • Twenty-four months after apicoetomy/periradicular surgery by same Provider		
D3425	Apicoectomy - molar (first root) • Ninety days after root canal therapy by same Provider • Twenty-four months after apicoetomy/periradicular surgery by same Provider		
D3426	Apicoectomy (each additional root)		
D3428	Bone graft in conjunction with periradicular surgery - per tooth, single site		
D3429	Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site		

Benefit		You Pay Coinsurance	
CDT Code	Benefit Description • Limitation	In Network	Out of Network
D3430	Retrograde filling - per root		
D3431	Biologic materials to aid in soft and osseous tissue regeneration, in conjunction with periradicular surgery		
D3471	Surgical repair of root resorption - anterior • Ninety days after root canal therapy by same Provider • Twenty-four months after apicoetomy/periradicular surgery by same Provider		
D3472	Surgical repair of root resorption – premolar • Ninety days after root canal therapy by same Provider • Twenty-four months after apicoetomy/periradicular surgery by same Provider		
D3473	Surgical repair of root resorption – molar • Ninety days after root canal therapy by same Provider • Twenty-four months after apicoetomy/periradicular surgery by same Provider		
D3910	Surgical procedure for isolation of tooth with rubber dam		
D3999	Unspecified endodontic procedure, by report		
Periodontal Services		50% Coinsurance	Not Covered
D4249	Clinical crown lengthening – hard tissue		
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant • Once per quadrant per thirty-six months • For Members ages 13 and up		
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant • Once per quadrant per thirty-six months • For Members ages 13 and up		
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site		
D4341	Periodontal scaling and root planing - four or more teeth per quadrant • Once per quadrant per twenty-four months • For Members ages 13 and up		
D4342	Periodontal scaling and root planing - one to three teeth per quadrant • Once per quadrant per twenty-four months • For Members ages 13 and up		

Benefit		You Pay Coinsurance	
CDT Code	Benefit Description • Limitation	In Network	Out of Network
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation • Once per quadrant per twenty-four months • For Members ages 13 and up		
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit		
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth		
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff) • Once with D4210/D4211/ D4260/D4261 - excludes provider who performed service • For Members ages 13 and up		
D4999	Unspecified periodontal procedure, by report • For Members ages 13 and up		
Oral Surgery Services		50% Coinsurance	Not Covered
D7111	Extraction, coronal remnants - primary tooth		
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)		
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated		
D7220	Removal of impacted tooth - soft tissue		
D7230	Removal of impacted tooth - partially bony		
D7240	Removal of impacted tooth - completely bony		
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications		
D7250	Removal of residual tooth roots (cutting procedure)		
D7260	Oroantral fistula closure		
D7261	Primary closure of a sinus perforation		
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth		
D7280	Exposure of an unerupted tooth		
D7283	Placement of device to facilitate eruption of impacted tooth • Covered with orthodontia		
D7284	Excisional biopsy of minor salivary glands		
D7285	Incisional biopsy of oral tissue-hard (bone, tooth) • One per arch per day		

Benefit		You Pay Coinsurance	
CDT Code	Benefit Description • Limitation	In Network	Out of Network
D7286	Incisional biopsy of oral tissue-soft • Three times per day		
D7290	Surgical repositioning of teeth • Once per arch per lifetime; with orthodontia		
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report • Once per arch per lifetime; with orthodontia		
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant		
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant		
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant • Following six months of any extraction		
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant		
D7340	Vestibuloplasty - ridge extension (secondary epithelialization) • Once per arch per sixty months		
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) • Once per arch per lifetime; with orthodontia		
D7410	Excision of benign lesion up to 1.25 cm		
D7411	Excision of benign lesion greater than 1.25 cm		
D7412	Excision of benign lesion, complicated		
D7413	Excision of malignant lesion up to 1.25 cm		
D7414	Excision of malignant lesion greater than 1.25 cm		
D7415	Excision of malignant lesion, complicated		
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm		
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm		
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm		
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm		
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm		
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm		
D7465	Destruction of lesion(s) by physical or chemical method, by report		

Benefit		You Pay Coinsurance	
CDT Code	Benefit Description • Limitation	In Network	Out of Network
D7471	Removal of lateral exostosis (maxilla or mandible) • Once per quadrant per lifetime		
D7472	Removal of torus palatinus • Once per quadrant per lifetime		
D7473	Removal of torus mandibularis • Once per quadrant per lifetime		
D7485	Reduction of osseous tuberosity • Once per quadrant per lifetime		
D7490	Radical resection of maxilla or mandible		
D7509	Marsupialization of odontogenic cyst		
D7510	Incision and drainage of abscess - intraoral soft tissue • Once per quadrant per day		
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces) • Once per quadrant per day		
D7520	Incision and drainage of abscess - extraoral soft tissue		
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)		
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue • Once per day		
D7540	Removal of reaction producing foreign bodies, musculoskeletal system • Once per day		
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone • Once per quadrant per day • Following thirty days of an extraction		
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body		
D7610	Maxilla - open reduction (teeth immobilized, if present)		
D7620	Maxilla - closed reduction (teeth immobilized, if present)		
D7630	Mandible - open reduction (teeth immobilized, if present)		
D7640	Mandible - closed reduction (teeth immobilized, if present)		
D7650	Malar and/or zygomatic arch - open reduction		
D7660	Malar and/or zygomatic arch - closed reduction		

Benefit		You Pay Coinsurance	
CDT Code	Benefit Description • Limitation	In Network	Out of Network
D7670	Alveolus - closed reduction, may include stabilization of teeth		
D7671	Alveolus - open reduction, may include stabilization of teeth		
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches		
D7710	Maxilla - open reduction		
D7720	Maxilla - closed reduction		
D7730	Mandible - open reduction		
D7740	Mandible - closed reduction		
D7750	Malar and/or zygomatic arch - open reduction		
D7760	Malar and/or zygomatic arch - closed reduction		
D7770	Alveolus - open reduction stabilization of teeth		
D7771	Alveolus, closed reduction stabilization of teeth		
D7780	Facial bones - complicated reduction with fixation and multiple approaches		
D7810	Open reduction of dislocation		
D7820	Closed reduction of dislocation		
D7830	Manipulation under anesthesia		
D7840	Condylectomy		
D7850	Surgical discectomy, with/without implant		
D7852	Disc repair		
D7854	Synovectomy		
D7856	Myotomy		
D7858	Joint reconstruction		
D7860	Arthrotomy		
D7865	Arthroplasty		
D7870	Arthrocentesis		
D7871	Non-arthroscopic lysis and lavage		
D7872	Arthroscopy - diagnosis, with or without biopsy		
D7873	Arthroscopy: lavage and lysis of adhesions		
D7874	Arthroscopy: disc repositioning and stabilization		
D7875	Arthroscopy: synovectomy		
D7876	Arthroscopy: discectomy		
D7877	Arthroscopy: debridement		
D7880	Occlusal orthotic device, by report		

Benefit		You Pay Coinsurance	
CDT Code	Benefit Description • Limitation	In Network	Out of Network
D7881	Occlusal orthotic device adjustment		
D7899	Unspecified TMD therapy, by report		
D7910	Suture of recent small wounds up to 5 cm		
D7911	Complicated suture - up to 5 cm		
D7912	Complicated suture - greater than 5 cm		
D7920	Skin graft (identify defect covered, location and type of graft)		
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site		
D7939	Indexing for osteotomy using dynamic robotic assisted or dynamic navigation		
D7940	Osteoplasty - for orthognathic deformities		
D7941	Osteotomy - mandibular rami		
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft		
D7944	Osteotomy - segmented or subapical		
D7945	Osteotomy - body of mandible		
D7946	LeFort I (maxilla - total)		
D7947	LeFort I (maxilla - segmented)		
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft		
D7949	LeFort II or LeFort III - with bone graft		
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report		
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach		
D7952	Sinus augmentation via a vertical approach		
D7955	Repair of maxillofacial soft and/or hard tissue defect		
D7961	Buccal / labial frenectomy (frenulectomy) • Once per arch per lifetime		
D7962	Lingual frenectomy (frenulectomy) • Once per arch per lifetime		
D7963	Frenuloplasty • Once per arch per day		
D7970	Excision of hyperplastic tissue - per arch • Once per arch per day		
D7971	Excision of pericoronal gingiva		
D7972	Surgical reduction of fibrous tuberosity • Once per quadrant per day		

Benefit		You Pay Coinsurance	
CDT Code	Benefit Description • Limitation	In Network	Out of Network
D7979	Non-surgical Sialolithotomy		
D7980	Surgical sialolithotomy		
D7981	Excision of salivary gland, by report		
D7982	Sialodochoplasty		
D7983	Closure of salivary fistula		
D7990	Emergency tracheotomy		
D7991	Coronoidectomy		
D7995	Synthetic graft - mandible or facial bones, by report		
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar • Once per arch per day		
D7999	Unspecified oral surgery procedure, by report		
Major Restorative Services		50% Coinsurance	Not Covered
D2710	Crown - resin-based composite (indirect) • Once per tooth per sixty months • For Members ages 13 and up		
D2712	Crown - 3/4 resin-based composite (indirect) • Once per tooth per sixty months • For Members ages 13 and up		
D2721	Crown - resin with predominantly base metal • Once per tooth per sixty months • For Members ages 13 and up		
D2740	Crown - porcelain/ceramic • Once per tooth per sixty months • For Members ages 13 and up		
D2751	Crown - porcelain fused to predominantly base metal • Once per tooth per sixty months • For Members ages 13 and up		
D2781	Crown - 3/4 cast predominantly base metal • Once per tooth per sixty months • For Members ages 13 and up		
D2783	Crown - 3/4 porcelain/ceramic • Once per tooth per sixty months • For Members ages 13 and up		
D2791	Crown - full cast predominantly base metal • Once per tooth per sixty months • For Members ages 13 and up		
D2954	Prefabricated post and core in addition to crown • Once per tooth		
D2976	Brand stabilization - per tooth		
D2991	Application of hydroxyapatite regeneration medicament – per toot		

Benefit		You Pay Coinsurance	
CDT Code	Benefit Description • Limitation	In Network	Out of Network
D6010	Surgical placement of implant body: endosteal implant		
D6011	Surgical access to an implant body (second stage implant surgery)		
D6012	Surgical placement of interim implant body for transitional prosthesis; endosteal implant		
D6013	Surgical placement of mini implant		
D6040	Surgical placement: eposteal implant		
D6050	Surgical placement: transosteal implant		
D6055	Connecting bar – implant supported or abutment supported		
D6056	Prefabricated abutment – includes modification and placement		
D6057	Custom fabricated abutment – includes placement		
D6058	Abutment supported porcelain/ceramic crown		
D6059	Abutment supported porcelain fused to metal crown (high noble metal)		
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)		
D6061	Abutment supported porcelain fused to metal crown (noble metal)		
D6062	Abutment supported cast metal crown (high noble metal)		
D6063	Abutment supported cast metal crown (predominantly base metal)		
D6064	Abutment supported cast metal crown (noble metal) (high noble metal)		
D6065	Implant supported porcelain/ceramic crown		
D6066	Implant supported crown - porcelain fused to high noble alloys		
D6067	Implant supported crown - high noble alloys		
D6068	Abutment supported retainer for porcelain/ceramic FPD		
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)		
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)		
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)		
D6072	Abutment supported retainer for cast metal FPD (high noble metal)		
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)		

Benefit		You Pay Coinsurance	
CDT Code	Benefit Description • Limitation	In Network	Out of Network
D6074	Abutment supported retainer for cast metal FPD (noble metal)		
D6075	Implant supported retainer for ceramic FPD		
D6076	Implant supported retainer FPD - porcelain fused to high noble alloys		
D6077	Implant supported retainer for metal FPD high noble alloys		
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments		
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure		
D6082	Implant supported crown - porcelain fused to predominantly base alloys		
D6083	Implant supported crown - porcelain fused to noble alloys		
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys		
D6085	Interim implant crown		
D6086	Implant supported crown - predominantly base alloys		
D6087	Implant supported crown - noble alloys		
D6088	Implant supported crown - titanium and titanium alloys		
D6089	Accessing and retorquing loose implant screw - per screw		
D6090	Repair implant supported prosthesis, by report		
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment		
D6092	Re-cement or re-bond implant/abutment supported crown • Covered twelve months after initial placement of crown by same Provider		
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture • Covered twelve months after initial placement of crown by same Provider		
D6094	Abutment supported crown - titanium and titanium alloys		
D6095	Repair implant abutment, by report		
D6096	Remove broken implant retaining screw		
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys		

Benefit		You Pay Coinsurance	
CDT Code	Benefit Description • Limitation	In Network	Out of Network
D6098	Implant supported retainer - porcelain fused to predominantly base alloys		
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys		
D6100	Surgical removal of implant body		
D6105	Removal of implant body not requiring bone removal or flap elevation		
D6110	Implant /abutment supported removable denture for edentulous arch – maxillary		
D6111	Implant /abutment supported removable denture for edentulous arch – mandibular		
D6112	Implant /abutment supported removable denture for partially edentulous arch – maxillary		
D6113	Implant /abutment supported removable denture for partially edentulous arch – mandibular		
D6114	Implant /abutment supported fixed denture for edentulous arch – maxillary		
D6115	Implant /abutment supported fixed denture for edentulous arch – mandibular		
D6116	Implant /abutment supported fixed denture for partially edentulous arch – maxillary		
D6117	Implant /abutment supported fixed denture for partially edentulous arch – mandibular		
D6118	Implant/abutment supported interim fixed denture for edentulous arch - mandibular		
D6119	Implant/abutment supported interim fixed denture for edentulous arch - maxillary		
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys		
D6121	Implant supported retainer for metal FPD – predominantly base alloys		
D6122	Implant supported retainer for metal FPD – noble alloys		
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys		
D6190	Radiographic/surgical implant index, by report		
D6191	Semi-precision abutment – placement		
D6192	Semi-precision attachment – placement		
D6194	Abutment supported retainer crown for FPD - titanium and titanium alloys		
D6195	Abutment supported retainer - porcelain fused to titanium and titanium		

Benefit		You Pay Coinsurance	
CDT Code	Benefit Description • Limitation	In Network	Out of Network
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant		
D6198	Remove interim implant component		
D6199	Unspecified implant procedure, by report		
D9120	Fixed partial denture sectioning		
D9222	Deep sedation/general anesthesia - first 15 minute		
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment		
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis • For Members under age 13 when they are uncooperative		
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes		
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment		
D9950	Occlusion analysis - mounted case • Once per twelve months; • For Members ages 13 and up with TMJ		
D9951	Occlusal adjustment - limited • Once per twelve months; • For Members ages 13 and up with TMJ		
D9952	Occlusal adjustment - complete • Once per twelve months; • For Members ages 13 and up with TMJ		
Prosthodontic Services - Removable		50% Coinsurance	Not Covered
D5110	Complete denture - maxillary • Once per sixty months		
D5120	Complete denture - mandibular • Once per sixty months		
D5130	Immediate denture - maxillary • Once per lifetime		
D5140	Immediate denture - mandibular • Once per lifetime		
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) • Once per sixty months		
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) • Once per sixty months		
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) • Once per sixty months		

Benefit		You Pay Coinsurance	
CDT Code	Benefit Description • Limitation	In Network	Out of Network
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) • Once per sixty months		
D5221	Immediate maxillary partial denture – resin base (including, retentive/clasping materials rests and teeth) • Once per arch per lifetime		
D5222	Immediate mandibular partial denture – resin base (including retentive/ claspings materials, rests and teeth) • Once per arch per lifetime		
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) • Once per arch per lifetime		
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) • Once per arch per lifetime		
D5410	Adjust complete denture - maxillary • Twice per twelve months; six months after initial placement, reline, or repair		
D5411	Adjust complete denture - mandibular • Twice per twelve months; six months after initial placement, reline, or repair		
D5421	Adjust partial denture - maxillary • Twice per twelve months; six months after initial placement, reline, or repair		
D5422	Adjust partial denture - mandibular • Twice per twelve months; six months after initial placement, reline, or repair		
D5511	Repair broken complete denture base, mandibular • Twice per twelve months; six months after initial placement		
D5512	Repair broken complete denture base, maxillary • Twice per twelve months; six months after initial placement		
D5520	Replace missing or broken teeth - complete denture (each tooth) • Twice per twelve months; six months after initial placement • Up to four teeth per visit		
D5611	Repair resin denture base, mandibular • Twice per twelve months; six months after initial placement		
D5612	Repair resin denture base, maxillary • Twice per twelve months; six months after initial placement		

Benefit		You Pay Coinsurance	
CDT Code	Benefit Description • Limitation	In Network	Out of Network
D5621	Repair cast framework, mandibular • Twice per twelve months; six months after initial placement		
D5622	Repair cast framework, maxillary • Twice per twelve months; six months after initial placement		
D5630	Repair or replace broken retentive/clasping materials - per tooth • Twice per twelve months per arch; six months after initial placement • Up to three clasps per visit		
D5640	Replace broken teeth - per tooth • Twice per twelve months per arch; six months after initial placement • Up to four teeth per visit		
D5650	Add tooth to existing partial denture • Once per tooth, per lifetime; six months after initial placement • Up to three teeth per visit		
D5660	Add clasp to existing partial denture - per tooth • Once per tooth, per lifetime; six months after initial placement • Up to three clasps per visit		
D5730	Reline complete maxillary denture (direct) • Once per six months following D5110/D5863 with extractions • Once per twelve months following D5110/D5863 without extractions		
D5731	Reline complete mandibular denture (direct) • Once per six months following D5120/D5864 with extractions • Once per twelve months following D5120/D5864 without extractions		
D5740	Reline maxillary partial denture (direct) • Once per six months following D5211/D5213 with extractions • Once per twelve months following D5211/D5213 without extractions		
D5741	Reline mandibular partial denture (direct) • Once per six months following D5212/D5214 with extractions • Once per twelve months following D5212/D5214 without extractions		
D5750	Reline complete maxillary denture (indirect) • Once per six months following D5130/D5863 with extractions • Once per twelve months following D5110/D5863 without extractions		

Benefit		You Pay Coinsurance	
CDT Code	Benefit Description • Limitation	In Network	Out of Network
D5751	Reline complete mandibular denture (indirect) • Once per six months following D5140/D5864 with extractions • Once per twelve months following D5120/D5864 without extractions		
D5760	Reline maxillary partial denture (indirect) • Once per six months following D5213 with extractions • Once per twelve months following D5213 without extractions		
D5761	Reline mandibular partial denture (indirect) • Once per six months following D5214 with extractions • Once per twelve months following D5214 without extractions		
D5850	Tissue conditioning, maxillary • Twice for each appliance per thirty-six months		
D5851	Tissue conditioning, mandibular • Twice for each appliance per thirty-six months		
D5862	Precision attachment, by report		
D5863	Overdenture – complete maxillary		
D5864	Overdenture – partial maxillary		
D5865	Overdenture – complete mandibular		
D5866	Overdenture – partial mandibular		
D5899	Unspecified removable prosthodontic procedure, by report		
Prosthodontic Services - Fixed		50% Coinsurance	Not Covered
D6211	Pontic - cast predominantly base metal • Once per tooth per sixty months; • For Members ages 13 and up and only in conjunction with D5211/D5212/D5213/D5214 and same date of service as D6721/D6740/D6751/D6781/D6783/D6791		
D6241	Pontic - porcelain fused to predominantly base metal • Once per tooth per sixty months; • For Members ages 13 and up and only in conjunction with D5211/D5212/D5213/D5214 and same date of service as D6721/D6740/D6751/D6781/D6783/D6791		
D6245	Pontic - porcelain/ceramic • Once per tooth per sixty months; • For Members ages 13 and up and only in conjunction with D5211/D5212/D5213/D5214 and same date of service as D6721/D6740/D6751/D6781/D6783/D6791		

Benefit		You Pay Coinsurance	
CDT Code	Benefit Description • Limitation	In Network	Out of Network
D6251	Pontic - resin with predominantly base metal • Once per tooth per sixty months; • For Members ages 13 and up and only in conjunction with D5211/D5212/D5213/D5214 and same date of service as D6721/D6740/D6751/D6781/D6783/D6791		
D6721	Retainer crown - resin with predominantly base metal • Once per tooth per sixty months; • For Members ages 13 and up and in conjunction with D5211/D5212/D5213/D5214		
D6740	Retainer crown - porcelain/ceramic • Once per tooth per sixty months; • For Members ages 13 and up and in conjunction with D5211/D5212/D5213/D5214		
D6751	Retainer crown - porcelain fused to predominantly base metal • Once per tooth per sixty months; • For Members ages 13 and up and in conjunction with D5211/D5212/D5213/D5214		
D6781	Retainer crown - 3/4 cast predominantly base metal • Once per tooth per sixty months; • For Members ages 13 and up and in conjunction with D5211/D5212/D5213/D5214		
D6783	Retainer crown - 3/4 porcelain/ceramic • Once per tooth per sixty months; • For Members ages 13 and up and in conjunction with D5211/D5212/D5213/D5214		
D6784	Retainer crown ¾ - titanium and titanium alloys • Once per tooth per sixty months; • For Members ages 13 and up and in conjunction with D5211/D5212/D5213/D5214		
D6791	Retainer crown - full cast predominantly base metal • Once per tooth per sixty months; • For Members ages 13 and up and in conjunction with D5211/D5212/D5213/D5214		
D6930	Re-cement or re-bond fixed partial denture • Covered twelve months after initial placement of crown by same Provider		
D6980	Fixed partial denture repair necessitated by restorative material failure • Covered twelve months after initial placement or repair of crown by same Provider		
D6999	Unspecified fixed prosthodontic procedure, by report		
Implant Services		50% Coinsurance	Not Covered
D5911	Facial moulage (sectional)		
D5912	Facial moulage (complete)		
D5913	Nasal prosthesis		

Benefit		You Pay Coinsurance	
CDT Code	Benefit Description • Limitation	In Network	Out of Network
D5914	Auricular prosthesis		
D5915	Orbital prosthesis		
D5916	Ocular prosthesis		
D5919	Facial prosthesis		
D5922	Nasal septal prosthesis		
D5923	Ocular prosthesis, interim		
D5924	Cranial prosthesis		
D5925	Facial augmentation implant prosthesis		
D5926	Nasal prosthesis, replacement		
D5927	Auricular prosthesis, replacement		
D5928	Orbital prosthesis, replacement		
D5929	Facial prosthesis, replacement		
D5931	Obturator prosthesis, surgical		
D5932	Obturator prosthesis, definitive		
D5933	Obturator prosthesis, modification • Twice per twelve months		
D5934	Mandibular resection prosthesis with guide flange		
D5935	Mandibular resection prosthesis without guide flange		
D5936	Obturator prosthesis, interim		
D5937	Trismus appliance (not for TMD treatment)		
D5951	Feeding aid		
D5952	Speech aid prosthesis, pediatric		
D5953	Speech aid prosthesis, adult		
D5954	Palatal augmentation prosthesis		
D5955	Palatal lift prosthesis, definitive		
D5958	Palatal lift prosthesis, interim		
D5959	Palatal lift prosthesis, modification • Twice per twelve months		
D5960	Speech aid prosthesis, modification • Twice per twelve months		
D5982	Surgical stent		
D5983	Radiation carrier		
D5984	Radiation shield		
D5985	Radiation cone locator		
D5986	Fluoride gel carrier		

Benefit		You Pay Coinsurance	
CDT Code	Benefit Description • Limitation	In Network	Out of Network
D5987	Commissure splint		
D5988	Surgical splint		
D5991	Vesiculobullous disease medicament carrier		
D5999	Unspecified maxillofacial prosthesis, by report		
Medically Necessary Orthodontic Care		50% Coinsurance	Not Covered
D8080	Comprehensive orthodontic treatment of the adolescent dentition		
D8210	Removable appliance therapy • Once per lifetime • For Members ages 6-12		
D8220	Fixed appliance therapy • Once per lifetime • For Members ages 6-12		
D8660	Pre-orthodontic treatment examination to monitor growth and development • Once every three months		
D8670	Periodic orthodontic treatment visit • Four times per Year (paid quarterly)		
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s) • Once per arch per course of treatment		
D8681	Removable orthodontic retainer adjustment		
D8696	Repair of orthodontic appliance – maxillary		
D8697	Repair of orthodontic appliance – mandibular		
D8698	Re-cement or re-bond fixed retainer – maxillary		
D8699	Re-cement or re-bond fixed retainer – mandibular		
D8701	Repair of fixed retainer, includes reattachment – maxillary		
D8702	Repair of fixed retainer, includes reattachment – mandibular		
D8703	Replacement of lost or broken retainer – maxillary		
D8704	Replacement of lost or broken retainer – mandibular		
D8999	Unspecified orthodontic procedure, by report		

Child Vision Care

The following vision care services are covered for Members until the end of the month in which they turn nineteen (19). To get the In Network benefit, You must use a Blue View Vision Provider. Visit Our website or call Us at the number on Your Identification Card if You need help finding a Blue View Vision Provider.

Please see "Child Vision Care" in the "What is Covered" section for more information on pediatric vision services

Benefit	You Pay Copayment / Coinsurance	
	In Network	Out of Network
Routine Eye Exam • Routine eye exam includes refraction • Covered once per Benefit Period per Member	No Charge	Not Covered
Standard Plastic or Glass Lenses • One (1) set of lenses per Benefit Period per Member • Covered lenses include factory scratch coating, UV coating, standard polycarbonate and standard photochromic lenses at no additional cost when received from In Network Providers		
Single Vision	No Charge	Not Covered
Bifocal	No Charge	Not Covered
Trifocal	No Charge	Not Covered
Progressive	No Charge	Not Covered
Lenticular	No Charge	Not Covered
Frames (formulary) • One (1) frame covered per Benefit Period per Member	No Charge	Not Covered
Contact Lenses (formulary) • A one (1) Year supply of elective or non-elective contact lenses is covered every Benefit Period (applicable to certain contact lenses within the vision formulary) • Non-elective contacts for aniridia and aphakia. Contact lenses for aniridia will be covered up to two (2) contact lenses per eye per Benefit Period. Contact lenses for aphakia will be covered up to six (6) contact lenses per eye per Benefit Period. Contact lens coverage for these conditions also includes fitting and dispensing		
Elective (conventional and disposable) • These are contact lenses chosen for comfort or appearance	No Charge	Not Covered

Benefit	You Pay Copayment / Coinsurance	
	In Network	Out of Network
Non-elective • These are contact lenses that are prescribed to You for a medical condition	No Charge	Not Covered
Important Note: Benefits for contact lenses are in lieu of Your eyeglass lens benefit. If You receive contact lenses, no benefit will be available for eyeglass lenses until the next Benefit Period.		
Low Vision • Low vision benefits are only available when received from Blue View Vision Providers		
Comprehensive Low Vision Exam • Covered once every five (5) Benefit Periods per Member	No Charge	Not Covered
Optical/Non-Optical Aids and Supplemental Testing • Limited to one (1) occurrence of either optical/non-optical aids or supplemental testing per Benefit Period per Member	No Charge	Not Covered

HOW YOUR COVERAGE WORKS

The purpose of this section is to help You understand how to receive the highest level of benefits available under this Plan. It provides details about In Network Providers who have entered into an agreement with Anthem and Out of Network Providers who have not. You will also find information about how to access a list of In Network Providers in Your Service Area and the importance of choosing a Primary Care Physician (PCP).

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

This is a Health Maintenance Organization (HMO) Plan

To get benefits for Covered Services, You must use In Network Providers, unless We have approved an Authorized Service or if Your care involves Emergency Care, ambulance services related to an Emergency for transportation to a Hospital, or Urgent Care services received at an Urgent Care Center.

This Plan is only offered and issued in certain geographic areas within the State of California. If You change Your residence to a location that is outside of the Service Area, but You continue to reside in the State of California, contact Anthem or the Exchange to enroll in a different individual health benefit plan.

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

Choice of Doctors and Providers

SERVICES MUST BE PERFORMED OR SUPPLIES FURNISHED BY AN IN NETWORK PROVIDER IN ORDER FOR BENEFITS TO BE PAYABLE. Services received from an Out of Network Provider at an In Network Facility when pre-authorized as an Authorized Referral or as a result of a Medical Emergency or Urgent Care are exceptions. Also, if You receive Covered Services at an In Network Facility in California at which, or as a result of which, You receive services provided by an Out of Network Provider, You will pay no more than the same Cost Sharing that You would pay for the same Covered Services received from an In Network Provider.

In Network Services

If Your care is rendered by a Primary Care Physician (PCP), Specialty Care Physician (SCP), or another In Network Provider, benefits will be paid at the In Network level. Regardless of Medical Necessity, no benefits will be paid for care that is not a Covered Service even if performed by a PCP, SCP, or another In Network Provider. All medical care must be under the direction of doctors, unless Medically Necessary or otherwise appropriate.

We may inform You that it is not Medically Necessary for You to receive services or remain in a Hospital or other Facility. This decision is made upon review of Your condition and treatment. You have the right to file a grievance as outlined in the "If You Have a Complaint or an Appeal" section of this Plan.

In Network Providers include PCPs, SCPs, other professional Providers, Hospitals, and other Facility Providers who contract with Us to perform services for You. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians and gynecologists, geriatricians or other In Network Providers as allowed by Us or as required by law. The PCP is the doctor who may provide, coordinate, and arrange Your healthcare services. SCPs are In Network doctors who provide specialty medical services not normally provided by a PCP.

For services rendered by In Network Providers:

- You will not be required to file any claims for services You obtain directly from In Network Providers. In Network Providers will seek compensation for Covered Services rendered from Us and not from You except for approved Deductibles, Coinsurance, and/or Copayments. You may be billed by Your In Network Provider(s) for any non-Covered Services You receive or when You have not acted in accordance with this Plan.

- When required, prior approval of benefits is the responsibility of the In Network Provider. See the "Requesting Approval for Benefits" section.

If there is no In Network Provider who is qualified to perform the treatment You require, contact Us prior to receiving the service or treatment, and We may approve an Out of Network Provider for that service as an Authorized Service.

If You receive Covered Services from an Out of Network Provider after We failed to provide You with accurate information in Our Provider Directory, or after We failed to respond to Your telephone or web-based inquiry within the time required by federal law, Covered Services will be covered at the In Network level.

Out of Network Services

Services which are not obtained from a PCP, SCP or another In Network Provider, or that are not an Authorized Service will be considered an Out of Network service and are not covered. The only exceptions are Emergency Care, Urgent Care received from an Urgent Care Center, and ambulance services related to an Emergency for transportation to a Hospital. **In these cases, Out of Network Providers are paid at the Reasonable and Customary Value.**

Also, if You receive Covered Services from an In Network Facility in California at which, or as a result of which, You receive services from an Out of Network Provider, You will pay no more than the same Cost Sharing that You would pay for the same Covered Services received from an In Network Provider.

For Your Cost Share responsibility and Provider reimbursement for Out of Network Mental Health and Substance Use Disorder services, please see **Mental Health and Substance Use Disorder (Chemical Dependency) Services**, in the section entitled "**What is Covered**."

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from non-participating or Out of Network Providers could be billed by the non-participating/Out of Network Provider for those services that are determined to be not payable as a result of these review processes. 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.

How to Find a Provider in the Network

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

- See Your Plan's directory of In Network Providers at www.anthem.com/ca, which lists the doctors, Providers, and Facilities that participate in this Plan's Network.
- Search for a Provider in Our mobile app or website. Details on how to download the app can be found on Our website, www.anthem.com/ca.
- Contact Member Services to ask for a list of doctors and Providers that participate in this Plan's Network based on specialty and geographic area. Member Services can help You determine the Provider's name, address, telephone number, professional qualifications, specialty, medical school attended, and board certifications.
- Check with Your doctor or Provider.

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

Enrollment in the selected Plan is dependent upon You residing within the Plan's geographical Service Area, and the network, Provider, and doctor availability within the geographical Service Area. If at the time of Your enrollment in the selected Plan, the network or doctor/Medical Group is not available or You do not reside 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.

Primary Care Physician (PCP)

The PCP is a doctor who can provide initial care, basic medical services and can be responsible for ongoing patient care. PCPs are usually internal medicine doctors, family practice doctors, general

practitioners, pediatricians, or obstetricians/gynecologists (OB/GYNs). PCPs may provide care in person or virtually. As Your first point of contact, the PCP gives a wide range of healthcare services, including initial diagnosis and treatment, health supervision, management of chronic conditions, and preventive care.

Selecting a Primary Care Physician (PCP)

Your Plan requires You to have a PCP from Our Network, and We will assign one. Your PCP selection will be displayed on Your Identification Card. You may then use that PCP or choose another In Network PCP from Our Provider Directory. Please see "How to Find a Provider in the Network" for more details on choosing and In Network PCP.

PCPs include family practitioner, pediatrician, internist, OB/GYN, or other qualified PCPs, as required by law, for services within the scope of their license. For example, an internist or general practitioner may be chosen for adults and a pediatrician may be selected for children. If You want to change Your PCP, contact Us or refer to Our web site, www.anthem.com/ca.

If You need to see a Specialist, please contact Your PCP to obtain a Referral authorization.

You do not need prior authorization from Anthem or from any other person (including a PCP) to obtain access to obstetrical or gynecological care from a healthcare professional within the Medical Group who specializes in obstetrics or gynecology. The OB/GYN, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making Referrals. For a list of In Network healthcare professionals who specialize in obstetrics or gynecology within Your Medical Group, contact Your Medical Group or Anthem at the phone number on Your ID Card.

Your Network of Providers

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

I**nformation about Your Network can be found in "Subscriber and Premium Information," by calling Member Services at the phone number on Your ID Card or on Our website www.anthem.com/ca**.

The First Thing To Do – Make an Appointment With Your PCP

Your PCP's job is to help You stay healthy, not just treat You when You are sick. After You choose a PCP, make an appointment with Your PCP. During this appointment, get to know Your PCP and help Your PCP get to know You. At Your first appointment, talk to Your PCP about:

- Personal health history.
- Family health history.
- Lifestyle.
- Any health concerns You have.

It is important to note, if You have not established a relationship with Your PCP, they may not be able to effectively treat You. To see a doctor, contact their office:

- Tell them You are an Anthem Member.
- Have Your Member Identification Card handy. The doctor's office may ask You for Your Member ID number.
- Tell them the reason for Your visit.

When You meet with Your PCP, be sure to have Your Member Identification Card available.

Your HMO

An HMO is a Health Maintenance Organization which provides or arranges Your care. Within an HMO, Medical Groups employ PCPs and SCPs, Your PCP will be Your initial point of contact for medical services. If Specialist care is needed, Your PCP will partner with the Medical Group in managing the care You need. Benefits of this Plan are for In Network PCP services and specialty care when You

receive a Referral. There are very few services that do not require a Referral from Your PCP or Medical Group in order to access care. Please see "How to Obtain Care" below or You can also ask Your PCP or Medical Group for more information about these services.

In Network Medical Groups are generally paid a capitation fee, a set and agreed to dollar amount per Member each month, for medical services. In Network Medical Groups may also receive additional reimbursement for certain types of specialty care or for overall efficiency. Medical groups may also receive additional compensation related to the management of services and Referrals. The terms of these arrangements may vary by Medical Group. Hospitals and other healthcare Facilities are paid negotiated fixed fees or on the basis of a negotiated discount from their standard fee-for-service rates. For additional information You may contact Member Services at the phone number on Your ID Card or You may contact Your Medical Group.

Services Out of Network and/or outside the network of the Medical Group or care obtained without a Referral are not covered except for Emergency Services or services authorized by Us or the Medical Group. To obtain benefits on the Plan it is important that You work closely with Your PCP and the Medical Group to ensure You do not obtain services of an Out of Network Provider, except in the case of an Emergency Medical Condition or with an Authorized Referral. If You receive Covered Services at an In Network Facility in California at which, or as a result of which, You receive services provided by an Out of Network Provider, You will pay no more than the same Cost Sharing that You would pay for the same Covered Services received from an In Network Provider.

Anthem's HMO offers a wide range of medical benefits as stated under "What is Covered." These benefits include but are not limited to prenatal, maternity and well-baby care, as well as certain preventive services such as physical exams and health education.

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

Changing Medical Groups or Primary Care Physicians

You may find out later on that You need to change Your Medical Group. You may move or You may have some other reason. Call Member Services at the phone number on Your ID Card. We will need to know why You want to change Your Medical Group.

We will approve Your request for a change if the PCP within the new Medical Group You have 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 within the Plan's geographical Service Area.

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

Anthem also allows You to change to a different Medical Group if You live within the Plan's geographical Service Area and You are not undergoing a course of treatment. For purposes of this section, a course of treatment is:

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

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

If You change Your Medical Group, any Referrals given to You by Your previous Medical Group will not be accepted by Your new Medical Group. If You still require a Referral for care, You will need to request a Referral from Your new PCP within Your new Medical Group. This means Your Referral may require

evaluation by Your new Medical Group or Us.

Note: We or Your new Medical Group may refer You to a different Provider than the one approved by Your prior Medical Group.

Anthem must approve Your request to transfer and You must be assigned to the new Medical Group or PCP before You obtain medical care from the new Medical Group or PCP. If You obtain medical care from a different Medical Group or PCP than You are assigned to, those services may be considered services provided by a non-Anthem HMO Provider. If they are provided by a non-Anthem HMO 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 the Plan's geographical Service Area, You must notify Anthem in writing and request a transfer to another Medical Group that is located within the geographical Service Area of the Plan. 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 HMO licensed Service Area, but You continue to reside in the State of California, contact Anthem to enroll in a different type of healthcare 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 fifteenth (15th) of the month. If Your course of treatment ends after the fifteenth (15th) of the month, the Effective Date of the transfer will be the first (1st) day of the month following the next month.

How to Obtain Care

The procedures You follow to obtain care depend on the type of care You need. If You are ever in doubt of the process to obtain care or when a Referral is needed, contact Your PCP.

Primary (General) Care

Your PCP is the first person You should consult for medical care. He or she is responsible for providing You with primary medical care and determining when You need Referral care.

Second Opinions

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

You have the right to a second opinion by an appropriately qualified healthcare professional within the Anthem HMO network. If there is no appropriately qualified healthcare professional within the HMO network, We will authorize a second opinion by an appropriately qualified healthcare professional, taking into account Your ability to travel.

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

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

Referral (Specialty) Care

If You need special care which cannot be provided by Your PCP at Your Medical Group, Your PCP will arrange to send You to a Specialist within Your Medical Group whenever possible or to a Provider outside of Your Medical Group.

If You are referred, Your PCP or Medical Group will give You a completed "Authorization for Referral

Services" form which specifies exactly what treatment or services Your doctor or Medical Group authorizes. Take this form to the healthcare Provider to whom You have been referred on the appointment date indicated on the authorization form. That Provider will fill in the appropriate parts and will send it back to Your Medical Group. If You do not receive the authorization form, ask for it from Your PCP before Your visit to the Specialist.

Payment will be made only for the number of visits and the medical care that is specifically authorized. Before obtaining any other care, be sure to check with Your PCP or Medical Group to make sure that such additional care is authorized. You are responsible for paying for services rendered that are not authorized.

Obstetrical and gynecological services and Reproductive or Sexual Healthcare Services may be received directly, without obtaining a Referral from Your PCP or Medical Group, from an obstetrician and gynecologist or family practice doctor who is a member of Your Medical Group or who has an arrangement with Your Medical Group to provide care for its patients, and who has been identified by Your Medical Group as available for providing obstetrical and gynecological care. In addition, services for Mental or Nervous Disorders may be received directly (without obtaining a Referral from Your PCP or Medical Group) from a mental and nervous disorder Specialist who is an Anthem HMO Behavioral Health Network Provider. For a list of In Network Providers who specialize in obstetrics/gynecology and Mental or Nervous Disorders, call Member Services at the phone number on Your ID Card or access Our website at www.anthem.com/ca.

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.

Dental Providers

You must select an In Network dentist to receive dental benefits. Please call Member Services at 800-627-0004 for help in finding an In Network dentist or visit Our website at www.anthem.com/ca. Please refer to Your ID Card for the name of the dental program that In Network Providers have agreed to service when You are choosing an In Network dentist.

Continuity of Care

Transition Assistance for New Members

Transition assistance is a process that allows for continuity of care for new Members whose prior health plan withdrew their health benefit plan from the market or ceased to provide coverage in the individual market. If this applies to You, You may request transition assistance if any one (1) of the following conditions applies:

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

3. A pregnancy.
    a. A pregnancy is the three (3) trimesters of pregnancy and the immediate postpartum period. Completion of Covered Services shall be provided for the duration of the pregnancy.
    b. For an individual who presents written documentation of being diagnosed with a maternal mental health condition from the individual's treating healthcare 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. "Maternal mental health condition" means 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 (1) Year after delivery.
4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) Year or less. Completion of Covered Services shall be provided for the duration of the terminal illness.
5. Completion of Covered Services shall not exceed twelve (12) months from the time the Member enrolls with Us.
6. Performance of a surgery or other procedure that We have authorized as part of a documented course of treatment and that has been recommended and documented by the Provider to occur within one-hundred and eighty (180) days of the time the Member enrolls with Anthem.

Please contact Member Services at the phone number on Your ID Card to request transition assistance or to obtain a copy of the written policy. Eligibility is based on the Member's clinical condition; it is not determined by diagnostic classifications. Transition assistance does not provide coverage for services not otherwise covered under the Plan.

We will notify You whether or not Your request for transition assistance is approved. We will also notify the Provider if the request is approved. Financial arrangements with Out of Network Providers are negotiated on a case-by-case basis. We will request that the Out of Network Provider agree to negotiate reimbursement and/or contractual requirements that apply to In Network Providers, including payment terms. If the Out of Network Provider does not agree to negotiate said reimbursement and/or contractual requirements, We are not required to continue that Provider's services.

If You disagree with Our determination regarding continuation of care, please refer to the section "If You Have a Complaint or an Appeal."

Transition Assistance for Continuity of Care after Termination of Provider

Transition assistance is a process that allows for continuity of care after termination of a Member's Provider. Subject to the terms and conditions set forth below, We will pay benefits at the In Network Provider level for Covered Services (subject to applicable Deductibles, Copayment and Coinsurance and other terms) rendered by a Provider whose participation has been terminated from Our Network for any reason other than termination for cause.

- The Member must be under the care of the In Network Provider at the time of Our termination of the Provider's participation in Our network. The terminated Provider must agree in writing to provide services to the Member in accordance with the terms and conditions of his/her agreement with Us prior to termination from Our network. The Provider must also agree in writing to accept the terms and reimbursement rates under his/her agreement with Anthem prior to termination from Our network. If the Provider does not agree with these contractual terms and conditions, We are not required to continue the Provider's services beyond the contract termination date.
- Such benefits will not apply to Providers who have been terminated due to medical disciplinary cause or reason, fraud or other criminal activity.

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

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

the duration of the acute condition.

2. A serious chronic condition.
    a. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by Us in consultation with the Member and the terminated Provider and consistent with good professional practice.
    b. Completion of Covered Services shall not exceed twelve (12) months from the Provider's contract termination date.
3. A pregnancy.
    a. A pregnancy is the three (3) trimesters of pregnancy and the immediate postpartum period. Completion of Covered Services shall be provided for the duration of the pregnancy.
    b. For an individual who presents written documentation of being diagnosed with a maternal mental health condition from the individual's treating healthcare 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. "Maternal mental health condition" means 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 (1) Year after delivery.
4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) Year or less. Completion of Covered Services shall be provided for the duration of a terminal illness, which may exceed twelve (12) months from the Provider's contract termination date.
5. The care of a newborn child between birth and age 36 months. Completion of Covered Services shall not exceed twelve (12) months from the Provider's contract termination date.
6. Performance of a surgery or other procedure that We have authorized as part of a documented course of treatment and that has been recommended and documented by the Provider to occur within one-hundred and eighty (180) days of the Provider's contract termination date.

If You would like information on the process or the policy and procedure for requesting completion of Covered Services, contact Member Services at the phone number on Your ID Card. Eligibility is based on the Member's clinical condition; it is not determined by diagnostic classifications. Continuation of care does not provide coverage for services not otherwise covered under the Plan.

We will notify You as to whether or not Your request for continuation of care is approved. We will also notify the Provider if the request is approved. If approved, the Member will be financially responsible only for applicable Deductibles, Coinsurance and/or Copayments under this Plan. Financial arrangements with terminated Providers are negotiated on a case-by-case basis. We will request that the terminated Provider agree to negotiate reimbursement and/or contractual requirements that apply to In Network Providers, including payment terms. If the terminated Provider does not agree to the same reimbursement and/or contractual requirements, We are not required to continue that Provider's services. If You disagree with Our determination regarding continuation of care, please refer to "If You Have a Complaint or an Appeal."

Identification Card

When You receive care, You must show Your Identification Card. Only a Member who has paid the Premiums under this Plan has the right to services or benefits under this Plan. If anyone receives services or benefits to which he/she is not entitled to under the terms of this Plan, he/she is responsible for the actual cost of the services or benefits.

After Hours Care

If You need care after normal business hours, Your doctor may have several options for You. You should call Your doctor's office for instructions if You need care in the evenings, on weekends, or during

the holidays and cannot wait until the office reopens.

- If Your condition is an Emergency, You should be taken to the nearest appropriate medical Facility. In the event of an Emergency call the 911 Emergency response system or the 988 suicide and crisis lifeline.
- Your coverage includes benefits for services rendered by Providers other than In Network Providers when the condition treated is an Emergency, as defined in this Plan.

Relationship of Parties (Anthem and In Network Providers)

The relationship between Anthem and In Network Providers is an independent contractor relationship. In Network Providers are not agents or employees of Ours, nor is Anthem, or any employee of Anthem, an employee or agent of In Network Providers.

Your healthcare Provider is solely responsible for all decisions regarding Your care and treatment, regardless of whether such care and treatment is a Covered Service under this Plan. We shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by You while receiving care from any In Network Provider or for any injuries suffered by You while receiving care from any In Network Provider's Facilities.

Your In Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to the provision of services or Referrals to other Providers, including In Network Providers, Out of Network Providers and disease management programs. If You have questions regarding such incentives or risk sharing relationships, please contact Your Provider or Us.

TIMELY ACCESS TO CARE

Timely Access to Medical Care

Anthem has contracted with healthcare service Providers to provide Covered Services in a manner appropriate for Your condition, consistent with good professional practice. Anthem ensures that its contracted Provider networks have the capacity and availability to offer appointments within the timeframes specified below. Where there is no In Network Provider available for a Medically Necessary Covered Service, an Authorized Referral for an Out of Network Provider may be provided at the In Network Cost Share amounts (Deductible, Copayment, and/or Coinsurance). If You receive precertification for an Out of Network Provider due to network adequacy issues, You will not be responsible for the difference between the Provider's Out of Network charges and the Negotiated Fee Rate. Please contact Us at the phone number on Your ID Card for Authorized Referral 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 and Substance Use Disorder care:

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

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

Anthem arranges for telephone triage or screening services for You twenty-four (24) hours per day, seven (7) days per week with a waiting time of no more than thirty (30) minutes.

Providers will utilize a telephone answering machine and/or an answering service and/or office staff, during and after business hours, to inform You of the wait time for a return call from the Provider and how the Member may obtain Urgent or Emergency Care or how to contact another Provider who is on-call for telephone triage or screening services.

If You need the services of an interpreter, the services will be coordinated with scheduled appointments and will not result in a delay of an In Network appointment.

Timely Access to Dental Care

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

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

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

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

If You need the services of an interpreter, the services will be coordinated with scheduled appointments and will not result in a delay of Your appointment.

Timely Access to Vision Care

Anthem has contracted with In Network vision Providers to provide Covered Services in a manner appropriate for Your condition, consistent with good professional practice. Anthem ensures that its network of In Network vision Providers have the capacity and availability to offer appointments within the following timeframes:

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

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

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

If You need the services of an interpreter, the services will be coordinated with scheduled appointments and will not result in a delay of Your appointment.

Triage or Screening Services

If You have questions about a particular health condition or if You need someone to help You determine whether or not care is needed, triage or screening services are available to You from Us by telephone. Triage or screening services are the evaluation of Your health by a doctor or a nurse who is trained to screen for the purpose of determining the urgency of Your need for care. Please contact the 24/7 NurseLine at 866-623-3790 twenty-four (24) hours a day, seven (7) days a week.

REQUESTING APPROVAL FOR BENEFITS

Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigational as those terms are defined in this Plan. Utilization Review aids in the delivery of cost-effective healthcare 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 part of the review, services that can be safely given to You in a lower level place of care or lower cost setting, will not be Medically Necessary if they are given in a higher level place of care, or higher cost setting. This means that a request for a service may be denied because it is not Medically Necessary for that service to be provided in the place of care or setting that is being requested. When this happens the service can be requested again in another setting or place of care and will be reviewed again for Medical Necessity. At times a different type of 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 approved if provided on an Outpatient basis in a Hospital setting.
- A service may be denied on an Outpatient basis in a Hospital setting, but may be approved at a free-standing imaging center, infusion center, Ambulatory Surgical Center, or in a doctor's office.
- A service may be denied at a Skilled Nursing Facility, but may be approved in a home setting.

Certain Services must be reviewed to determine Medical Necessity in order for You to get benefits. 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 is more cost effective, available and appropriate. "Clinically equivalent" means treatments that for most Members, will give You similar results for a disease or condition.

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

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

1. You must be eligible for benefits.
2. Premium must be paid for the time period that services are given.
3. The service or supply must be a Covered Service under Your Plan.
4. The service cannot be subject to an exclusion under Your Plan.
5. 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 or Investigational as those terms are defined in this Plan. The review may include the place or setting of the service. For further information, please see "Reviewing Where Services are Provided" above.

  For admissions following Emergency Care, You, Your authorized representative or doctor must

tell Us as soon as possible. For labor/childbirth admissions, Precertification is not required for the first forty-eight (48) hours for a vaginal delivery or ninety-six (96) hours for a cesarean section. Admissions longer than 48/96 hours require concurrent review.

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

Both pre-service and continued stay/concurrent reviews may be considered urgent when, in the view of the treating Provider or any doctor with knowledge of Your medical condition, without such care or treatment, Your life or health or Your ability to regain maximum function could be seriously threatened or You could be subjected to severe pain that cannot be adequately managed without such care or treatment.

Urgent reviews are conducted under a shorter timeframe than standard reviews.

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

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

- All Inpatient Facility admissions (except for Emergency admissions and Inpatient Hospital stays for the delivery of a child or mastectomy surgery, including the length of Hospital stays associated with mastectomy and/or breast reconstruction surgery for breast cancer). For Emergency admissions, You, Your authorized representative or doctor must tell Us as soon as possible.
- Mental Health and Substance Use Disorder services:
    - Inpatient Facility admissions for Mental Health and Substance Use Disorder services, including detoxification and rehabilitation (except for Emergency admissions)
    - Transcranial magnetic stimulation (TMS)
    - Residential treatment (including detoxification and rehabilitation)
    - Partial Hospitalization
    - Intensive Outpatient Programs
    - Behavioral health treatment for autism spectrum disorder
- Skilled Nursing Facility stays
- Transcranial magnetic stimulation (TMS)
- Bariatric surgery and organ and tissue transplants
- All infusion therapy (in any setting) inclusive of Specialty Drugs and related services (for each course of Therapy) in any setting, including, but not limited to: doctor's office, infusion center, Outpatient Hospital or clinic, or Your home or other residential setting
- Home care services
- Inpatient hospice care
- Surgical procedures, wherever performed
- Cryopreservation
- Temporomandibular services
- Diagnostic procedures, tests and advanced imaging procedures, wherever performed
- The following reconstructive services:
    - Dermabrasion of the face or other site
    - Rosacea treatment
    - Scar revision
    - Tattooing

  - Collagen injections
  - Electrolysis
  - Hair transplants (hairplasty)
  - Botox injections
  - Chemical peels
- Genetic testing
- Implants, prosthetics, assistive devices and durable medical equipment
- Ambulance in a nonemergency
- Hyperbaric oxygen treatment
- New and emerging technology
- Unlisted/unspecified codes
- Physical therapy
- Occupational therapy
- Speech therapy

For a list of current procedures, or the site of surgical procedures, requiring Precertification, please call Member Services at the phone number on Your ID Card.

Who is Responsible for Precertification

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

Provider Network Status	Responsibility to Get Precertification	Comments
In Network	Provider	The Provider must get Precertification when required.
Out of Network	Member	The Member has no benefit coverage for an Out of Network Provider unless: • The Member gets approval to use an Out of Network Provider before the service is given or • The Member requires an Emergency Care admission (see note below). The 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 not to be Medically Necessary.

Provider Network Status	Responsibility to Get Precertification	Comments
BlueCard® Provider	Member **(Except for Inpatient admissions)**	The 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 an Emergency Care admission (see note below). If these are true, then • The Member must get Precertification when required (call Member Services). • The 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 not to be Medically Necessary. • **BlueCard® Providers must obtain Precertification for all Inpatient admissions.**
Note: Precertification is not required to receive Emergency Care. For Emergency Care admissions, You, Your authorized representative or doctor must tell Us as soon as possible.		

How Decisions are Made

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

You are entitled to ask for and get, free of charge, reasonable access to any records concerning Your request. To ask for this information, call the Precertification phone number on the back of Your Identification Card.

If You are not satisfied with Our decision under this section of Your benefits, please refer to the “If You Have a Complaint or an Appeal” section to see what rights may be available to You.

Decision and Notice Requirements

We will review requests for benefits 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, We will follow State laws. If You live in and/or get services in a state other than the State where Your Plan was issued, other state-specific requirements may apply. You may call the phone number on the back of Your Identification Card for more details.

Type of Review	Timeframe Requirement for Decision and Notification
Urgent pre-service review	Seventy-two (72) hours from the receipt of the request
Non-urgent pre-service review	Five (5) business days from the receipt of the request

Concurrent/continued stay review when hospitalized at the time of the request and no previous authorization exists	Twenty-four (24) hours from the receipt of the request, We may request additional information within the first twenty-four (24) hours and then extend to seventy-two (72) hours
Urgent concurrent/continued stay review when request is received more than twenty-four (24) hours before the end of the previous authorization	Twenty-four (24) hours from the receipt of the request
Urgent concurrent/continued stay review when request is received less than twenty-four (24) hours before the end of the previous authorization	Seventy-two (72) hours from the receipt of the request
Non-urgent concurrent/continued stay review	Five (5) business days from the receipt of the request
Post-service review	Thirty (30) calendar days from the receipt of the request

If more information is needed to make Our decision, We will tell the requesting Provider of the specific information needed to finish the review. If We do not get the specific information We need by the required timeframe, We will make a decision based upon the information We have.

We will notify You and Your Provider of Our decision as required by State and federal law. Notice may be given by one (1) or more of the following methods: verbal, written and/or electronic.

Important Information

We may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including Utilization Review, case management, and disease management) and/or offer an alternative benefit if such change is in furtherance of the provision of cost effective, value based and/or quality services.

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

Just because We exempt a process, Provider or claim from the standards which otherwise would apply, it does not mean that We will do so in the future, or will do so in the future for any other Provider, claim or Member. We may stop or modify any such exemption with advance notice.

You may find out whether a Provider is taking part in certain programs by checking Your on-line Provider Directory, on-line Precertification list or contacting the Member Services number on the back of Your Identification Card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then We may use one (1) or more clinical Utilization Review guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to the Plan's Members.

Health Plan Individual Case Management

Our health plan case management programs (case management) help coordinate services for Members with healthcare 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 healthcare needs. This is reached through contact and team work with You and/or Your chosen representative, treating doctor(s), and other Providers.

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

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care that is not listed as a Covered Service. We may also extend Covered Services beyond the benefit maximums of this Plan. We will make Our decisions case-by-case if the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one (1) 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 representative in writing.

WHAT IS COVERED

This section describes the Covered Services available under this Agreement. Covered Services are subject to all the terms and conditions listed in this Agreement including, but not limited to, benefit maximums, Deductibles, Copayments, Coinsurance, exclusions and Medical Necessity requirements.

Please read the following sections of this Agreement for more information about the Covered Services described in this section:

- "Schedule of Cost Share and Benefits" – for amounts You need to pay and benefit limits
- "Requesting Approval for Benefits" – for details on selecting Providers and services that require Precertification

  IMPORTANT: The "Requesting Approval for Benefits" section includes a list of services that require Precertification. For any of the services listed in this section, You should refer to "Requesting Approval for Benefits" to determine if Precertification is required.
- "What is Not Covered (Exclusions)" – for details on services that are not covered

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

You should also know that many Covered Services can be received in several settings, including a doctor's office, an Urgent Care Center, an Outpatient Facility, or an Inpatient Facility. Benefits will often vary depending on where You choose to get Covered Services and this can result in a change in the amount You need to pay.

Community Assistance, Recovery, and Empowerment (CARE) Act

Benefits are provided for all healthcare 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 In Network or Out of Network 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, 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 healthcare 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 provided pursuant to a CARE agreement or CARE plan, regardless if the services are received from In Network or Out of Network Providers.

Cost Shares for Prescription Drugs are subject to Your Plan's benefits. Please see the "Schedule of Cost Share and Benefits" for details on Your Cost Shares. Also, for more information on covered Prescription Drugs, please refer to "What is Covered – Prescription Drugs."

Medical Services

Ambulance Services (Air, Ground and Water)

Medically Necessary ambulance services are covered when:

- You are transported by a State licensed vehicle that is designed, equipped and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics or other certified medical professionals. Ambulance services include medical and mental health Medically Necessary nonemergency ambulance transportation, including psychiatric transportation for safety issues. This includes ground, fixed wing, rotary wing or water transportation. Ambulance services do not include transportation by car, taxi, bus, gurney van, wheelchair van and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Provider.
- And one (1) or more of the following are met:

  You are taken:

  1. From Your home, scene of an accident or Medical Emergency to a Hospital,
  2. Between Hospitals, including when We require You to move from an Out of Network Hospital to an In Network Hospital, or
  3. Between a Hospital, Skilled Nursing Facility (ground transport only) or approved Facility.

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

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

If requested through a 911 Emergency response system or 988 suicide and crisis lifeline call, ambulance charges are covered if it is reasonably believed that a Medical Emergency existed even if You are not transported to a Hospital. Payment of benefits for ambulance services may be made directly to the Provider of service unless proof of payment is received by Us prior to the benefits being paid.

In some areas a 911 Emergency response system or a 988 suicide and crisis lifeline has been established. These systems are to be used only when there is an Emergency Medical Condition that requires an Emergency response.

If You reasonably believe that You are experiencing an Emergency, You should call 911, 988 or go directly to the nearest Hospital Emergency room.

Ground Ambulance

Services are subject to Medical Necessity review by Us.

All scheduled ground ambulance services for nonemergency transports, not including acute Facility to acute Facility transport, require Precertification.

Note: Your payment responsibility to ground ambulance Providers will be at the In Network Cost Share. You will not owe a ground ambulance Provider more than the In Network Cost Sharing amount.

Water Ambulance

Services are subject to Medical Necessity review by Us.

All scheduled ambulance services for nonemergency transports, not including acute Facility to acute Facility transport, require Precertification. We retain the right to select the water transportation Provider.

Air Ambulance

Air ambulance services are subject to Medical Necessity review by Us. We retain the right to select the air ambulance Provider. This includes fixed or rotary wing transportation.

Note: Your payment responsibility to air ambulance Providers will be at the In Network Cost Share. You

will not owe an air ambulance Provider more than the In Network Cost Sharing amount.

Air ambulance services for nonemergency Hospital to Hospital transports require Precertification.

Hospital to Hospital Air Ambulance Transport

Air ambulance transport is for purposes of transferring from one Hospital to another Hospital and is a Covered Service if such air ambulance transport is Medically Necessary, for example, if transportation by ground ambulance would endanger Your health or the transferring Hospital does not have adequate Facilities to provide the medical services needed. Examples of such specialized medical services that are generally not available at all types of Facilities may include, but are not limited to, burn care, cardiac care, trauma care, and critical care. Transport from one (1) Hospital to another Hospital is covered only if the Hospital to which the patient is transferred is the nearest one with medically appropriate Facilities.

Fixed and Rotary Wing Air Ambulance

Fixed wing or rotary wing air ambulance is furnished when Your medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing or rotary wing air ambulance may be necessary because Your condition requires rapid transport to a treatment Facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate Facility. Transport by fixed wing or rotary wing air ambulance may also be necessary because You are located in a place that is inaccessible to a ground or water ambulance Provider.

Autism Spectrum Disorder Services

Behavioral Health Treatment for Autism Spectrum Disorder

Precertification is required for all services related to behavioral health treatment for autism spectrum disorder (see "Requesting Approval for Benefits" for details).

Benefits for Covered Services and supplies provided for behavioral health treatment for autism spectrum disorder are subject to the same Cost Sharing provisions as other medical services or Prescription Drugs covered by this Agreement, except as specifically stated in this section. These benefits are subject to all other terms, conditions, limitations and exclusions, including under "What is Covered."

Services may be provided in a Provider's office, in the Member's home or school or in a Facility, such as the Inpatient or Outpatient department of a Hospital. See the section "Mental Health and Substance Use Disorder (Chemical Dependency) Services" below for more detail.

Our Provider network will be limited to certain qualified autism service Providers who may supervise and employ qualified autism service professionals or paraprofessionals who provide and administer behavioral health treatment for a Provider that has contracted with Anthem.

For purposes of this section "behavioral health treatment" means 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 criteria:

A. The treatment is prescribed by a licensed doctor or is developed by a licensed psychologist.

B. The treatment is provided under a treatment plan prescribed by a qualified autism service Provider and is administered by one (1) of the following:
    1. A qualified autism service Provider
    2. A qualified autism service professional supervised and employed by the qualified autism service Provider responsible for the treatment plan
    3. A qualified autism service paraprofessional supervised and employed by the qualified autism service Provider responsible for the treatment plan

C. The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism service Provider for the specific patient being treated. The treatment plan shall be reviewed no less than once every six (6) months by the qualified autism service Provider and modified whenever appropriate, and shall be consistent with applicable State law that imposes requirements on the provision of behavioral health treatment services to certain persons pursuant to which the qualified autism service Provider does all of the following:
    1. Describes the patient's behavioral health impairments to be treated

2. Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported
3. Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating autism spectrum disorder
4. Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate

D. The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a family member for participating in the treatment program. The treatment plan shall be made available to Anthem upon request.

For purposes of this section "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.

For purposes of this section "intensive behavioral intervention" means any form of applied behavioral analysis that is comprehensive, designed to address all domains of functioning and 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.

For purposes of this section "autism spectrum disorder" means one (1) or more of the disorders defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

For purposes of this section "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 disorder, provided the services are within the experience and competence of the person who is nationally certified, or
- A person licensed as a doctor, 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 disorder, provided the services are within the experience and competence of the licensee.

For purposes of this section "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 defined in the State regulations for an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program, or
    - 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, or
    - Who meets equivalent criteria in the state in which he or she practices if not providing services in California.
- Has training and experience in providing services for autism spectrum disorder pursuant to applicable State law.
- 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.

For purposes of this section "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 set forth in State regulations adopted pursuant to State law concerning the use of paraprofessionals in group practice Provider behavioral intervention services.
- 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.
- 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.

Conditions of Services

- Coverage is not provided for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program.
- The treatment plan shall be made available to Anthem upon request.

Biomarker Testing Services

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:

1. Labeled indications for a test that has been approved or cleared by the FDA;
2. Indicated tests for an FDA-approved Drug;
3. National coverage determinations made by the federal Centers for Medicare and Medicaid Services;
4. Local coverage determinations made by a Medicare Administrative Contractor for California;
5. 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
6. Standards set by the National Academy of Medicine.

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 "If You Have a Complaint or an Appeal" section.

Clinical Trials

Benefits include coverage for services, such as routine patient care costs given to You as a participant in an approved clinical trial if the services are Covered Services under this Agreement. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one (1) of the following:
    a. The National Institutes of Health
    b. The Centers for Disease Control and Prevention
    c. The Agency for Health Care Research and Quality
    d. The Centers for Medicare & Medicaid Services
    e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs

f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review. The peer review requirement shall not be applicable to cancer clinical trials provided by i-iii below:
    i. The Department of Veterans Affairs
    ii. The Department of Defense
    iii. The Department of Energy

2. Studies or investigations done as part of an Investigational new drug application reviewed by the Food and Drug Administration (FDA)
3. Studies or investigations done for drug trials which are exempt from the Investigational new drug application

Your Agreement may require You to use an In Network Provider to maximize Your benefits.

Routine patient care costs include items, services and drugs provided to You in connection with an approved clinical trial and that would otherwise be covered by this Agreement.

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.

Dental Services

Preparing the Mouth for Medical Treatments

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

- Evaluation
- Orthognathic (jawbone) surgery
- Dental X-rays
- Extractions, including surgical extractions
- Anesthesia

Admissions for dental care up to three (3) days of Inpatient Hospital services when a Hospital stay is Medically Necessary.

Dental Anesthesia

General anesthesia and associated Facility charges for dental procedures in a Hospital or Ambulatory Surgery Center are covered if the Member is:

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

Medically Necessary dental or orthodontic services are covered if they are integral to reconstructive surgery for cleft palate procedures. Cleft palate is a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

Note: If You decide to receive dental services that are not covered under this Agreement, an In Network Provider who is a dentist may charge You his or her usual and customary rate for those services. Prior to providing You with dental services that are not a Covered Service, the dentist should provide a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If You would like more information about the dental services that are covered under this Agreement, please call Member Services at the phone number on Your ID Card.

Diabetes Services

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

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

    Note: This equipment and supplies are covered in the "Medical Supplies, Durable Medical Equipment and Appliances" benefit.
2. Diabetes Outpatient self-management education services, which:
    a. Are designed to teach the Member who is a patient, and the patient's family, about the disease process and the daily management of diabetic therapy.
    b. Include self-management training, education and nutrition therapy to enable the Member to properly use the equipment, supplies and medications necessary to manage the disease.
    c. Are supervised by a doctor.

    Note: Diabetes education services are covered at no cost to the Member under the "Preventive Care Services" benefit.
3. The following medications and supplies are covered in the "Prescription Drugs" benefit:
    a. Insulin, glucagon and other Prescription Drugs for the treatment of diabetes
    b. Insulin syringes
    c. Urine testing strips and lancet puncture devices

    Note: These items must be obtained either from a Retail Pharmacy or through the Home Delivery Prescription Drug program.
4. Screening for gestational diabetes and type 2 diabetes mellitus are covered in the "Preventive Care Services" benefit.

Diagnostic Services Outpatient

Your Agreement includes benefits for tests or procedures to find or check a condition when specific symptoms exist.

Tests must be ordered by a Provider and include diagnostic services ordered before a surgery or Hospital admission. Benefits include the following services:

Diagnostic Laboratory and Pathology Services

Diagnostic Imaging Services and Electronic Diagnostic Tests

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

Advanced Imaging Services

Benefits are also available for advanced imaging services, which include, but are not limited to:

- CT scan
- CTA scan
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Magnetic resonance spectroscopy (MRS)
- Nuclear cardiology
- PET scans
- PET/CT fusion scans
- QCT bone densitometry
- Diagnostic CT colonography

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

Doctor (Physician) Visits

Covered Services include:

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

Retail Health Clinic Care for limited basic healthcare services to Members on a “walk-in” basis. These clinics are normally found in major Pharmacies or retail stores. Healthcare services are typically given by physician assistants or nurse practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

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

Allergy Services for Medically Necessary allergy testing and treatment, including allergy serum and allergy shots.

Health Education for counseling, programs and material to help You take an active role in protecting and improving Your health, including programs for tobacco cessation, chronic conditions (such as diabetes and asthma) and stress management. At Anthem Blue Cross, We believe it is important for You to have control of Your healthcare and have access to health programs to help You establish or maintain good health habits.

Osteoporosis for services related to diagnosis, treatment, and appropriate management of osteoporosis including, but not limited to, all FDA-approved technologies, including bone mass measurement technologies as deemed Medically Necessary.

Online Visits. Covered Services include a medical visit with the doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal laboratory or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for Referrals to doctors outside the online care panel, benefit Precertification, or doctor to doctor discussions except as approved under the “What Is Covered” section. For Mental Health and Substance Use Disorder Online Visits, see the “Mental Health and Substance Use Disorder (Chemical Dependency) Services” section.

Telehealth Covered Services that are appropriately provided by a telehealth Provider in accordance with applicable legal requirements will be eligible for benefits under this Agreement. Telehealth means the mode of delivering healthcare or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and mental health. In-person contact between a healthcare

Provider and the patient is not required for these services, and the type of setting where these services are provided is not limited. Telehealth does not include the use of texting. Benefits for telehealth are provided on the same basis and to the same extent as the same Covered Service provided through in-person diagnosis, consultation, or treatment. Coverage shall not be limited only to services delivered by select third-party corporate telehealth Providers. If You have any questions about this coverage, or receive a bill please contact Member Services at the number on the back of Your Identification Card.

Specialist e-Consultations are electronic communications between Your PCP, who is rendering care to You, and an In Network Specialist to help evaluate Your condition or diagnosis. The consultation will be at no cost to You. Your PCP may consider the information provided by the In Network Specialist in determining Your treatment. The consultation will be conducted using electronic information and communication technologies and the results may be documented in an electronic health record.

Phenylketonuria (PKU) benefits for the testing and treatment of phenylketonuria (PKU) are paid on the same basis as any other medical condition. Coverage for treatment of PKU shall include those formulas and special food products that are part of a diet prescribed by a licensed doctor and managed by a healthcare professional in consultation with a doctor who specializes in the treatment of metabolic disease and who is In Network or to whom You have received an Authorized Referral. The diet must be deemed Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

The cost of the necessary formulas and special food products is covered only as it exceeds the cost of a normal diet. "Formula" means an enteral product or products for use at home. The formula must be prescribed by a doctor or nurse practitioner, or ordered by a registered dietician upon Referral by a healthcare Provider authorized to prescribe dietary treatments, and is Medically Necessary for the treatment of PKU. Formulas and special food products used in the treatment of PKU that are obtained from a Pharmacy are covered under Your Agreement's Prescription Drug benefits. Formulas and special food products that are not obtained from a Pharmacy are covered under this benefit.

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

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

Note: It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one (1) gram of protein per serving.

Emergency Care Services

If You are experiencing an Emergency please call the 911 Emergency response system or 988 suicide and crisis lifeline or visit the nearest Hospital for treatment.

Medically Necessary services will be covered whether You get care from an In Network or Out of Network Provider. For information on Your Cost Shares for Emergency Services, please see the "Schedule of Cost Share and Benefits," the subsection "Inter-Plan Arrangements" in "How Your Claims are Paid" and the benefit "Ambulance Services" above.

Benefits are available in a Hospital Emergency room or independent freestanding emergency department for services and supplies to treat the onset of symptoms for an Emergency, which is defined below.

Emergency (Emergency Medical Condition)

"Emergency" or "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: 1) placing the patient's health in serious jeopardy, 2) serious impairment to bodily functions, or 3) serious dysfunction of any bodily organ or part. Such conditions include, but are not limited to, chest pain, stroke, poisoning, serious breathing problems, unconsciousness, severe burns or cuts, uncontrolled bleeding, or seizures and such other

acute conditions.

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

Emergency Medical Condition includes a Psychiatric Emergency Medical Condition, which is a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

- 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.

Emergency Care means a medical or behavioral health exam done in the Emergency department of a Hospital, or independent freestanding emergency department, and includes services routinely available in the Emergency department to evaluate an Emergency Medical Condition. It includes any further medical or behavioral health exams and treatment required to stabilize the patient.

Stabilize, with respect to an Emergency Medical Condition, regardless of the department of the Hospital in which such further examination or treatment is furnished, means: To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a Facility. With respect to a pregnant woman who is having contractions, the term “stabilize” also means to deliver (including the placenta), if there is inadequate time to affect a safe transfer to another Hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Medically Necessary services will be covered whether You get care from an In Network or Out of Network Provider. Emergency Care You get from an Out of Network Provider will be covered as an In Network service, but You may have to pay the difference between the Out of Network Provider’s charge and the Reasonable and Customary Value for water ambulance services received in California. If Emergency Care is rendered within California by an Out of Network Provider (with the exception of a water ambulance Provider), You will not be responsible for any amount in excess of the Reasonable and Customary Value and You will only pay Your Copayment or Coinsurance and any applicable Deductible. For Emergency Services rendered outside of California by an Out of Network Provider, reimbursement is based on the Inter-Plan Arrangements for out-of-area services.

If You are admitted to the Hospital from the Emergency room, be sure that You or Your doctor calls Us as soon as possible. If You or Your doctor does not call Us, You may have to pay for services that are determined to be not Medically Necessary.

Treatment You get after Your condition has stabilized is not Emergency Care. If You continue to get care from an Out of Network Provider, Covered Services will not be available unless We agree to cover them as an Authorized Service. However, if You receive Covered Services at an In Network Facility in California at which, or as a result of which, You receive services provided by an Out of Network Provider, You will pay no more than the same Cost Sharing that You would pay for the same Covered Services received from an In Network Provider.

Fertility Preservation Services

Fertility preservation services to prevent iatrogenic infertility are covered when Medically Necessary. Iatrogenic infertility means infertility caused directly or indirectly, as a possible side effect, by surgery, chemotherapy, radiation, or other covered medical treatment. Note that this benefit covers fertility preservation services only, as described. Fertility preservation services under this section do not include testing or treatment of infertility. “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.

Gender Identity

Transgender Services

Benefits are provided for services and supplies in connection with gender transition when a doctor has

diagnosed You with Gender Identity Disorder or Gender Dysphoria. Benefits are provided according to the terms and conditions of this Agreement that apply to all other medical conditions, including Medical Necessity requirements, Precertification and exclusions for cosmetic services.

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

Transgender Surgery Travel Expense

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

Travel expenses include the following for the Member and one (1) companion:

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

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

Habilitative Services

Habilitative Services are healthcare services and devices that help You keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings.

Note: Limits for Habilitative and Rehabilitative Services shall not be combined. Anthem does not have limits on Habilitative or Rehabilitative Services.

Home Care Services

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

Covered Services include, but are not limited to:

- Visits by a licensed healthcare professional, including nursing services by an R.N. or L.P.N., a therapist or home health aide
- Infusion therapy; refer to "Therapy Services Outpatient," later in this section for more information
- Medical/social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the home healthcare Provider. Other organizations may give services only when approved by Us, and their duties must be assigned

and supervised by a professional nurse on the staff of the home healthcare Provider.

- Medical supplies
- Durable medical equipment
- Therapy services
- Private duty nursing in the home

Limitations:

- Limited to up to two (2) hours per visit for visits by a nurse, medical social worker or physical, occupational, or speech therapist and up to four (4) hours per visit for visits by a home health aide and
- Up to three (3) visits per day.
- The ordering doctor must be treating the illness or injury necessitating the home healthcare and renew the order for these services once every thirty (30) days.
- Providers in California must be a California licensed Home Healthcare Agency or Visiting Nurse Association.
- These limitations and home healthcare services (as described in this section) do not include behavioral health treatment for autism spectrum disorder (see “Autism Spectrum Disorder Services” above).

Benefits may also be available for Inpatient Hospital Care in Your home. These benefits are separate from the Home Care Services benefit and are described in the “Inpatient Hospital Care” section below.

Hospice Care

Hospice care is a coordinated plan of home, Inpatient and/or Outpatient care that provides palliative, supportive medical, psychological, psychosocial and other health services to terminally ill patients.

Covered Services and supplies are those listed below if part of an approved treatment plan and when rendered by a hospice Provider for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care means appropriate care which controls pain and relieves symptoms, but is not meant to cure a terminal illness.

- Care rendered by an interdisciplinary team with the development and maintenance of an appropriate plan of care
- Short-term Inpatient Facility care when required in periods of crisis or as respite care
- Skilled nursing services, home health aide services and homemaker services provided by or under the supervision of a registered nurse
- Social services and counseling services provided by a licensed social worker
- Nutritional support such as intravenous hydration and feeding tubes
- Physical therapy, occupational therapy, speech therapy and respiratory therapy
- Pharmaceuticals, medical equipment and supplies necessary for the palliative treatment of Your condition including oxygen and related respiratory therapy supplies
- Bereavement services, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following the Member’s death. Bereavement services are available to surviving covered family members.

In order to receive hospice benefits 1) Your doctor and the hospice medical director must certify that You are terminally ill and have approximately twelve (12) months to live, and 2) Your doctor must consent to Your care by the hospice and must be consulted in the development of Your treatment plan. You may access hospice care while also participating in a clinical trial or continuing disease modifying therapy, as ordered by Your treating Provider. Disease modifying therapy treats the underlying terminal illness. The hospice must maintain a written treatment plan on file and furnish to Us upon request.

Covered Services beyond those listed above as ordered by Your treating Provider, may be available while in hospice and are detailed in other sections of this Agreement.

Hospital Services

Inpatient Hospital Care

Precertification is not required for Emergency and Inpatient Hospital stays for the delivery of a child or mastectomy surgery, including the length of Hospital stays associated with mastectomy and/or breast reconstruction surgery for breast cancer.

Covered Services include acute care in a Hospital setting. Benefits for room, board, nursing and ancillary services include:

- A room with two (2) or more beds
- A private room. The most the Agreement will cover for private rooms is the Hospital's average semi-private room rate unless it is Medically Necessary that You use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by Us. The unit must have facilities, equipment and supportive services for intensive care or critically ill patients.
- Routine nursery care for newborns during the mother's normal Hospital stay
- Meals, special diets
- General nursing services
- Operating, childbirth and treatment rooms and equipment
- Prescribed drugs
- Anesthesia, anesthesia supplies and services given by the Hospital or other Provider
- Medical and surgical dressings and supplies, casts, and splints
- Diagnostic services
- Therapy services
- Acute psychiatric Facilities which is a Hospital specializing in psychiatric treatment or a designated psychiatric unit of a Hospital licensed by the State to provide twenty-four (24) hour acute Inpatient care. For the purpose of this Agreement, the term acute psychiatric Facility also includes a psychiatric health Facility which is an acute twenty-four (24) hour Facility as defined by California law. Also see the definition of "Residential Treatment Center."

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

Inpatient Professional Services

Covered Services include:

- Medical care visits
- Intensive medical care when Your condition requires it
- Treatment for a health problem by a doctor who is not Your surgeon while You are in the Hospital for surgery. Benefits include treatment by two (2) or more doctors during one (1) Hospital stay when the nature or severity of Your health problem calls for the skill of separate doctors.
- A personal bedside exam by another doctor when asked for by Your doctor. Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.
- Surgery and general anesthesia
- Newborn exam. A doctor other than the one who delivered the child must do the exam.

- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology

Outpatient Hospital Care

Your Agreement includes Covered Services in an:

- Outpatient Hospital
- Freestanding Ambulatory Surgical Center
- Mental Health and Substance Use Disorder Facility
- Other Facilities approved by Us

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

- Surgical rooms and equipment
- Prescription Drugs, including Specialty Drugs
- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility
- Medical and surgical dressings and supplies, casts, and splints
- Diagnostic services
- Therapy services
- Chemotherapy
- Infusion therapy
- Radiation
- Dialysis

Maternity and Reproductive Health Services

Maternity Services

Covered Services include services needed during a normal or complicated pregnancy and for services needed for a miscarriage. Maternity services incurred prior to Your Effective Date are not covered.

Covered maternity services include:

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed nurse midwife
- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent and screening of a newborn for genetic diseases provided through a program established by law or regulation
- Prenatal, postnatal, and postpartum services
- Fetal screenings, which are genetic or chromosomal tests of the fetus. Prenatal genetic testing for specific genetic disorders for which genetic counseling is available
- Expanded alpha-fetoprotein testing, a Statewide prenatal genetic testing program administered by California's State Department of Health Services, with zero Cost Share

Note: Under federal law, We may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than forty-eight (48) hours after vaginal birth, or less than ninety-six (96) hours after a cesarean section (C-section). However, federal law as a rule does not stop the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours, or ninety-six (96) hours, as applicable. In any case, as provided by federal law, We may not require a Provider to get Precertification from Us before prescribing a length of stay which is not more than forty-eight (48) hours for a vaginal birth or ninety-six (96) hours after a C-section.

Please see "Continuity of Care" in the "How Your Coverage Works" section regarding a request to continue to see the same Provider for services.

Abortion Services

Benefits include all abortion and abortion-related services, including pre-abortion and follow-up services. Coverage for Outpatient abortion services does not require precertification. Covered Services are available at no cost.

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

Family Planning Services

Please see the benefit "Preventive Care Services" below for additional information on women's contraceptives, sterilization procedures and counseling. Anthem 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.

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 In Network Provider, unless there is no Generic equivalent, the Generic is unavailable or the Generic would be medically inappropriate as determined by Your doctor at which time the brand name would be covered with no Deductible, Copayment or Coinsurance when obtained from an In Network Provider. Some categories and classes of contraceptives do not have Generics available and, in each of these categories, at least one brand name is available at a $0 Cost Share when You receive it from an In Network Provider. If Your Provider determines that a brand name with an available Generic therapeutic equivalent is necessary because a Generic 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 In Network Provider. If there is one (1) or more therapeutic equivalent of a contraceptive drug, device or product, Anthem will cover at least one (1), if available, at a $0 Cost Share when obtained from an In Network Provider. Certain contraceptives are covered under the "Preventive Care Services" or the "Maternity and Reproductive Health Services" benefits. Please see those sections 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, provided at no cost at In Network Pharmacies, without medical management restrictions. Prior authorization is not required.
- Voluntary tubal ligation and other similar sterilization procedures.
- Vasectomies and related services. Covered Services are available with no Copayment, Coinsurance, or other Cost Sharing.
- 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.

Medical Supplies, Durable Medical Equipment and Appliances

Durable Medical Equipment and Medical Devices

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

- Is meant for repeated use and is not disposable
- Is used for a medical purpose and is of no further use when medical need ends
- Is meant for use outside a medical Facility

- Is only for the use of the patient
- Is made to serve a medical use
- Is ordered by a Provider

Benefits include purchase-only equipment and devices, purchase or rent-to-purchase equipment and devices, and continuous rental equipment and devices. Continuous rental equipment must be approved by Us. We may limit the amount of coverage for ongoing rental of equipment. We may not cover more in rental costs than the cost of simply purchasing the equipment.

Benefits include repair and replacement costs, except when damage is due to neglect. Benefits also include supplies and equipment needed for the use of the equipment or device.

Coverage is limited to the standard item of equipment that adequately meets Your medical needs. We decide whether to rent or purchase the equipment, and We select the vendor. You must return the equipment to Us or pay Us the fair market price of the equipment when We are no longer covering it. We cover the following durable medical equipment for use in Your home (or another location used as Your home):

- Standard curved handle or quad cane and replacement supplies
- Standard or forearm crutches and replacement supplies
- Dry pressure pad for a mattress
- IV pole
- Enteral pump and supplies
- Bone stimulator
- Cervical traction (over door) equipment
- Phototherapy blankets for treatment of jaundice in newborns
- Non-segmental home model pneumatic compressor for the lower extremities

Oxygen and equipment for its administration are also Covered Services.

Hearing Supplies

Benefits are available for Members who are certified as deaf or hearing impaired by either a doctor or licensed audiologist. Covered Services include:

- Routine hearing screenings (see the benefit “Preventive Care Services” below)
- Hearing exams to determine the need for hearing correction (see the benefit “Preventive Care Services” below)
- Services related to the ear or hearing, such as Outpatient care to treat an ear infection and Outpatient Prescription Drugs, supplies and supplements (see the benefits “Doctor (Physician) Visits” above and “Prescription Drugs” below)
- Cochlear implants - A surgically implanted device that allows hearing

Orthotics

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

Prosthetics

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

Benefits include the purchase, fitting, adjustments, repairs and replacements. Covered Services may

include, but are not limited to:

- Artificial limbs and accessories
- One (1) pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes
- Breast prosthesis (whether internal or external) after a mastectomy, as required by the Women's Health and Cancer Rights Act. Custom-made prostheses when Medically Necessary and up to three (3) brassieres required to hold a prosthesis every twelve (12) months and adhesive skin support attachment for use with external breast prosthesis.
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury or congenital defect
- Prosthetic devices (except electronic voice producing machines) to restore a method of speaking after laryngectomy
- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care
- Restoration prosthesis (composite facial prosthesis)

Medical and Surgical Supplies

Your Agreement includes coverage for medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes, needles, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services do not include items often stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Diabetic Equipment and Supplies

Your Agreement includes coverage for diabetic equipment and supplies (insulin pump, glucose monitor, lancets and test strips, etc.).

Blood and Blood Products

Your Agreement also includes coverage for the administration of blood products.

Ostomy and Urological Supplies

Your Agreement includes coverage for ostomy and urological supplies soft goods formulary (listed in the generic):

- Adhesives - liquid, brush, tube, disc or pad
- Adhesive removers
- Belts - ostomy
- Belts - hernia
- Catheters
- Catheter insertion trays
- Cleaners
- Drainage bags/bottles - bedside and leg
- Dressing supplies
- Irrigation supplies
- Lubricants
- Miscellaneous supplies - urinary connectors; gas filters; ostomy deodorants; drain tube attachment devices; soma caps tape; colostomy plugs; ostomy inserts; irrigation syringes, bulbs and pistons; tubing; catheter clamps, leg straps and anchoring devices; penile or urethral clamps and compression devices

- Pouches - urinary, drainable, ostomy
- Rings - ostomy rings
- Skin barriers
- Tape - all sizes, waterproof and non-waterproof

Asthma Treatment Equipment and Supplies

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

Mental Health and Substance Use Disorder (Chemical Dependency) Services

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

Precertification is required for certain Mental Health and Substance Use Disorder services except in an Emergency (for a list of services that require Precertification, see "Requesting Approval for Benefits").

(See the "Autism Spectrum Disorder Services" section above for coverage and Precertification requirements for those services.)

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

If We fail to arrange services for the Medically Necessary treatment of a Mental Health or Substance Use Disorder, You may arrange to obtain care from any appropriately licensed Provider(s), regardless of whether the Provider is In Network or Out of Network, so long as Your first appointment with the Provider or admission to the Provider occurs no more than 90 calendar days after the date the request for covered Medically Necessary Mental Health or Substance Use Disorder services was initially submitted to Us. If an appointment or admission to a Provider is not available within 90 calendar days of initially submitting a request, You may arrange an appointment or admission for the earliest possible date outside the 90-day window so long as the appointment or admission was confirmed within 90 days.

If you receive services for the Medically Necessary treatment of a Mental Health or Substance Use Disorder from an Out of Network Provider, We will reimburse all claims from the Provider(s) for the Medically Necessary treatment of a Mental Health or Substance Use Disorder services delivered to You by the Provider(s). You will pay no more than the same Cost Sharing that You would pay for the same Covered Services received from an In Network Provider.

Coverage is also provided for Emergency services for treatment of Mental Health and Substance Use Disorders, 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 received outside Anthem's Service Area. Cost Sharing for Emergency Services received from Out of Network Providers will be the same as In Network 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.

Covered Services include the following:

Outpatient Office Visits, which include:

- Individual and group mental health evaluation and treatment
- Outpatient services to monitor drug therapy and medication management
- Intensive community-based treatment, including assertive community treatment and intensive

case management

- Narcotic (opioid) treatment programs and methadone maintenance treatment
- Outpatient Prescription Drugs prescribed for Mental Health and Substance Use Disorder pharmacotherapy, including office-based opioid treatment. For more information on covered Prescription Drugs, please refer to "What is Covered – Prescription Drugs."
- Individual, family and group substance use and mental health counseling
- Medical treatment for withdrawal symptoms
- Behavioral health treatment for autism spectrum disorder delivered in an office setting
- Online visits. Covered Services include a medical visit with the doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal laboratory or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for Referrals to doctors outside the online care panel, benefit Precertification, or doctor to doctor discussions except as approved under the "What Is Covered" section
- Urgent Care services rendered inside and outside the Anthem's Service Area

Other Outpatient Items and Services, including:

- Partial Hospitalization Programs and Intensive Outpatient Programs
- Behavioral health treatment for autism spectrum disorder delivered outside an office setting, such as in the home or a school setting
- Outpatient psychological and neuropsychological testing
- Day treatment programs for Substance Use Disorder
- Intensive Outpatient Programs for Substance Use Disorder
- Multidisciplinary treatment for an intensive Outpatient psychiatric treatment program for mental health
- Electroconvulsive therapy
- 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

Other Services

- 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
- 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

Inpatient Services in a Joint Commission on Accreditation of Healthcare Organization-accredited Hospital or any Facility that We must cover per State law. Inpatient benefits include the following:

- Inpatient psychiatric hospitalization, including room and board, drugs, and services of doctors and other Providers who are licensed healthcare 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, doctor services, drugs, dependency recovery services, education and counseling
- Residential treatment which is specialized twenty-four (24) hour treatment in a licensed Joint Commission on Accreditation of Healthcare Organization or Commission on Accreditation of Rehabilitation Facilities (CARF)-accredited 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)
- Behavioral health treatment for autism spectrum disorder delivered in an Inpatient Facility
- 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/Surgeon fee when billed separately from the Inpatient services.

Providers who can provide Covered Services include:

- Psychiatrist
- Psychologist
- Licensed clinical social worker (L.C.S.W.)
- Mental health clinical nurse specialist
- Licensed marriage and family therapist (L.M.F.T.)
- Licensed professional counselor (L.P.C.), or
- Qualified autism service Providers, qualified autism service professionals and qualified autism service paraprofessionals. See the definitions of these in the section “Autism Spectrum Disorder Services” above.
- Registered psychological assistant, as described in the California Business and Professions Code
- Psychology trainee or person supervised as set forth in the California Business and Professions Code
- Associate clinical social worker functioning pursuant to the California Business and Professions Code
- Associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to the California Business and Professions Code
- Associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to the California Business and Professions Code

Preventive Care Services

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

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

Covered Services fall under the following broad groups:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force.

Examples include screenings for:

- Breast cancer
- Cervical cancer
- High blood pressure
- Type 2 diabetes mellitus
- Cholesterol
- Child or adult obesity
- Colorectal cancer screenings, including a required colonoscopy following a positive result on a test or procedure, other than a colonoscopy
- Preexposure prophylaxis (PrEP) for prevention of HIV infection

2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration, including:
    - The American Academy of Pediatrics Bright Futures Recommendations for pediatric preventive healthcare and
    - The Uniform Screening Panel recommended by the U.S. Department of Health and Human Services Secretary's Discretionary Advisory Committee on Heritable Disorders in Newborns and Children
4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
    - Women's contraceptives, sterilization procedures and counseling. This includes the eighteen (18) FDA-approved contraceptive methods:
        - Generic contraceptive drugs unless there is no Generic equivalent, the Generic Drug is unavailable or the Generic Drug would be medically inappropriate as determined by Your doctor at which time the Brand Name Drug would be covered with no Deductible, Copayment or Coinsurance when obtained from an In Network Pharmacy. Some categories and classes of contraceptives do not have Generics 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 In Network Provider. If Your Provider determines that a Brand Name Drug with an available Generic therapeutic equivalent is necessary because a Generic therapeutic equivalent drug is not appropriate for You, You may obtain coverage of the Brand Name Drug with a $0 Cost Share if Your Provider submits an exception request to receive prior approval. Your doctor must complete a contraceptive exception form and return it to Us. You or Your doctor can find the form online at www.anthem.com/ca 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 Share. Brand Name Drugs (with a Generic equivalent) will be covered as Preventive Care benefits when Medically Necessary, otherwise they will be covered under the Prescription Drug Benefit subject to the applicable Prescription Drug Deductible, Copayment and/or Coinsurance amounts as described in the "Schedule of Cost Share and Benefits." Also see "Prescription Drugs" below. If there is one (1) or more therapeutic equivalent of a contraceptive drug, device or product, Anthem will cover at least one (1), if available at a $0 Cost Share.
        - Injectable contraceptives and patches
        - Contraceptive devices such as diaphragms, intra-uterine devices (IUDs), cervical caps and implants
        - Over-the-counter FDA-approved contraceptives for women as prescribed
        - Family planning counseling and education
        - Voluntary sterilization procedures
        - Education and counseling as to contraception and follow-up services related to the drugs, devices, products and procedures including, but not limited to, managing side effects and counseling for continued adherence and device

insertion and removal
    - For FDA-approved, Self-Administered hormonal contraceptives, up to a twelve (12) month supply is covered when dispensed or furnished at one (1) time by a Provider or pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies
- Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one (1) per calendar Year or as required by law
- Gestational diabetes screening
- Well woman visits that are age and developmentally appropriate, including preconception and prenatal care
- Screening and counseling for sexually transmitted infections
- Screening and counseling for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence, and
- testing for human papillomavirus (HPV)

5. Human papillomavirus (HPV) vaccine for Members for whom the vaccine is approved by the FDA
6. Home test kits for sexually transmitted diseases (STD), including any laboratory costs of processing the kit:
    - Must be deemed medically necessary or appropriate and ordered directly by a clinician or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs, when ordered by an In Network Provider and
    - 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
7. Preventive care services for 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 Pharmacy
    - Nicotine replacement therapy products obtained at a Retail or Home Delivery Pharmacy when prescribed by a Provider, including over-the-counter (OTC) nicotine gum, lozenges and patches
8. Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider including:
    - Aspirin
    - Folic acid supplement
    - Bowel preparations

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

You may call Member Services at the number on Your Identification Card for more details about these services or view the federal government's websites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits
- http://www.ahrq.gov
- http://www.cdc.gov/vaccines/acip/index.html

Rehabilitative Services

Rehabilitative Services are healthcare services that help You keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric Rehabilitative Services in a variety of Inpatient and/or Outpatient settings.

Note: Limits for Habilitative and Rehabilitative Services shall not be combined. Anthem does not have

limits on Habilitative or Rehabilitative Services.

Skilled Nursing Facility

When You require Inpatient skilled nursing and related services for convalescent and rehabilitative care, Covered Services are available if the Facility is licensed or certified under State law as a Skilled Nursing Facility. Custodial care is not a Covered Service.

Covered services include:

- Doctor and nursing services
- Room and board
- Drugs prescribed by a doctor as part of Your plan of care in the Skilled Nursing Facility
- Durable medical equipment if Skilled Nursing Facilities ordinarily furnish the equipment
- Imaging and laboratory services that Skilled Nursing Facilities ordinarily provide
- Medical social services
- Blood, blood products and their administration
- Medical supplies
- Physical, occupational and speech therapy, and
- Respiratory therapy

Surgery

Your Agreement covers surgical services on an Inpatient or Outpatient basis, including surgeries performed in a doctor's office or an Ambulatory Surgical Center. Covered Services include:

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

Oral Surgery

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

Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia; or other craniofacial anomalies associated with cleft palate
- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part
- Oral/surgical correction of accidental injuries
- Treatment of non-dental lesions, such as removal of tumors and biopsies
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses

Reconstructive Surgery

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy.

Note: This section does not apply to orthognathic surgery.

Mastectomy Notice

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

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

Bariatric Surgery

Services and supplies will be provided in connection with Medically Necessary surgery for weight loss, only for morbid obesity. You or Your doctor must obtain Precertification for all bariatric surgical procedures.

Bariatric Travel Expense

The following travel expense benefits will be provided in connection with a covered bariatric surgical procedure only when the Member's home is fifty (50) miles or more from the nearest bariatric surgery Facility. All travel expenses must be approved by Anthem in advance.

- Transportation for the Member to and from the surgery Facility up to $130 per trip for a maximum of three (3) trips (one (1) pre-surgical visit, the initial surgery and one (1) follow-up visit)
- Transportation for one (1) companion to and from the surgery Facility up to $130 per trip for a maximum of two (2) trips (the initial surgery and one (1) follow-up visit)
- One (1) hotel room, double occupancy for the Member and one (1) companion not to exceed $100 per day for the pre-surgical visit and the follow-up visit, up to two (2) days per trip or as Medically Necessary. Limited to one (1) room, double occupancy
- Hotel accommodations for one (1) companion not to exceed $100 per day for the duration of the Member's initial surgery stay, up to four (4) days. Limited to one (1) room, double occupancy

Member Services will confirm if the bariatric travel benefit is provided in connection with access to the selected bariatric surgery Facility. Details regarding reimbursement can be obtained by calling the Member Services toll free at the phone number on Your ID Card. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

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

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

Therapy Services Outpatient

Physical Medicine Therapy Services

Your Agreement includes coverage for therapy services. Some physical therapy services may also be a Habilitative Services. Habilitation Services are covered under the same terms and conditions applied to Rehabilitation Services under the Agreement (see the benefits "Habilitative Services" and "Rehabilitative Services" above for details). To be a Covered Service, the therapy must be Medically Necessary. Treatment is covered when provided by a physical, occupational or speech therapist who acts within the scope of their license. Coverage for physical therapy and occupational or speech therapy services requires Referral by a doctor. Covered Services include:

- **Physical Therapy** – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat,

physical agents, bio-mechanical and neuro-physiological principles and devices. It does not include massage therapy services at spas or health clubs.

- **Speech Therapy and Speech-Language Pathology (SLP) Services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.
- **Occupational Therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- **Acupuncture** – Treatment by an acupuncturist who acts within the scope of their license using needles along specific nerve pathways to ease pain. All supplies used in conjunction with the acupuncture treatment will be included in the payment for the visit and will not be reimbursed in addition to the visit.

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation** – Medical evaluation, training, supervised exercise, and psychosocial support to care for You after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Dialysis** – Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an Outpatient dialysis Facility or doctor's office. Covered Services also include home dialysis and training for You and the person who will help You with home self-dialysis.
- **Infusion Therapy** – Doctor prescribed infusion therapy (each course of therapy must be Medically Necessary). If services are performed in the home, those services must be billed by and performed by a Provider licensed by State and local laws. See the section "Prescription Drugs Administered by a Medical Provider" for more details.
    - Drugs and other substances used in infusion therapy
    - Professional services to order, prepare, dispense, deliver, administer, train or monitor, including clinical Pharmacy support and any drugs or other substances used in a course of therapy, including, but not limited to, parenteral therapy and total parenteral nutrition (TPN)
    - Durable, reusable supplies, and durable medical equipment including, but not limited to, pump, pole and electric monitor
    - Blood transfusions, including blood processing and the cost of un-replaced blood and blood products
- **Pulmonary Rehabilitation** – Includes Outpatient short-term respiratory care to restore Your health after an illness or injury.
- **Radiation Therapy** – Treatment of an illness by X-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, administration and treatment planning.
- **Respiratory/Inhalation Therapy** – Includes the use of dry or moist gases in the lungs, non-pressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood

This section describes benefits for certain covered transplant procedures that You get during the transplant benefit period. Any Covered Services related to a covered transplant procedure, received before or after the transplant benefit period, are covered under the regular Inpatient and Outpatient benefits described elsewhere in this Agreement.

Covered Transplant Procedure

A covered transplant procedure is any Medically Necessary human organ and bone marrow/stem cell/cord blood transplants and infusions as determined by Anthem, including necessary acquisition procedures, mobilization, collection and storage, and including Medically Necessary myeloablative or reduced intensity preparative chemotherapy or radiation therapy or a combination of these therapies.

The initial evaluation, any added tests to determine Your eligibility as a candidate for a transplant by Your Provider, and the collection and storage of bone marrow/stem cells are included in the covered transplant procedure benefit regardless of the date of service.

Unrelated Donor Searches

Your Agreement includes human leukocyte antigen (HLA) testing, also referred to as histocompatibility locus antigen testing, for A, B and DR antigens, for use in bone marrow transplantation per transplant. The testing must be done at an accredited Facility.

When approved by Us, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell/cord blood transplants performed by an authorized licensed registry for bone marrow/stem cell/cord blood transplants for a covered transplant procedure. Donor search charges are limited to the ten (10) best matched donors per transplant, identified by an authorized registry.

Live Donor Health Services

Medically Necessary charges for the procurement, performed by an authorized licensed registry for bone marrow/stem cell/cord blood transplants, of an organ from a live donor are covered up to the Negotiated Fee Rate, including complications from the donor procedure for up to ninety (90) days from the date of procurement. A live donor is a person who provides the organ, part of an organ, or tissue for transplantation while alive to another person.

Transplant Benefit Period

The transplant benefit period starts one (1) day prior to a covered transplant solid organ procedure and one (1) day prior to high dose chemotherapy or preparative regimen for bone marrow stem cell transplants and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the In Network transplant Provider agreement. Contact the case manager for specific In Network transplant Provider information for services received at or coordinated by an In Network transplant Provider Facility. Services received from an Out of Network transplant Facility start on the day of the covered transplant procedure and continue to the date of discharge.

Prior Approval and Precertification

In order to maximize Your benefits, You will need to call Our transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. We will assist You in maximizing Your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, In Network transplant Provider requirements, or exclusions are applicable. Please call Us to find out which Hospitals are In Network transplant Providers. Contact the Member Services telephone number on the back of Your Identification Card and ask for the transplant coordinator. Even if We issue a prior approval for the covered transplant procedure, You or Your Provider must call Our transplant department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Precertification is required before We will cover benefits for a transplant. Your doctor must certify, and We must agree, that the transplant is Medically Necessary. Your doctor should send a written request for Precertification to Us as soon as possible to start this process. Please see the “Requesting Approval

for Benefits" section for how to obtain Precertification.

Please note that there are instances where Your Provider requests approval for human leukocyte antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The collection and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search services performed by an authorized registry and/or a collection and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Coverage will not be denied, if otherwise available under this Agreement for the costs of transplantation services based upon HIV status.

Transportation and Lodging

We will provide travel expenses incurred by the Member, up to a maximum $10,000 per transplant, as determined by Us, when You obtain prior approval and are required to travel more than seventy-five (75) miles from Your residence to reach the Facility where Your transplant evaluation and/or transplant work-up and covered transplant procedure will be performed. Our assistance with travel expenses includes transportation to and from the Facility and lodging for the patient and one (1) companion. Travel costs for the donor are generally not covered, unless We make an exception and approve them in advance of the procedure. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two (2) companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

For lodging and ground transportation benefits, We will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code.

The human organ and bone marrow/stem cell/cord blood transplant services benefits or requirements described above do not apply to the following:

- Cornea, ventricular assist devices; and
- Any Covered Services, related to a covered transplant procedure, received prior to or after the transplant benefit period. Please note that the initial evaluation and any necessary additional testing to determine Your eligibility as a candidate for transplant by Your Provider and the mobilization, collection and storage of bone marrow/stem cells is included in the covered transplant procedure benefit regardless of the date of service.

The above services are covered as Inpatient services, Outpatient services or doctor home visits and office services depending where the service is performed and are subject to Member Cost Shares.

Urgent Care Services

Often an urgent rather than an Emergency health problem exists. An urgent health problem is an unexpected illness or injury that calls for care that cannot wait until a regularly scheduled office visit. Urgent health problems are not life threatening and do not call for the use of an Emergency room. Urgent health problems include earache, sore throat and fever (not above one-hundred and four (104) degrees). Benefits for Urgent Care may include:

- X-ray services
- Care for broken bones
- Tests such as flu, urinalysis, pregnancy test, rapid strep
- Laboratory services
- Stitches for simple cuts, and
- Draining an abscess

Vision Services

Benefits include medical and surgical treatment of injuries and illnesses of the eye.

We cover special contact lenses for aniridia when prescribed by an In Network doctor or In Network

optometrist and up to two (2) Medically Necessary contact lenses per eye (including fitting and dispensing) in any Benefit Period to treat aniridia (missing iris) at no charge. We will not cover an aniridia contact lens if We provided an allowance toward (or otherwise covered) more than one (1) aniridia contact lens for that eye within the previous twelve (12) months (including when We provided an allowance toward, or otherwise covered, one (1) or more aniridia contact lenses under any other Agreement).

Benefits include medical and surgical treatment of injuries and illnesses of the eye, including contact lenses to treat aphakia and aniridia. Vision screenings required by federal law are covered under the "Preventive Care Services" benefit.

Prescription Drugs

This section describes how You can obtain covered Prescription Drugs administered by a medical Provider or through a Retail Pharmacy, Our Home Delivery Pharmacy, or Our Specialty Pharmacy. Please see the information below that describes how Prescription Drugs are covered.

Prescription Drugs Administered by a Medical Provider

Your Agreement 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 and are Covered Services. This may include drugs for infusion therapy, chemotherapy, blood products, certain injectables, and any drug that must be administered by a Provider. This section applies when a Provider orders the drug and a medical Provider administers it to You in a medical setting. Benefits for drugs that You inject or get through Your Pharmacy benefit (i.e., Self-Administered Drugs) are not covered under this section. Benefits for those drugs are described in the "Prescription Drug Benefit at a Retail, Home Delivery, or Specialty Pharmacy" section.

Important Details About Prescription Drug Coverage

Your Agreement 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 (1) 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 (1) drug, drug regimen or treatment be used prior to use of another drug, drug regimen or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated
- Use of an Anthem Prescription Drug List (a formulary developed by Anthem which is a list of 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 section "Exception Request for a Quantity, Dose or Frequency Limitation, Step Therapy, or a Drug not on the Prescription Drug List."

Precertification

Precertification may be required for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will give the results of Our decision to both You and Your Provider.

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 Agreement. Your Provider may check with Us to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

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

If Precertification is denied, You have the right to file a grievance as outlined in the "If You Have a Complaint or an Appeal" section of this Agreement.

Note: Antiretroviral Drugs that are Medically Necessary for the prevention of AIDS/HIV, including

preexposure prophylaxis (PrEP) or postexposure prophylaxis (PEP), are not subject to Precertification or step therapy. Also, if the FDA has approved one (1) or more therapeutic equivalents of a drug, device, or product for the prevention of AIDS/HIV, then at least one (1) therapeutically equivalent version will be covered without Precertification or step therapy.

Designated Pharmacy Provider

Anthem may establish one (1) or more Designated Pharmacy Provider programs which provide specific Pharmacy services (including shipment of Prescription Drugs) to Members. An In Network Provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the In Network Provider must have signed a Designated Pharmacy Provider agreement with Us. You or Your Provider can contact Member Services to learn which Pharmacy or Pharmacies are part of a Designated Pharmacy Provider program.

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

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

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

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

Therapeutic Equivalents

Therapeutic Equivalents is a program that tells You and Your doctor about alternatives to certain prescribed drugs. We may contact You and Your doctor to make You aware of these choices. Only You and Your doctor can determine if the therapeutic equivalent is right for You. For questions or issues about therapeutic drug equivalents, call Pharmacy Member Services at the phone number on the back of Your Identification Card.

Prescription Drug Benefit at a Retail, Home Delivery, or Specialty Pharmacy

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

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

Prescription Drug Benefits

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

Prior Authorization and Step Therapy Exceptions

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

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

The criteria, which are called drug edits, may include requirements based on one (1) 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, 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 (1) drug, drug regimen or treatment be used prior to use of another drug, drug regimen or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated
- Use of a Prescription Drug List (as described below)

If You or Your prescribing doctor disagree with Our decision, You may file an exception request. Please see the section "Exception Request for a Quantity, Dose or Frequency Limitation, Step Therapy, or a Drug not on the Prescription Drug List."

You or Your Provider can get the list of the drugs that require prior authorization by calling Pharmacy Member Services at the phone number on the back of Your Identification Card or check Our website at www.anthem.com/ca. 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 Agreement. Your Provider may check with Us to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

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

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

1. Seventy-two (72) hours for non-urgent requests, or
2. Twenty-four (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 Agreement.

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

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

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

1. The Prescription Drug Anthem requires is contraindicated or is likely, or expected, to cause an adverse reaction or physical or mental harm to the Member in comparison to the requested Prescription Drug, based on the known clinical characteristics of the Member and the known characteristics and history of the Member's Prescription Drug regimen.
2. The Prescription Drug Anthem requires is expected to be ineffective based on the known clinical characteristics of the Member and the known characteristics and history of the Member's

Prescription Drug regimen.

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

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

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

If prior authorization or the step therapy exception request is denied, You have the right to file a grievance as outlined in the "If You Have a Complaint or an Appeal" section of this Agreement.

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

Note: Antiretroviral Drugs that are Medically Necessary for the prevention of AIDS/HIV, including preexposure prophylaxis (PrEP) or postexposure prophylaxis (PEP), are not subject to prior authorization or step therapy. Also, if the FDA has approved one (1) or more therapeutic equivalents of a drug, device or product for the prevention of AIDS/HIV, then at least one (1) therapeutically equivalent version will be covered without prior authorization or step therapy.

Covered Prescription Drugs

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

Benefits are available for the following:

- Prescription Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy
- Specialty Drugs
- Self-Administered Drugs. These are drugs that do not need administration or monitoring by a Provider in an office or Facility. Injectables and infused drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit
- Self-injectable insulin and supplies and equipment used to administer insulin
- Self-Administered contraceptives, including oral contraceptive drugs, self-injectable contraceptive drugs, contraceptive patches, and contraceptive rings. Coverage is also provided for up to a twelve (12) month supply of FDA-approved, Self-Administered hormonal

contraceptives, when dispensed or furnished at one (1) time by a Provider or pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies. Anthem 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.

- Generic FDA-approved contraceptive drugs at $0 Cost Share when obtained from an In Network Pharmacy, unless there is no Generic equivalent, the Generic Drug is unavailable or the Generic Drug would be medically inappropriate as determined by Your doctor at which time the Brand Name Drug would be covered with no Deductible, Copayment or Coinsurance when obtained from an In Network Pharmacy. Some categories and classes of contraceptives do not have Generics 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 In Network Pharmacy. If Your Provider determines that a Brand Name Drug with an available Generic therapeutic equivalent is necessary because a Generic therapeutic equivalent drug is not appropriate for You, You may obtain coverage of the Brand Name Drug with a $0 Cost Share from an In Network Pharmacy. If there is one (1) or more therapeutic equivalent of a contraceptive drug, device or product, Anthem will cover at least one (1), if available, at a $0 Cost Share when obtained from an In Network Pharmacy. Certain contraceptives are covered under the “Preventive Care Services” or the “Maternity and Reproductive Health Services” benefits. Please see those sections 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, provided at no cost at In Network Pharmacies, without medical management restrictions. Prior authorization is not required.
- Flu shots (including administration)

Where You Can Get Prescription Drugs

In Network Pharmacy

You can visit one (1) of the local Retail Pharmacies in Our network. Give the Pharmacy the Prescription from Your doctor and Your Identification Card and they will file Your claim for You. You will need to pay any Copayment, Coinsurance, and/or Deductible that applies when You get the drug. If You do not have Your Identification Card, the Pharmacy will charge You the full retail price of the Prescription and will not be able to file the claim for You. You will need to ask the Pharmacy for a detailed receipt and send it to Us with a written request for payment.

Note: If We determine that You may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, Your selection of In Network Pharmacies may be limited. If this happens, We may require You to select a single In Network Pharmacy that will provide and coordinate all future Pharmacy services. Benefits will only be paid if You use the single In Network Pharmacy. We will contact You if We determine that use of a single In Network Pharmacy is needed and give You options as to which In Network Pharmacy You may use. If You do not select one of the In Network Pharmacies We offer within thirty-one (31) days, We will select a single In Network Pharmacy for You. If You disagree with Our decision, You may ask Us to reconsider it as outlined in the “If You have a Complaint or an Appeal” section of this Agreement.

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 Providers for Controlled Substance Prescriptions may be limited. If this happens, We may require You to select a single In Network Provider that will provide and coordinate all Controlled Substance Prescriptions. Benefits for Controlled Substance Prescriptions will only be paid if You use the single In Network Provider. We will contact You if We determine that use of a single In Network Provider is needed and give You options as to which In Network Provider You may use. If You do not select one (1) of the In Network Providers We offer within thirty-one (31) days, We will select a single In Network Provider for You. If You disagree with Our decision, You may ask Us to reconsider it as outlined in the “If You Have a Complaint or an Appeal” section of this Agreement.

Specialty Pharmacy

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

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

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

When You Order Your Prescription Through the PBM's Specialty Pharmacy

You can only have Your Prescription for a Specialty Drug filled through the PBM's Specialty Pharmacy. Specialty Drugs are limited to a thirty (30) day supply per fill. The PBM's Specialty Pharmacy will deliver Your Specialty Drugs to You by mail or common carrier for Self-Administration in Your home. You cannot pick up Your medication at Anthem.

How to Obtain an Exception to the PBM's Specialty Pharmacy Program

If You believe that You should not be required to get Your Specialty Drug through the PBM's Specialty Pharmacy program, You or Your doctor must complete a Specialty Pharmacy program exception form to request an exception and send it to Us. The form can be mailed or faxed to Us. If You need a copy of the form, You may call Pharmacy Member Services on the phone number on the back of Your Identification Card to request one. You can also get the form online at www.anthem.com/ca. If We have given You an exception, it will be in writing for the approved amount of time as medically appropriate. If You believe that You still should not be required to get Your medication through the PBM's Specialty Pharmacy program, when Your prior exception approval expires, 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.

Specialty Pharmacy Program

If You are out of a Specialty Drug which must be obtained through the PBM's Specialty Pharmacy program, We will authorize an override of the Specialty Pharmacy program requirement for seventy-two (72) hours, or until the next business day following a holiday or weekend to allow You to get a seventy-two (72) hour Emergency supply of medication, or the smallest packaged quantity, whichever is greater, if Your doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment/Coinsurance, if any.

If You order Your Specialty Drug through the PBM's Specialty Pharmacy 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 thirty (30) day supply or less to allow You to get an Emergency supply of medication from a participating Pharmacy near You. A Member Services representative from the PBM's Specialty Pharmacy will coordinate the exception and You will not be required to pay additional Coinsurance.

Home Delivery Pharmacy

The PBM also has a Home Delivery Pharmacy which lets You get certain drugs by mail if You take them on a regular basis (Maintenance Medication). 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 Pharmacy. Your doctor may also call the Home Delivery Pharmacy.

Maintenance Medication

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

When using Home Delivery, We suggest that You order Your refill two (2) weeks before You need it to

avoid running out of Your medication. For any questions concerning the Home Delivery program, You can call Pharmacy Member Services toll-free at 833-236-6196.

The Prescription must state the dosage and Your name and address; it must be signed by Your doctor.

The first Home Delivery Prescription You submit must include a completed patient profile form. This form will be sent to You upon becoming eligible for this program. Any subsequent Home Delivery Prescriptions for that Member need only the Prescription and payment enclosed.

You must authorize the pharmacist to release information needed in connection with the filling of a Prescription to the designated Home Delivery Prescription Drug program.

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the Home Delivery Prescription Drug program including, but not limited to, antibiotics, drugs not on the Prescription Drug List, drugs and medications to treat infertility, impotence and/or sexual dysfunction, injectables, including Self-Administered injectables except insulin. Please check with the Home Delivery Prescription Drug program Member Services department at 833-236-6196 for availability of the drug or medication.

What You Pay for Prescription Drugs

If the retail or home delivery price for a covered Prescription and/or refill is less than the applicable Copayment or Coinsurance amount, You will not be required to pay more than that price. The retail or home delivery price paid will constitute the applicable Cost Sharing and will apply toward the Deductible (if any) and Out of Pocket Maximum in the same manner as a Copayment or Coinsurance.

Tiers

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

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

As part of your Pharmacy benefit, you may be required to try an AB-rated Generic equivalent, Biosimilar (Interchangeable Biological Product) before receiving coverage for the equivalent Brand Name Drug.

If You have a prior authorization for a Brand Name Drug or biological product and a Generic or Biosimilar (Interchangeable Biological Product) drug becomes available on the market, your existing prior authorization may be updated to the newly available Generic or Biosimilar.

Note: If there is a Generic equivalent to a Brand Name Drug, the lowest Cost Sharing will be applied.

Prescription Drug List

We also have a Prescription Drug List (a formulary) which is a list of drugs that have been reviewed and recommended for use based on their quality and cost effectiveness. Benefits may not be covered for certain drugs if they are not on the Prescription Drug List.

The Prescription Drug List is developed by Us based upon clinical findings, and where proper, the cost of the drug relative to other drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over-the-counter medicines, Generic Drugs, the use of one (1) drug over

another by Our Members, and where proper, certain clinical economic reasons.

If You have a question regarding whether a drug is on the Prescription Drug List, please refer to Our website at www.anthem.com/ca.

We retain the right to decide coverage based upon medication dosages, dosage forms, manufacturer and administration methods (i.e., oral, injected, topical, or inhaled) and may cover one (1) form instead of another as Medically Necessary.

This Agreement limits Prescription Drug coverage to those Prescription Drugs listed on Our Prescription Drug List. This formulary contains a limited number of Prescription Drugs, and may be different than the formulary for other Anthem products. Benefits may not be covered for certain Prescription Drugs if they are not on the Prescription Drug List. Generally, it includes select Generic Drugs with limited Brand Name Drug coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Prescription Drug List from time to time. Inclusion of a drug or related item on the covered Prescription Drug List is not a guarantee of coverage. A description of the Prescription Drugs that are listed on this Prescription Drug List is available upon request and at www.anthem.com/ca.

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

If You or Your doctor believe You need an exception to a limit to a quantity, dose or frequency limitation, to step therapy, or need a Prescription Drug that is not on the Prescription Drug List, Your doctor must complete a uniform prior authorization 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. We will grant the exception request if We agree that it is Medically Necessary and appropriate.

We will make a coverage decision within seventy-two (72) hours of receiving Your request. If We approve the exception request, coverage will be provided for the duration of Your Prescription, 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 seventy-two (72) hours of receiving Your request. If the IRO approves the request, coverage will be provided for the duration of Your Prescription, including refills.

You or Your doctor may also submit a request for a Prescription Drug that is not on the Prescription Drug List based on exigent circumstances. 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 on the Prescription Drug List.

We will make a coverage decision within twenty-four (24) hours of receiving Your request. If We approve the coverage of the drug, coverage of the drug will be provided for the duration of the Prescription, including refills, or duration of the exigency, as applicable. If We deny coverage of the drug, You have the right to request an external review by an IRO. The IRO will make a coverage decision within twenty-four (24) hours of receiving Your request. If the IRO approves the coverage of the drug, coverage of the drug will be provided for the duration of the exigency. The external exception review process is in addition to a Member's right to file a grievance or request an Independent Medical Review by the Department of Managed Health Care.

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

Coverage of a drug approved as a result of Your request or Your doctor's request for an exception will only be provided if You are a Member enrolled under the Agreement.

Drug Utilization Review

If there are patterns of over utilization or misuse of drugs, We will notify Your personal doctor and Your pharmacist. We reserve the right to limit benefits to prevent over utilization of drugs.

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits

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

If You are going on vacation and You need more than the day supply allowed, You should ask Your pharmacist to call Our PBM and ask for an override for one (1) early refill. If You need more than one (1) early refill, please call Pharmacy Member Services at the number on the back of Your Identification Card.

Therapeutic Equivalents

Therapeutic Equivalents is a program that tells You and Your doctor about alternatives to certain prescribed drugs. We may contact You and Your doctor to make You aware of these choices. Only You and Your doctor can determine if the therapeutic equivalent is right for You. For questions or issues about therapeutic drug equivalents, call Pharmacy Member Services at the phone number on the back of Your Identification Card.

Partial Fill Program

A Pharmacist may dispense a Schedule II drug as a partial fill if requested by You or Your Provider. Anthem will prorate an enrollee's Cost Sharing for a partial fill of a Prescription of an oral, solid dosage form Prescription Drug. A Schedule II drug is a drug that has a high potential to result in severe dependence.

Split Fill Dispensing Program

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

The Prescription Drugs that are included under this program have been identified as requiring more frequent follow-up to monitor response to treatment and potential reactions or side-effects. You can access the list of these Prescription Drugs by calling the toll-free Pharmacy Member Services number on Your Member ID Card or log on to the Member website at www.anthem.com/ca.

Drug Cost Share Assistance Programs

If You participate in certain drug Cost Share assistance programs offered by drug manufacturers or other third parties to reduce the Cost Share (Copayment, Coinsurance) You pay for certain Specialty Drugs, the reduced amount You pay will be the amount We apply to Your Deductible and/or Out of Pocket Limit when the Specialty Drug is provided by an In Network Provider. Your eligibility to participate in such programs is dependent on the programs' applicable terms and conditions, which may be subject to change from time to time. We may discontinue applying such reduced amounts to Your Cost Share at any given time.

Special Programs

Except where prohibited by federal regulations (such as HSA rules), from time to time We may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery drugs, over-the-counter drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time. In addition, We may allow access to network rates for drugs not listed on Our Prescription Drug List.

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

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

You will be able to take advantage of a portion of the cost savings anticipated by Anthem from rebates

on Prescription Drugs purchased by You from Retail, Home Delivery, or Specialty Pharmacies under this section. If the Prescription Drug purchased by You is eligible for a rebate, most of the estimated value of that rebate will be used to reduce the Negotiated Fee Rate 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 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.

Child Dental Care

Your Dental Benefits. Dental care treatment decisions are made by You and Your dentist. We cover treatment based on what benefits You have, not whether the care is Medically or dentally Necessary. Anthem shall comply with applicable Federal, State, or local laws, rules, or regulations. In the event Anthem is subject to a newly enacted or amended law, rule, or regulation that conflicts with Pediatric Dental EHB requirements, Anthem shall comply with the law, rule, or regulation and any applicable guidance from its regulatory authority. Where Pediatric Dental EHB requirements exceed requirements imposed by law, Anthem shall comply with the Pediatric Dental EHB requirements. The only exception is when You get orthodontic care — We do review those services to make sure they are appropriate.

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

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

Pediatric Dental Essential Health Benefits. Dental care services are covered for Members until the end of the month in which they turn 19. All Covered Services are subject to the terms, limitations and exclusions of this Agreement. See the "Schedule of Cost Share and Benefits" for benefit descriptions and any applicable Deductible, Coinsurance, Copayment, and benefit limitation information.

Medically Necessary Orthodontic Care

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

Medically Necessary Orthodontic Care. This Agreement will only cover orthodontic care when it is Medically Necessary to restore the form and function of the oral cavity, such as through the result of an injury or from dysfunction resulting from congenital deformities. To be considered Medically Necessary orthodontic care, at least one (1) of the following criteria must be present:

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

Orthodontic Treatment may include the following:

- Pre-orthodontic treatment visits are covered once every three (3) months
- Periodic treatment visits are covered four (4) times per Year
- Comprehensive or complete treatment. A full treatment case that includes all radiographs (such as cephalometric (two (2) films per twelve (12) months), 2D oral/facial images (four (4) per day), 3D photographic images, models, orthodontic appliances and office visits
- Orthodontic Retention is covered once per arch per course of treatment
- Repair of orthodontic appliance, maxillary and mandibular, is covered once per appliance
- Recement or rebond fixed retainer - maxillary and mandibular

- Repair of fixed retainer, includes reattachment - maxillary and mandibular
- Replacement of lost or broken retainer, maxillary and mandibular is covered once per arch per course of treatment within twenty-four (24) months of placement of orthodontic retainer
- Complex surgical procedures. Surgical procedures given for orthodontic reasons, such as exposing impacted or unerupted teeth, or repositioning of the teeth are covered once per arch per lifetime, with orthodontia, and transseptal fiberotomy is covered once per arch per lifetime, with orthodontia
- Unspecified

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

The first (1st) payment for orthodontic care is made when treatment begins. Treatment begins when the appliances are installed. Your dental Provider should submit the necessary forms telling Us when Your appliance is installed. Payments are then made at six (6) month intervals until the treatment is finished or coverage under this Agreement ends. Your Cost Share for Medically Necessary orthodontic care applies to Your course of treatment as long as You remain enrolled in the Plan.

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

What Orthodontic Care Does NOT Include. Coverage is NOT provided for:

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

Child Vision Care

These vision care services are covered for Members until the end of the month in which they turn 19. To get In Network benefits, use a Blue View Vision eye care Provider. For help finding one, try "Find a Doctor" on Our website or call Us at the number on Your Identification Card.

Routine Eye Exam with Refraction

This Agreement covers a complete routine eye exam with dilation if needed. The exam is used to check all aspects of Your vision.

Eyeglass Lenses

Standard plastic (CR39) or glass eyeglass lenses up to 55mm are covered, whether they are single vision, bifocal, trifocal (FT 25-28), progressive or lenticular. Polycarbonate lenses may be obtained at no extra cost.

There are a number of additional covered lens options that are available through Your Blue View Vision Provider. See the "Schedule of Cost Share and Benefits" for the list of covered lens options.

Frames

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

Contact Lenses

Each Year, You get a lens benefit for eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one (1) of those three (3) options in a given Year. Your Blue View Vision Provider will have a collection of various types of contact lenses for different eye conditions and prescriptions for You to choose from. They can tell You which contacts are included at no extra charge – and which ones will cost You more.

Elective contact lenses are ones You choose for comfort or appearance.

Non-elective contact lenses are ones prescribed for certain eye conditions:

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

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

Note: We will not pay for non-elective contact lenses for any Member who has had elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

Low Vision

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

WHAT IS NOT COVERED (EXCLUSIONS)

In this section You will find a review of items that are not covered by Your Agreement. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by Your Agreement.

We will have the right to make the final decision about whether services or supplies are Medically Necessary and if they will be covered by Your Agreement.

The following services are not covered:

- Services rendered by Providers located outside the United States, unless the services are for Emergency Care, Urgent Care services received from an Urgent Care Center or ambulance services related to an Emergency for transportation to a Hospital.
- Services by Out of Network Providers unless:
    - The services are for Emergency Care, ambulance services related to an Emergency for transportation to a Hospital, or Urgent Care services received at an Urgent Care Center or
    - The services are approved in advance by Us.
- However, if You receive Covered Services at an In Network Facility in California at which, or as a result of which, You receive services provided by an Out of Network Provider, You will pay no more than the same Cost Sharing that You would pay for the same Covered Services received from an In Network Provider.

Medical Services

Your Medical benefits do not cover:

Accidental Injury. Services for accidental injury to the teeth are not covered under this Plan.

Administrative Charges. Charges to complete claim forms, charges to get medical records or reports, and Membership, administrative, or access fees charged by doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling You to give You test results.

Affiliated Providers. Services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.

A**fter Hours or Holiday Charges.** Additional charges beyond the Negotiated Fee Rate for basic and primary services requested after normal Provider service hours or on holidays. This exclusion does not apply to Emergency Services.

Aids for Non-verbal Communication. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices approved by Us.

Allergy Tests/Treatment. The following services, supplies or care are not covered:

- IgE RAST tests unless intradermal tests are contraindicated
- Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain
- Food allergy test panels (including SAGE food allergy panels)
- Services for, and related to, many forms of immunotherapy. This includes, but is not limited to, oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies
- Specific non-standard allergy services and supplies, including, but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan's test), treatment of non-specific candida sensitivity, and urine autoinjections
- Antigen leukocyte cellular antibody test (ALCAT)
- Cytotoxic test
- HEMOCODE food tolerance system
- IgG food sensitivity test
- Immuno blood print test
- Leukocyte histamine release test (LHRT)

Alternative/Complementary Medicine. For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy (unless part of a physical therapy treatment plan), reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bio-energetic synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback. This exclusion does not apply to the Medically Necessary treatment of Mental Health and Substance Use Disorder as required by State law.

Ambulance. Usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or doctor is not a Covered Service. Non-Covered Services for ambulance include, but are not limited to, trips to:

- A doctor's office or clinic
- A morgue or funeral home

Coverage is not available for air ambulance transport from a Hospital capable of treating the patient

because the patient and/or the patient's family prefer a specific Hospital or doctor. Air ambulance services are not covered for transport to a Hospital that is not an acute care Hospital, such as a nursing Facility or a rehabilitation Facility, doctor's office, or Your home.

Autopsies and Postmortem Testing.

Before Effective Date or After Termination Date. Charges for care You get before Your Effective Date or after Your coverage ends, except as written in this Agreement.

Charges Not Supported by Medical Records. Charges for services not described in Your medical records.

Charges Over the Negotiated Fee Rate. Charges over the Negotiated Fee Rate for Covered Services except for Surprise Billing Claims.

Chiropractic Services. Spinal manipulation services are excluded. This includes chiropractic manipulations and/or adjustments as part of a course of chiropractic treatment including, but not limited to, manipulating the muscle and connective tissue. Services that are otherwise covered under this Agreement that are provided by a chiropractor acting within the scope of his or her license are covered.

Clinical Trials. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Any Investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Agreement for non-investigational treatments; or
- Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Compound Drugs. Compound Drugs unless all the ingredients are FDA-approved, require a Prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to the non-FDA-approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants as determined by the PBM.

Corrective Eye Surgery. For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

Cosmetic Services. Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how You look. This exclusion does not apply to services mandated by State or federal law, or as covered in the "What is Covered" sections (Medical, Prescription Drugs, Child Dental, Child Vision) of this Agreement.

Cosmetic Surgery. Surgery that is performed to alter or reshape normal structures of the body in order to improve appearance. This exclusion does not apply to the Medically Necessary treatment of Mental Health and Substance Use Disorder as required by State law.

Counseling Services. Counseling services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy, except for Medically Necessary treatment of a Mental Health condition identified as a "mental disorder" in the DSM IV. This exclusion does not apply to the Medically Necessary treatment of Mental Health and Substance Use Disorder as required by State law.

Court Ordered Care. For court ordered testing or care, unless the service is Medically Necessary and authorized.

Custodial Care, Services/Care Other Facilities. We do not provide benefits for procedures,

equipment, services, supplies or charges for the following, except as determined to be Medically Necessary for the treatment of Mental Health and Substance Use Disorder as required by State law:

- Custodial care or assistance with activities for daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting and taking medicine) except as part of Hospice Care, Skilled Nursing Facility or Inpatient Hospital care
- Convalescent care or rest cures
- Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included
- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care Facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution

Delivery Charges. Charges for delivery of Prescription Drugs.

Dental Implants for Members age Nineteen (19) and Over. Dental implants for Members age 19 and over (material implanted into or on bone or soft tissue) or any associated procedure as part of the implantation or removal of implants except as specified in "Dental Care" in the "What is Covered" section.

Dental X-Rays, Supplies and Appliances. For dental X-rays, supplies and appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or as specified in "Dental Services" or "Child Dental Care" in the "What is Covered" section. The only exceptions to this are for any of the following:

- Transplant preparation
- Initiation of an immunosuppressive
- Direct treatment of acute traumatic injury, cancer, or cleft palate

Devices. Devices that are:

- Not generally accepted under professional medical standards as being safe or effective even though they are approved by the FDA
- Not approved by the FDA

Diagnostic Admissions. Inpatient room and board or any charges in connection with a Hospital stay primarily for diagnostic tests which could have been performed safely on an Outpatient basis.

Disposable Supplies. Disposable supplies for home use. Bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads, and other incontinence supplies. This exclusion shall not apply to disposable supplies specified in the "Emergency Room," "Diabetes Services," "Home Care Services," "Hospice Care," "Hospital Services," "Medical Supplies, Durable Medical Equipment and Appliances," "Skilled Nursing Facility," "Surgery," "Urgent Care Services," or other Covered Services in the "What is Covered" section.

Doctor or Other Practitioners' Charges. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Doctor or Other Providers' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member
- Surcharges for furnishing and/or receiving medical records and reports
- Charges for doing research with Providers not directly responsible for Your care
- Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending doctor

- For membership, administrative, or access fees charged by doctors or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results

Doctor Stand-by Charges. For stand-by charges of a doctor.

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

Drugs, Medications or Other Substances. Covered Services do not include drugs, medications or other substances that are not generally accepted under professional medical standards as being safe, effective or whose use is in question in current published peer-reviewed medical and pharmaceutical literature and evidence-based outcomes. This does not apply to FDA-approved drugs, medications or other substances.

Drugs Over Quantity or Age Limits. Drugs which are over any quantity or age limits set by the Agreement or Us.

Drugs Over the Quantity Prescribed or Refills After One Year. Drugs in amounts over the quantity prescribed, or for any refill given more than one (1) Year after the date of the original Prescription Order.

Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications. Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications as determined by Anthem.

Drugs That Do Not Need a Prescription. Drugs that do not need a Prescription by federal law (including drugs that need a Prescription by State law, but not by federal law). This exclusion does not apply to over-the-counter drugs that We must cover under State or federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a doctor.

Durable Medical Equipment. Covered Services do not include durable medical equipment except as specified in “Medical Supplies, Durable Medical Equipment and Appliances” in the “What is Covered” section. Non-Covered Services or supplies include, but are not limited to:

- Orthopedic devices, shoes or shoe inserts except as specified in “Medical Supplies, Durable Medical Equipment and Appliances” in the “What is Covered” section
- Air purifiers, air conditioners, humidifiers
- Exercise equipment, treadmills
- Pools and spas
- Elevators
- Supplies for comfort, hygiene or beautification
- Correction appliances or support appliances and supplies such as stockings

Education/Training. For services, supplies, or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to, boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based. This exclusion does not apply to the Medically Necessary treatment of autism spectrum disorder or to diabetes education.

Exams - Research Screenings. For examinations relating to research screenings.

Experimental or Investigational Services. Services or supplies that are Experimental or Investigational. This exclusion applies to services related to Experimental/Investigational services, whether You get them before, during, or after You get the Experimental/Investigational service or supply.

The fact that a service or supply is the only available treatment will not make it a Covered Service if it is Experimental/Investigational.

If the Member has a life-threatening or seriously debilitating condition and the requested treatment is not

a Covered Service because it is Experimental or Investigational, the Member may request an Independent Medical Review. See the "If You Have a Complaint or an Appeal" section for further details.

This exclusion does not apply to services covered in "Clinical Trials" in the "What is Covered" section nor to the complications that may arise from non-Covered Services such as cosmetic surgery or Experimental Services.

Eyeglasses/Contact Lenses. For prescription, fitting, or purchase of eyeglasses or contact lenses except as specified in "Vision Services" in the "What is Covered" section. This exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition. This exclusion does not apply to Members under age 19.

Foot Care – Routine. For routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting or debriding; hygienic and preventive maintenance foot care, including but not limited to:

- Cleaning and soaking the feet
- Applying skin creams in order to maintain skin tone
- Other services that are performed when there is not a localized illness, injury or symptom involving the foot

Foot Orthotics. Foot orthotics, orthopedic shoes or footwear or support items except as specifically covered under "Orthotics" in the "What is Covered" section.

Free Care. Free care services You would not have to pay for if You did not have this Agreement. This includes, but is not limited to, government programs, services during a jail or prison sentence, services You get from Workers' Compensation, and services from free clinics.

Genetic Testing and Counseling. Benefits are not provided for genetic testing or genetic counseling except as specified as a Covered Service in this Agreement or as required by law.

Government Coverage. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

Gynecomastia. For surgical treatment of gynecomastia.

Hair Loss or Growth Treatment. Items and services for the promotion, prevention, or other treatment of hair loss or hair growth.

Health Club Memberships and Fitness Services. Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a doctor. This exclusion also applies to health spas.

Hearing Aids, including Bone-Anchored Hearing Aids. Hearing aids and hearing tests to determine their efficacy and hearing tests to determine an appropriate hearing aid, except as specified in "Preventive Care Services" in the "What is Covered" section. This exclusion does not apply to cochlear implants.

NOTE: The Hearing Aid Coverage for Children Program (HACCP) offers State-funded hearing aid coverage to eligible children and youth, ages 0 to 20. To learn more and apply, visit www.dhcs.ca.gov/HACCP.

Home Care. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a home healthcare Provider, except as specified in "Hospice Care" in the "What is Covered" section

- Food, housing, homemaker services and home delivered meals with the exception of Medically Necessary enteral and parenteral formulas
- Personal comfort items

This exclusion does not apply to the Medically Necessary treatment of Mental Health and Substance Use Disorder as required by State law.

Hospice Care. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Services or supplies for personal comfort or convenience, including homemaker services
- Food services, meals, formulas and supplements except as specified in "Hospice Care" or even if the food, meal, formula or supplement is the sole source of nutrition except as specified in "Diabetes Services" in the "What is Covered" section
- Services not directly related to the medical care of the Member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services
- Services provided by volunteers

This exclusion does not apply to the Medically Necessary treatment of Mental Health and Substance Use Disorder as required by State law.

Human Growth Hormone. Human growth hormone.

Impotency. For services and supplies related to male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing. This exclusion does not apply to the Medically Necessary treatment of Mental Health and Substance Use Disorder as required by State law.

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

Infertility Testing and Treatment. For testing or treatment related to fertilization or infertility such as diagnostic tests performed to determine the reason for infertility and any service billed with a CPT (current procedural terminology) code that indicates an infertility related diagnosis, except as specified in "Maternity and Reproductive Services" in the "What is Covered" section.

In-vitro Fertilization (IVF) or Pre-implant Genetic Diagnosis (PGD) of Embryos. Services or supplies for in-vitro fertilization (IVF) or pre-implant genetic diagnosis (PGD) of embryos, whether provided or not provided in connection with infertility treatment.

Medical Equipment, Devices, and Supplies. We do not provide benefits for supplies, equipment and appliances that include comfort, luxury or convenience items or features that exceed what is Medically Necessary in Your situation. Reimbursement will be based on the Negotiated Fee Rate for a standard item that is a Covered Service, serves the same purpose and is Medically Necessary. Any expense that exceeds the Negotiated Fee Rate for the standard item which is a Covered Service is Your responsibility.

Missed/Cancelled Appointments. For missed or cancelled appointments.

No Legal Obligation to Pay. Services You actually receive for which You have no legal obligation to pay or for which no charge would be made if You did not have health plan or insurance coverage, except services received at a non-governmental charitable research Hospital. Such a Hospital must meet the following guidelines: a) it must be internationally known as being devoted mainly to medical research, and b) at least ten percent of its Yearly budget must be spent on research not directly related to patient care, and c) at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care, and d) it must accept patients who are unable to pay, and e) two-thirds of its patients must have conditions directly related to the Hospital research.

However, if You have Medicare, Your Medicare coverage will not affect the Covered Services covered under this Agreement, except as follows:

- Your Medicare coverage will be applied first (primary) to any services covered by both Medicare and this Agreement
- If You receive a service that is covered both by Medicare and this Agreement, Our coverage will apply only to the Medicare Deductibles, Coinsurance and other charges for Covered Services that You must pay above what is payable by Your Medicare coverage
- For a particular claim, the combination of Medicare benefits and the benefits We will provide under this Agreement for that claim will not be more than the billed charge for the Covered Service You received

We will apply any expenses paid by Medicare for Covered Services covered under this Agreement toward Your Deductible, except expenses paid by Medicare Part D.

Non-approved Drugs. Drugs not approved by the FDA.

Non-authorized Services. Any services not authorized except as expressly provided herein.

Non-authorized Travel Related Expenses. For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or as specified in "Surgery," "Transgender Services," or "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" in the "What is Covered" section.

Nonemergency Care Received in Emergency Room. For care received in an Emergency room that is not Emergency Care, except as specified in "Emergency Care Services" in the "What is Covered" section. This includes, but is not limited to, suture removal in an Emergency room.

Non-licensed Providers. Treatment or Services provided:

- By a non-licensed Provider under the supervision of a licensed doctor, except as specified in "Autism Spectrum Disorder Services" in the "What is Covered" section
- For which a healthcare Provider license is not required

This exclusion does not apply to the Medically Necessary treatment of Mental Health and Substance Use Disorder as required by State law.

Non-prescription Lenses, Eyeglasses or Contacts. Any non-prescription lenses, eyeglasses or contacts.

Not Medically Necessary. Any services or supplies which are not Medically Necessary, mandated by State or federal law, or as covered in the "What is Covered" sections (Medical, Prescription Drugs, Child Dental, Child Vision) of this Agreement.

Nutritional and Dietary Supplements. For nutritional and dietary supplements, except as specified in "Diabetes Services" or "Doctor (Physician) Visits" in the "What is Covered" section or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over-the-counter, which by law do not require either the written Prescription or dispensing by a licensed pharmacist. This exclusion does not apply to the Medically Necessary treatment of Mental Health and Substance Use Disorder as required by State law.

Oral Appliances for Snoring. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

Orthodontic Services. This includes dental braces, other orthodontic appliances and any related service except as specified as a Covered Service in this Agreement. This exclusion does not apply to Members up to age 19 or with cleft palate conditions.

Orthotic Devices. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect

- Replacement of lost or stolen items

Out of Network Providers. Services from an Out of Network Provider except as specified in "Emergency Care Services" in the "What is Covered" section or the "How Your Claims are Paid" section.

Outdoor Treatment Camps and/or Programs and/or Wilderness Programs unless Medically Necessary.

Over-the-Counter. For drugs, devices, products or supplies with over-the-counter equivalents and any drugs, devices, products or supplies that are therapeutically comparable to an over-the-counter drug device, product, or supply, except as specified in "Preventive Care Services" in the "What is Covered" section or as required by law. This exclusion does not apply to over-the-counter drugs that We must cover under State or federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a doctor.

Personal Care, Convenience and Mobile/Wearable Devices. For personal hygiene, environmental control, or convenience items including, but not limited to:

- Air conditioners, humidifiers, air purifiers
- Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a doctor. This exclusion also applies to health spas or similar facility.
- Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program
- Charges from a health spa or similar facility
- Personal comfort and convenience items during an Inpatient stay, including, but not limited to, daily television rental, telephone services, cots or visitor's meals
- Charges for non-medical self-care except as otherwise stated
- Purchase or rental of supplies for common household use, such as water purifiers
- Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds
- Infant helmets to treat positional plagiocephaly
- Consumer wearable/personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications
- Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails)
- Safety helmets for Members with neuromuscular diseases; or
- Sports helmets

Physical Exams and Immunizations - Other Purposes. Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes. This exclusion does not apply to the Medically Necessary treatment of Mental Health and Substance Use Disorder as required by State law.

Private Duty Nursing. Inpatient or Outpatient services of a private duty nurse unless provided by a home healthcare Provider or a hospice Provider.

Provider Services. Services You get from Providers that are not licensed by law to provide Covered Services, as defined in this Agreement. Examples of such Providers may include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

Residential Accommodations to treat behavioral health conditions, except when provided in a Hospital or Residential Treatment Center and except when provided as Medically Necessary treatment of Mental Health and Substance Use Disorder as required by State law.

Reversal of Sterilization. For reversal of sterilization.

Self-Help Training/Care. For self-help training and other forms of non-medical self-care, except as specified in "Diabetes Services" in the "What is Covered" section or as required by law. This exclusion does not apply to the Medically Necessary treatment of Mental Health and Substance Use Disorder as required by State law.

Services Not Approved by the FDA. Drugs, supplements, tests, vaccines, devices, radioactive materials and any other services that by law require FDA approval in order to be sold in the U.S. but are not approved by the FDA. This exclusion applies to services provided anywhere, even outside the U.S.

This exclusion does not apply to any of the following:

- Services covered in "Emergency Care Services" and "Urgent Care Services" in the "What is Covered" section that You receive outside the U.S.
- Experimental or Investigational services when an Investigational application has been filed with the FDA and the manufacturer or the other source makes the services available to You or Anthem through an FDA-authorized procedure, except that We do not cover services that are customarily provided by research sponsors free of charge to enrollees in a clinical trial or other Investigational treatment protocol
- Services covered in "Clinical Trials" in the "What is Covered" section

Services or Supplies from Family Members. Services prescribed, ordered, referred by or received from a member of Your immediate family, including Your spouse, domestic partner, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.

Services, Supplies, or Devices. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Received from an individual or entity that is not a Provider, as defined in this Agreement, or recognized by Us;
- Separate charges for services by professionals employed by a Facility which makes their services available;
- Not prescribed, performed, or directed by a Provider licensed to do so, unless otherwise required by law or regulation.

We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Amounts above the Negotiated Fee Rate for a service;
- Neurofeedback and related diagnostic tests;
- The following therapies:
    - Group speech therapy; or
    - Group or individual exercise classes or personal training sessions.

This exclusion does not apply to the Medically Necessary treatment of Mental Health and Substance Use Disorder as required by State law.

Shock Wave Treatment. Extracorporeal shock wave treatment for plantar fasciitis and other musculoskeletal conditions.

Spinal Decompression Devices. Spinal decompression devices. This includes, but is not limited to, vertebral axial decompression (Vax-D) and DRX9000. Cervical traction (over door) equipment is not excluded.

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

Teeth - Congenital Anomaly. Treatment of congenitally missing, malpositioned, or super numerary

teeth, even if part of a congenital anomaly, except as specified in “Dental Services” or “Child Dental Services” in the “What is Covered” section or as required by law. This exclusion does not apply to Members under the age 19.

Teeth, Jawbone, Gums. For treatment of the teeth, jawbone or gums that is required as a result of a medical condition, except as expressly required by law, or as specified in “Dental Services” or “Child Dental Services” in the “What is Covered” section.

Temporomandibular or Craniomandibular Joint Treatment. Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

Therapy – Other. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Gastric electrical stimulation
- Hippotherapy
- Intestinal rehabilitation therapy
- Prolotherapy
- Recreational therapy
- Sensory integration therapy (SIT)

This exclusion does not apply to the Medically Necessary treatment of Mental Health and Substance Use Disorder as required by State law.

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

Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood Exclusions. Non-Covered Services for transportation and lodging include, but are not limited to:

- Child care
- Meals
- Mileage within the medical transplant Facility city
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us
- Frequent flyer miles
- Coupons, vouchers, or travel tickets
- Prepayments or deposits
- Services for a condition that is not directly related, or a direct result, of the transplant
- Telephone calls
- Laundry
- Postage
- Entertainment
- Travel expenses for donor companion/caregiver, unless a minor
- Return visits for the donor for a treatment of a condition found during the evaluation

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

Vision Orthoptic Training. For vision orthoptic training. This exclusion does not apply to Members through the end of the month in which the Member turns age 19.

Waived Copayment, Coinsurance, or Deductible. For any service for which You are responsible under the terms of this Agreement to pay a Copayment, Coinsurance, or Deductible and the Copayment, Coinsurance or Deductible is waived by an Out of Network Provider.

Weight Loss Programs. For weight loss programs, whether or not they are pursued under medical or doctor supervision, except as specified as a Covered Service in this Agreement. This exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

This exclusion does not apply to Medically Necessary treatments for morbid obesity including bariatric surgery.

Workers' Compensation. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to You, then this exclusion does not apply. This exclusion applies if You receive the benefits in whole or in part. This exclusion also applies whether or not You claim the benefits or compensation. It also applies whether or not You recover from any third party. If We provide benefits for such injuries, conditions or diseases, We shall be entitled to establish a lien of other recovery under California Labor Code or any other applicable law.

Prescription Drugs

Your Prescription Drug benefits for Prescription Drugs purchased at a Retail, Home Delivery, or Specialty Pharmacy do not cover:

- Administration Charges for the Administration of any Drug except for covered immunizations as approved by Us or the PBM.
- An Allergenic Extract or Vaccine.
- Charges Not Supported by Medical Records. Charges for Pharmacy services not related to conditions, diagnoses, and/or recommended medications described in Your medical records.
- Clinically Equivalent Alternatives. Certain Prescription Drugs may not be covered if You could use a clinically equivalent drug, unless required by law or as otherwise set forth in this Agreement. "Clinically equivalent" means drugs that, for most Members, will give You similar results for a disease or condition. If You have questions about whether a certain drug is covered and which drugs fall into this group, please call the number on the back of Your Identification Card or visit Our website at www.anthem.com/ca.
- Compound Drugs. Compound Drugs unless all the ingredients are FDA-approved, require a Prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to the non-FDA approved Compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants as determined by the PBM.
- Contrary to Approved Medical and Professional Standards. Drugs given to You or prescribed in a way that is against approved medical and professional standards of practice.
- Cosmetic Services. Prescription Drugs given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how You look. This exclusion does not apply to services mandated by State or federal law.
- Delivery Charges. Charges for delivery of Prescription Drugs.
- Drugs, Medications or Other Substances. Covered Services do not include drugs, medications or other substances that are not generally accepted under professional medical standards as being safe, effective or whose use is in question in current published peer-reviewed medical and pharmaceutical literature and evidence-based outcomes. This does not apply to FDA-approved drugs, medications or other substances.
- Drugs Not Approved by the FDA.
- Drugs Over Quantity or Age Limits. Drugs which are over any quantity or age limits set by the Agreement or Us.
- Drugs Over the Quantity Prescribed or Refills After One Year. Drugs in amounts over the quantity prescribed, or for any refill given more than one (1) Year after the date of the original Prescription Order.
- Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications. Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications as determined by Anthem.
- Drugs That Do Not Need a Prescription. Drugs that do not need a Prescription by federal law (including drugs that need a Prescription by State law, but not by federal law), except for injectable insulin. This exclusion does not apply to over-the-counter drugs that We must cover under State or federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a doctor.
- Items Covered as Durable Medical Equipment (DME). Therapeutic DME, devices and supplies except peak flow meters, spacers, glucose monitors.
- Lost or Stolen Drugs. Refills of lost or stolen drugs.
- Mail Service Programs other than the PBM's Home Delivery Mail Service. Prescription Drugs dispensed by any mail service program other than the PBM's Home Delivery mail service, unless

We must cover them by law.

- Nutritional or Dietary Supplements. Nutritional and/or dietary supplements, except as described in this Agreement or that We must cover by law. This exclusion includes, but is not limited to, nutritional formulas and dietary supplements that You can buy over-the-counter and those You can get without a written Prescription or from a licensed pharmacist. This exclusion does not apply to the Medically Necessary treatment of Mental Health and Substance Use Disorder as required by State law.
- Onychomycosis Drugs. Drugs for onychomycosis (toenail fungus) except when We allow it to treat Members who are immuno-compromised or diabetic.
- Over-the-Counter Items may not be Covered. Drugs, devices and products, or Prescription Drugs with over-the-counter equivalents and any drugs, devices or products that are therapeutically comparable to an over-the-counter drug, device or product. This includes Prescription Drugs when any version or strength becomes available over-the-counter. This exclusion does not apply to over-the-counter drugs that We must cover under State or federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a doctor.
- Prescription Drugs used to Treat Infertility.
- Services or Supplies from Family Members. Services prescribed, ordered, referred by or received from a member of Your immediate family, including Your spouse, domestic partner, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law or self.
- Services We conclude are not Medically Necessary. This includes services that do not meet Our medical policy, clinical coverage, or benefit policy guidelines.
- Syringes. Hypodermic syringes except when given for use with insulin and other covered self-injectable drugs and medicine.
- Weight Loss Drugs. When prescribed solely for the purposes of losing weight, except when Medically Necessary for the treatment of morbid obesity. Members who are prescribed weight loss drugs that are Medically Necessary for the treatment of morbid obesity may be required to enroll in a comprehensive weight loss program, which is approved and covered by the Plan, for a reasonable period of time prior to or concurrent with receiving the Prescription Drug. This exclusion does not apply to the Medically Necessary treatment of Mental Health and Substance Use Disorder as required by State law.

Child Dental Care

Your dental care services do not include services incurred for or in connection with any of the items below:

- Dental care for Members age 19 and older, except as specified in “Dental Services” in the “What is Covered” section.
- Services of Anesthesiologist, unless required by law.
- Anesthesia Services, (such as intravenous or non-intravenous conscious sedation and general anesthesia) are not covered when given separate from a covered oral surgery service, except as required by law.
- Dental Services, Appliances or Restorations that are necessary to alter, restore or maintain occlusion. This includes increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Dental Services provided solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (such as cavities) exist.
- Case Presentations, office visits, consultations.
- Incomplete Services where the final permanent appliance (denture, partial, bridge) or restoration (crown, filling) has not been placed.
- Enamel Microabrasion and Odontoplasty.
- Biological Tests for Determination of Periodontal Disease or Pathologic Agents, except as specified in “Dental Services” or “Child Dental Care” in the “What is Covered” section.
- Collection of Oral Cytology Samples via scraping of the oral mucosa, except as specified in “Dental Services” or “Child Dental Care” in the “What is Covered” section.
- Separate Services billed when they are an inherent component of another Covered Service.
- Services for the Replacement of an existing partial denture with a bridge, unless the partial denture cannot satisfactorily restore the case.
- Additional, Elective or Enhanced Prosthodontic Procedures including, but not limited to, connector bar(s), stress breakers and precision attachments.
- Provisional Splinting, Temporary Procedures or Interim Stabilization.
- Pulp Vitality Tests.
- Adjunctive Diagnostic Tests.
- Cone Beam Images.
- Anatomical Crown Exposure.
- Temporary Anchorage Devices.
- Oral Hygiene Instructions when billed separately, as this is part of the oral exam benefit.
- Repair or Replacement of Lost or Broken Appliances.
- Removal of Pulpal Debridement, Pulp Cap, Post, Pins, Resorbable or Non-resorbable Filling Materials, nor the procedures used to prepare and place materials in the canals (tooth roots).
- Root Canal Obstruction, Internal Root Repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- The Controlled Release of Therapeutic Agents or Biologic Modifiers used to aid in soft tissue and osseous tissue regeneration.
- For Dental Services received prior to the Effective Date of this Agreement or received after the coverage under this Agreement has ended.
- Dental Services given by someone other than a licensed Provider (dentist or doctor) or their

employees.

- Services to Treat Temporomandibular Joint Disorder (TMJ), except as specified in “Dental Services,” “Doctor (Physician) Visits,” or “Child Dental Care” in the “What is Covered” section.
- Dental Services for which You would have no legal obligation to pay in the absence of this or like coverage.
- For any Condition, Disease, Defect, Ailment or Injury arising out of and in the course of employment if benefits are available under the Workers’ Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.
- Local Anesthetic when billed separately from Covered Services, as this is included as part of the final services, such as for restorative services (fillings, crowns).

Child Vision Care

Your vision care services do not include services incurred for or in connection with any of the items below:

- Vision care for Members age 19 and older, except as specified in “Vision Services” in the “What is Covered” section.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers’ Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- For services or supplies prescribed, ordered or referred by, or received from a member of the Member’s immediate family, including the Member’s spouse or domestic partner, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports.
- For missed or cancelled appointments.
- For safety glasses and accompanying frames.
- For two (2) pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, including Inpatient or Outpatient Hospital vision care, except as specified in “Vision Services” or “Child Vision Care” in the “What is Covered” section.
- Lost or broken lenses or frames, unless the Member has reached their normal interval for service when seeking replacements.
- For services or supplies not specified in “Vision Services” or “Child Vision Care” in the “What is Covered” section.
- Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, except as specified in “Vision Services” or “Child Vision Care” in the “What is Covered” section.
- For services or supplies combined with any other offer, coupon or in-store advertisement, or for certain brands of frames where the manufacturer does not allow discounts.
- No benefits are available for frames or contact lenses purchased outside of Our formulary.
- Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed Provider.
- Blended lenses.
- Oversize lenses.
- For sunglasses.

HOW YOUR CLAIMS ARE PAID

This section describes how Your claims are administered, explains the Cost Sharing features of Your Plan, and outlines other important provisions. The specific Cost Sharing features, and the applicable benefit percentages and/or limitations are outlined in the "Schedule of Cost Share and Benefits" section.

We consider Covered Services to be incurred on the date a service is provided. This is important because You must be actively enrolled on the date the service is provided.

Cost Sharing Requirements

Cost Sharing is how Anthem shares the cost of healthcare services with You. It means what Anthem is responsible for paying and what You are responsible for paying. You meet Your Cost Sharing requirements through Your payment of Deductibles, Copayments, and/or Coinsurance (as described below).

Anthem works with doctors, Hospitals, Pharmacies and other healthcare Providers to control healthcare costs. As part of this effort, most Providers who contract with Anthem agree to control costs by giving discounts to Anthem. Most other insurers maintain similar arrangements with Providers.

The contracts between Anthem and Our In Network Providers include a "hold harmless" clause which provides that You cannot be held responsible by the Provider for claims owed by Anthem for healthcare services covered under this Plan.

Covered Services that are not obtained from a PCP, SCP or another In Network Provider, or that are not Authorized Services will not be covered. The only exceptions are Emergency Care, ambulance services related to an Emergency for transportation to a Hospital, or Urgent Care services received at an Urgent Care Center.

Copayment

Copayment means the fixed dollar amount You may be responsible for when You visit a Provider or fill a Prescription for covered Prescription Drugs at the Retail or Home Delivery Pharmacy. Your Copayment responsibility is shown in Your "Schedule of Cost Share and Benefits." You may have a Copayment for certain services. Whether a Copayment applies to a Covered Service, depends on Your Plan's benefit design.

Copayments satisfied in a Benefit Period will accumulate towards the Out of Pocket Maximum.

Coinsurance

Coinsurance means the percentage of the Negotiated Fee Rate for which You are responsible for a specified Covered Service. For example, if Your Coinsurance percentage listed on Your "Schedule of Cost Share and Benefits" is 20%, You are responsible for 20% of the Negotiated Fee Rate. See the explanation of Negotiated Fee Rate in this section for additional information. Whether a Coinsurance applies to a Covered Service depends on Your Plan's benefit design.

Coinsurance amounts satisfied in a Benefit Period will accumulate towards the Out of Pocket Maximum.

Deductibles

Please refer to the "Schedule of Cost Share and Benefits" for services that do not apply to the Deductible.

Your In Network Deductible responsibility for Covered Services provided by In Network Providers for medical services is separate from Your In Network Deductible responsibility for Covered Services provided by In Network Pharmacy Providers for Prescription Drugs. Before We will make payments for certain Covered Services, You must first satisfy the applicable In Network Deductible.

Your In Network Deductible amount is determined by the number of family members enrolled in this Plan. If only one (1) person is enrolled in this Plan, then only the In Network Individual Deductible applies. If more than one (1) person is enrolled in this Plan, then both the In Network Individual Deductible and the In Network Family Deductible apply.

- **In Network Individual Deductible for one (1) Member**

  Once the total allowable charges applying to the In Network Individual Deductible have been met, no further In Network Deductible for the Member will be required for the remainder of that Benefit Period.

- **In Network Family Deductible for two (2) or more Members**

  - Once the total allowable charges applying to the In Network Individual Deductible have been met for one (1) Member, no further In Network Deductible for the Member will be required for the remainder of that Benefit Period. The Member's In Network Individual Deductible will contribute towards the In Network Family Deductible.
  - All other family Members will be subject to the remainder of the In Network Family Deductible until the In Network Family Deductible is satisfied. No one (1) individual Member can contribute more than their individual Deductible amount. All Deductible amounts paid for Covered Services by each individual Member in a family during a Benefit Period will contribute to the remainder of the family's Deductible.

The In Network Deductible amounts are listed in the "Schedule of Cost Share and Benefits."

The enrollment of newborn or adopted children will cause the applicable Deductible to change from an Individual Deductible to a Family Deductible. Additional information on newborn or adopted children is explained under "When Membership Changes (Eligibility)."

During each Benefit Period, each Member is responsible for Covered Services incurred up to the Deductible amounts. These Deductibles are not prorated for a partial Year. Only Covered Services will apply toward the Deductibles. A claim must be submitted in order for Us to record Your eligible covered Deductible expense. We will record Your Deductibles in Our files in the order in which Your claims are processed, not necessarily in the order in which You receive the service or supply.

If You submit a claim for services which have a maximum payment limit and Your Deductible is not satisfied, We will apply only the allowed per visit or per day amount, whichever applies, toward Your Deductible.

Your Deductibles for Covered Services will apply towards Your Out of Pocket Maximums.

Out of Pocket Maximums

The Out of Pocket Maximum includes all Deductibles, Copayments, and Coinsurance You pay during a Benefit Period for all essential health benefits, medical services, child dental services, child vision services and Prescription Drug services combined. It does not include charges over the Negotiated Fee Rate or amounts You pay for non-Covered Services.

Cost Shares paid for Out of Network Emergency Care, including Emergency medical transportation (ambulance), Emergency Hospital care and services pre-authorized by Anthem will apply to the In Network Out of Pocket Maximum. Prescription Drugs that are not on the Prescription Drug List, but are approved by Anthem as exceptions will accumulate towards the In Network Out of Pocket Maximum.

Your In Network Out of Pocket Maximum is determined by the number of Members enrolled in this Plan. If only one (1) person is enrolled in this Plan, then only the In Network Individual Out of Pocket Maximum applies. If more than one (1) person is enrolled in this Plan, then both the In Network Individual Out of Pocket Maximum and the In Network Family Out of Pocket Maximum apply.

- **In Network Individual Out of Pocket Maximum for one (1) Member**

  Once the total allowable charges applying to the In Network Individual Out of Pocket Maximum have been met, Anthem will provide 100% of the Negotiated Fee Rate for the In Network Covered Services for the remainder of that Benefit Period.

- **In Network Family Out of Pocket Maximum for two (2) or more Members**

  - Once the total allowable charges applying to the In Network Individual Out of Pocket

Maximum have been met for one (1) Member, Anthem will provide benefits at 100% of the Negotiated Fee Rate for In Network Covered Services for the remainder of that Benefit Period for that Member. The Member's In Network Individual Out of Pocket Maximum will contribute towards the In Network Family Out of Pocket Maximum.

- All other family Members will be subject to the remainder of the In Network Family Out of Pocket Maximum until the In Network Family Out of Pocket Maximum is satisfied. All Cost Shares paid for Covered Services by each additional individual Member in a family during a Benefit Period will contribute to the remainder of the In Network Family Out of Pocket Maximum. No one (1) individual Member can contribute more than their individual Out of Pocket Maximum. Once the total allowable charges applying to the In Network Family Out of Pocket Maximum have been met, Anthem will provide benefits at 100% of the Negotiated Fee Rate for In Network Covered Services for the remainder of that Benefit Period.

The In Network Out of Pocket Maximum amounts are listed in the "Schedule of Cost Share and Benefits."

The enrollment of newborn or adopted children will cause the applicable Out of Pocket Maximum to change from an individual Out of Pocket Maximum to a family Out of Pocket Maximum. Additional information on newborn or adopted children is explained under "When Membership Changes (Eligibility)."

Reminder: Carry Your ID Card. Your Anthem ID Card identifies You and contains important healthcare coverage information. Carrying Your ID Card at all times will ensure You always have access to this coverage information when You need it. Make sure You show Your ID Card to Your doctor, Hospital, pharmacist or other healthcare Provider so they know You are covered with Anthem.

Once the Out of Pocket Maximum is satisfied, no additional Cost Sharing will be required for the remainder of the Benefit Period.

Note: You should keep the itemized bills from Your doctors to track Your out-of-pocket expenses. These itemized bills should not be submitted to Us unless:

1. You are seeking reimbursement for In Network services, and
2. If an In Network Provider did not submit the claim, or
3. If You disagree with Our calculation of Your out-of-pocket expenses.

Out of Pocket Maximum Exceptions

Please read this section very carefully. Not all money that You pay toward Your healthcare costs are counted toward Your Out of Pocket Maximum.

Amounts You incur towards Your Deductibles, Copayments, and/or Coinsurance count towards the Out of Pocket Maximum. However, the following will never count towards the Out of Pocket Maximum, nor will they ever be paid under this Plan:

- Amounts over any Plan maximum or limitation and/or
- Expenses for services not covered under this Plan.

Liability of Subscriber to Pay Providers

By statue and in accordance with Anthem's In Network Provider agreements, Members will not be required to pay any In Network Provider for amounts owed to that Provider by Anthem (other than Deductibles, Copayments, and/or Coinsurance), even in the unlikely event that Anthem fails to pay the Provider. Members are liable, however, to pay Out of Network Providers for any amounts not paid to those Providers by Anthem.

For Emergency Care rendered within California by an Out of Network Provider, other than a water ambulance Provider:

- You will not be responsible for any amount in excess of the Reasonable and Customary Value.
- However, You are responsible for any charges in excess of the Reasonable and Customary Value that may be billed by an Out of Network water ambulance Provider.

For Your Cost Share responsibility and Provider reimbursement for Out of Network Mental Health and Substance Use Disorder services, please see **Mental Health and Substance Use Disorder (Chemical Dependency) Services**, in the section entitled "**What is Covered**."

Benefit Period Maximum

Some Covered Services have a maximum number of days or visits that Anthem will allow during a Benefit Period. When the Deductible is applied to a Covered Service that has a maximum number of days or visits, the maximum benefits may be reduced by the amount applied to the Deductible, whether or not the Covered Service is paid by Us. These maximums apply even if You have satisfied the applicable Out of Pocket Maximum. See the "Schedule of Cost Share and Benefits" for those services which have a benefit limit.

Balance Billing

In Network Providers are prohibited from balance billing. An In Network Provider has signed an agreement, either directly or indirectly, with Anthem, or another organization to accept the Negotiated Fee Rate or reimbursement rate for Covered Services rendered to a Member who is his or her patient. A Member is not liable for any fee in excess of this determination or negotiated fee, except what is due under the Plan, e.g., Deductibles (if any) or Coinsurance.

Except for Surprise Billing Claims, when You receive Covered Services from an Out of Network Provider, You may be responsible for paying any difference between the Reasonable and Customary Value and the Provider's actual charges. This amount can be significant. However, if You receive Covered Services at an In Network Facility in California at which, or as a result of which, You receive services from an Out of Network Provider, You will pay no more than the Cost Sharing for the same Covered Services received from an In Network Provider.

For Your Cost Share responsibility and Provider reimbursement for Out of Network Mental Health and Substance Use Disorder services, please see **Mental Health and Substance Use Disorder (Chemical Dependency) Services**, in the section entitled "**What is Covered**."

Negotiated Fee Rate

General

In Network Medical Groups are generally paid a capitation fee, a set and agreed to dollar amount per Member each month, for medical services. In Network Medical Groups may also receive additional reimbursement for certain types of specialty care or for overall efficiency. Medical groups may also receive additional compensation related to the management of services and Referrals. The terms of these arrangements may vary by medical group. Hospitals and other healthcare Facilities are paid negotiated fixed fees or on the basis of a negotiated discount from their standard fee-for-service rates. For additional information, You may contact Member Services by calling the telephone number on the back of Your Identification Card or You may contact Your Medical Group.

You will be required to pay a portion of the Negotiated Fee Rate to the extent You have Member Cost Share responsibility for Covered Services. Cost Sharing for services with Copayments is the lesser of the Copayment amount or Negotiated Fee Rate. Generally, services received from an Out of Network Provider are not covered under this Plan except for Emergency Care, Urgent Care services received at an Urgent Care Center, when allowed as a result of an Authorized Referral by Us, or when You receive Covered Services at an In Network Facility in California at which, or as a result of which, You receive nonemergency services provided by an Out of Network Provider as described in "Member Cost Share" below.

For Your Cost Share responsibility and Provider reimbursement for Out of Network Mental Health and Substance Use Disorder services, please see **Mental Health and Substance Use Disorder (Chemical Dependency) Services**, in the section entitled "**What is Covered**."

For Emergency Care and Urgent Care services that You receive from an Out of Network Provider, payment is based on the Reasonable and Customary Value. You are not responsible for any amount over the Cost Share for Emergency Services when You receive Emergency Services regardless of whether they are received from an In Network or Out of Network Provider. When You receive Emergency or Urgent Care services within California from an Out of Network Provider, (with the

exception of an ambulance Provider), You are not responsible to pay charges in excess of the Reasonable and Customary Value. Please see "Emergency Care Services" and "Urgent Care Services" in the "What is Covered" section, the "Schedule of Cost Share and Benefits" and "Inter-Plan Arrangements" information below. If You receive services from an In Network Facility in California at which, or as a result of which, You receive nonemergency Covered Services provided by an Out of Network Provider, You will pay no more than the same Cost Sharing that You would pay for those same nonemergency Covered Services received from an In Network Provider, and You will not owe the Out of Network Provider more than the In Network Cost Sharing for such nonemergency Covered Services. See "Member Cost Share" below for more information.

Member Cost Share

For certain Covered Services and depending on Your Plan design, You may be required to pay a part of the Negotiated Fee Rate as Your Cost Share amount (for example, Deductible, Copayment, and/or Coinsurance).

Please see Your "Schedule of Cost Share and Benefits" for Your Cost Share responsibilities and limitations, or call Member Services toll free at the telephone number on the back of Your Identification Card to learn about this Plan's benefits or Cost Share amounts.

We will not provide any reimbursement for non-Covered Services. You will be responsible for the total amount billed by Your Provider for non-Covered Services, regardless of whether such services are performed by an In Network or Out of Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of Your Plan and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example day/visit limits.

You are responsible for confirming that the Provider You are seeing or have been referred to see is an In Network Provider for this Plan. It is important to understand that Anthem has many contracting Providers who may not be part of the network of Providers to provide services under this Plan. Any claims incurred with an Anthem contracted Provider who is not an In Network Provider under this Plan will be paid at the Out of Network level of benefits, even if You have been referred by another Anthem contracted Provider, except for Surprise Billing Claims, Air Ambulance Providers, Ground Ambulance Providers, services received by an Out of Network Provider as a result of a Medical Emergency or Urgent Care services received at an Urgent Care Center, Authorized Referrals for Out of Network Providers where there are no In Network Providers available for Medically Necessary Covered Services.

For Your Cost Share responsibility and Provider reimbursement for Out of Network Mental Health and Substance Use Disorder services, please see **Mental Health and Substance Use Disorder (Chemical Dependency) Services**, in the section entitled "**What is Covered**."

Authorized Referrals

In some circumstances, such as where there is no In Network Provider available for the Covered Service, a Referral may be authorized at the In Network Cost Share amounts (Copayment or Coinsurance) to apply to a claim for a Covered Service You receive from an Out of Network Provider. Please see the "How Your Coverage Works" section for further information on Referral requirements. If You receive services at an In Network Facility in California at which, or as a result of which, You receive nonemergency Covered Services provided by an Out of Network Provider, You will pay the Out of Network Provider no more than the same Cost Sharing that You would pay for the same Covered Services received from an In Network Provider. See "Member Cost Share" above for more information.

As a reminder, refer to the "Emergency Care" benefit in "What is Covered" to understand the differences between obtaining out-of-area Emergency Services within the State of California and for services outside California. Only Emergency Services and Urgent

Care services received at an Urgent Care Center outside California will utilize the Inter-Plan Arrangements.

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 (1) 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 (1) of two (2) 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 covers only limited healthcare services received outside of California. For example, Emergency Care or Urgent Care services received at an Urgent Care Center obtained outside of California is always covered. Any other services will not be covered when processed through any Inter-Plan Arrangements, unless authorized by Anthem.

Inter-Plan Arrangements Eligibility - Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are Prescription Drugs that You obtain from a Pharmacy and most dental or vision benefits.

A. BlueCard® Program

Under the BlueCard® Program, when You receive Covered Services within the geographic area served by a Host Blue, We will still fulfill Our contractual obligations. But, the Host Blue is responsible for: a) contracting with its Providers; and b) handling its interactions with those Providers.

When You receive Covered Services outside of California and the claim is processed through the BlueCard® Program, the amount You pay is calculated based on the lower of:

- The billed charges for Covered Services or
- The negotiated price that the Host Blue makes available to Us.

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

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

B. Special Cases: Value-Based Programs

BlueCard® Program

If You receive Covered Services under a value-based program inside a Host Blue's Service Area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or

care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to Anthem through average pricing or fee schedule adjustments. Additional information is available upon request.

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

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

D. Non-participating Providers Outside California

1. Allowed Amounts and Member Liability Calculation

When Covered Services are provided outside of California by non-participating providers, We may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable State or federal law. In these situations, the amount You pay for such services as Deductible, Copayment or Coinsurance will be based on that allowed amount. Also, You may be responsible for the difference between the amount that the non-participating provider bills and the payment We will make for the Covered Services as set forth in this paragraph. Federal or State law, as applicable, will govern payments for Out of Network Emergency Services.

2. Exceptions

In certain situations, We may use other pricing methods, such as billed charges, the pricing We would use if the healthcare services had been obtained within California, or a special negotiated price to determine the amount We will pay for services provided by non-participating providers. In these situations, You may be liable for the difference between the amount that the non-participating provider bills and the payment We make for the Covered Services as set forth in this paragraph.

Member Services is also available to assist You in determining Your allowed amount for a particular service from a non-participating provider. In order for Us to assist You, You will need to obtain from the non-participating provider the specific procedure code(s) and diagnosis code(s) for the services the provider will render. You will also need to know the provider's charges to calculate Your out-of-pocket responsibility. Although Member Services can assist You with this information, the final allowed amount for Your claim will be based on the actual claim submitted by the provider. You may call Member Services toll free at the telephone number on the back of Your Identification Card for their assistance.

E. Blue Cross Global® Core Program

If You plan to travel outside the United States, call Member Services to find out Your Blue Cross 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 Care, including ambulance, and Urgent Care services 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 Global® Core service center any time. They are available twenty-four (24) hours a day, seven (7) days a week. The toll free number is 800-810-2583. Or You can call them collect at 804-673-1177.

Keep in mind, if You need Emergency medical care, go to the nearest Hospital. There is no need to call before You receive care. Please refer to the "Requesting Approval for Benefits" section.

How Claims are Paid with Blue Cross Global® Core

In most cases, when You arrange Inpatient Hospital care with Blue Cross Global® Core, claims will be filed for You. The only amounts that You may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply.

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

- Doctor's services
- Inpatient Hospital care not arranged through Blue Cross Global® Core and
- Outpatient services

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

Additional information on Blue Cross Global® Core claims:

- You are responsible, at Your expense, for obtaining an English language translation of foreign country Provider claims and medical records.
- The exchange rate utilized for:
  - Inpatient Hospital care is based on the date of admission
  - Outpatient and professional services are based on the date of service

When You need Blue Cross Global® Core claim forms You can get international claims forms in the following ways:

- Call the Blue Cross 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.

Notice of Claim and Proof of Loss

After You get Covered Services, We must receive written notice of Your claim in order for benefits to be paid.

- In Network Providers will submit claims for You. They are responsible for ensuring that claims have the information We need to determine benefits. If the claim does not include enough information, We will ask them for more details, and they will be required to supply those details within certain timeframes.
- Out of Network claims can be submitted by the Provider if the Provider is willing to file on Your behalf. However, if the Provider is not submitting on Your behalf, You will be required to submit the claim. Claim forms are usually available from the Provider. If they do not have a claim form, You can send a written request to Us, or contact Member Services and ask for a claim form to be sent to You. If You do not receive the claim form, You can still submit written notice of the claim without the claim form. The same information that would be given on the claim form must be included in the written notice of claim, including:
  - Name of patient
  - Patient's relationship with the Subscriber
  - Identification number
  - Date, type, and place of service
  - Your signature and the Provider's signature

  Out of Network claims must be submitted within one-hundred and eighty (180) days after the date of service. Failure to file a claim within one-hundred and eighty (180) days shall not invalidate nor reduce any claim if there was good cause for the delay to file the claim within such time, provided such proof is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time the claim is required to be filed.

  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.

Claim Filing for Out of Network Emergency Services

If Emergency Services are provided by an Out of Network Provider, the Provider may bill Us directly for the services, and Your claim will be processed as required by law. The Out of Network Provider will be paid the Reasonable and Customary Value for such services. You are not responsible for amounts that exceed the applicable Cost Share for Emergency Services.

Time Benefits Payable

When using an In Network Provider they will bill Anthem directly for services rendered to You. In order for the Provider to submit a claim on Your behalf, You must give the 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) working days for clean claims. "Clean claim" means a claim submitted by You or a 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) working days, and We subsequently pay the claim, We will pay interest to the Provider that submitted the claim, as required under CA 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.

Claim Denials

If benefits are denied, in whole or in part, Anthem will send the Member a written notice within the established time periods described in the section “Time Benefits Payable.” The Member or the Member’s duly authorized representative may appeal the denial as described in the “If You Have a Complaint or an Appeal” section. The adverse determination notice will include the reason(s) for the denial, reference to the Plan provisions(s) on which the denial is based, whether additional information is needed to process the claim and why the information is needed, the claim Appeal procedures and time limits.

If the denial involves a Utilization Review determination, the notice will also specify:

- Whether an internal rule, guideline, protocol or other criterion was relied upon in making the claim decision and that this information is available to the Member upon request and at no charge.
- That an explanation of the scientific or clinical judgment for a decision based on Medical Necessity, Experimental or Investigational Procedures or a similar limitation is available to the Member upon request and at no charge.

Where to Send Your Claim

Prior to submitting Your Member claim form and itemized bill, You should make copies of the documents for Your own records and attach the original bills to the completed Member claim form. The bills and the Member claim form should be mailed to:

Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

Right of Recovery and Adjustment

Whenever payment has been made in error, or in excess of the maximum amount of payment necessary to satisfy the provisions of this Plan, We will have the right to recover such payment from You or, if applicable, the Provider or otherwise make appropriate adjustments to claims. In most instances, such recovery or adjustment activity shall be limited to the Benefit Period in which the error is discovered.

We have oversight responsibility of compliance with Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries

made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, We have established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery or adjustment amounts. We will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount. We may not give You notice of overpayments made by Us or You if the recovery method makes providing such notice administratively burdensome.

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.

This authorization remains valid until expressly revoked by notifying Us, Our affiliates, agents or designees in writing of such revocation at any time (except to the extent any action has been taken based on this authorization and/or except as release of such information may be required or authorized by law). Refusal to consent to the release of such information to Us, Our affiliates, agents or designees will permit Us to deny claims for 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 this Plan. We reserve the right to make payments directly to You as opposed to any Provider for Covered Service. In the event that payment is made directly to You, You have the responsibility to apply this payment to the claim from the Out of Network Provider. Payments and notice regarding the receipt and/or adjudication of claims may also be sent to an alternate recipient (which is defined herein as any child of a Subscriber who is recognized under a "Qualified Medical Child Support Order" as having a right to enrollment under the Subscriber'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.

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 this Plan are not assignable by any Member without the written consent of Anthem. This prohibition against assignment includes rights to receive payment, claim benefits under this Plan and/or law, and sue or otherwise begin legal action. Any assignment made without written consent from Anthem will be void and unenforceable.

Explanation of Benefits

After You receive medical care, You will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage You receive. The EOB is not a bill, but a statement from Us to help You understand the coverage You are receiving. The EOB shows:

- Total amounts charged for services/supplies received
- The amount of the charges satisfied by Your coverage
- The amount for which You are responsible (if any)
- General information about Your Appeals rights and for information regarding the right to bring an action after the Appeals process

Payment Owed to You at Death

Upon the death of a Member, claims will be payable to either the Member's estate or a beneficiary designated to Us. If the Provider is an In Network Provider, claims payments will be made to the Provider.

Claims Review for Fraud, Waste and Abuse

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and

other inappropriate activity. Members seeking services from non-participating or Out of Network Providers could be billed by the non-participating/Out of Network Provider for those services that are determined to be not payable as a result of these review processes. 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.

We also may identify certain Pharmacies to review for potential fraud, waste, abuse or other inappropriate activity when claims data suggests there may be inappropriate billing practices. If a Pharmacy is selected, then We may use one (1) or more clinical utilization management strategies in the adjudication of claims submitted by this Pharmacy, even if those strategies are not used for all Pharmacies delivering services to this Plan's Members.

Payment Innovation Programs

We pay 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 healthcare 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 a Network Provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, 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 healthcare. The Program payments are not made as payment for specific covered healthcare services provided to You, but instead, are based on the Network Provider's achievement of these pre-defined standards. You are not responsible for any Copayment or Coinsurance amounts related to payments made by Us or to Us under the Program(s), and You do not share in any payments made by Network Providers to Us under the Program(s).

IF YOU HAVE A COMPLAINT OR AN APPEAL

This section has information on how You can request review in the event that Your Agreement is terminated, cancelled or not renewed or address concerns or dissatisfaction about Your medical care or Our coverage decisions. Information on filing a complaint regarding discrimination based on race, color, national origin, age, disability, or sex can be found in the Language Assistance Services section of this Agreement.

If You have a question about Your eligibility, Your benefits under this Agreement, or concerning a claim, please call Member Services at 833-913-2232, or You may write to Us. Please address Your correspondence to:

Anthem Blue Cross
Attn: Member Services Department
P.O. Box 60007
Los Angeles, CA 90060-0007

Our Member Services staff will answer Your questions or assist You in resolving Your issue.

Dental Coverage Appeals

Please submit Appeals regarding Your dental coverage to the following address:

Anthem Blue Cross
P. O. Box 1122
Minneapolis, MN 55440-1122

Blue View Vision Coverage Appeals

Please submit Appeals regarding Your vision coverage to the following address:

Blue View Vision
P. O. Box 9304
Minneapolis, MN 55440-9304

Prescription Drug Exception Request

You may submit a grievance under this section for denials of Prescription Drugs related to the Prescription Drug List, prior authorization, or step therapy exception requests.

Please refer to "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 List” in “Prescription Drugs” under ”What is Covered” for the process for submitting a prior authorization form for prior authorization and step therapy exceptions or an exception request for drugs not on the Prescription Drug List.

Grievances

“Grievance” means a written or oral expression of dissatisfaction regarding Anthem and/or Provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration, or Appeal made by a Member or the Member’s representative. A grievance also includes a written or oral expression of dissatisfaction to Us or to the Department of Managed Health Care (DMHC) by a Member who believes this Agreement has been or will be improperly terminated or not renewed. Where Anthem is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

If You are dissatisfied and wish to file a grievance, You may request a copy of the grievance form to complete and return to Us. You may also ask the Member Services representative to complete the form for You over the telephone. You may also submit a grievance form online at www.anthem.com/ca or mail it to the following address:

Anthem
Attn: Grievances and Appeals
P.O. Box 4310
Woodland Hills, CA 91365-4310

You must submit Your grievance to Us no later than one-hundred eighty (180) days following the date You receive a denial notice from Us or any other incident or action with which You are dissatisfied, including, but not limited to, what You believe to be an improper termination or non-renewal. You must include all pertinent information from Your ID Card and the details and circumstances of Your concern or problem. Upon receipt of Your grievance, Your issue will become part of Our formal grievance process and will be resolved accordingly.

All grievances received by Us will be acknowledged in writing within five (5) days. We will send You a confirmation letter within five (5) days after We receive Your grievance. After We have reviewed Your grievance, We will send You a written statement on its resolution or pending status. If Your case involves an imminent and serious threat to Your health including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, You have the right to request an expedited review of a grievance.

You may file an expedited appeal which You may submit by telephone or online.

By phone: 800-365-0609 or 866-333-4823 (TDD line for the hearing and speech impaired).
Online: www.anthem.com/ca

Expedited grievances **must be resolved** within three (3) days.

If You are dissatisfied with the resolution of Your grievance, or if Your grievance has not been resolved after at least thirty (30) days, You may submit Your grievance to the Department of Managed Health Care. For review prior to binding arbitration see the section “Department of Managed Health Care” below. If Your case involves an imminent and serious threat to Your health, as described above, You are not required to complete Our grievance process, but may immediately submit Your grievance to the Department of Managed Health Care for review.

If You believe Your healthcare coverage has been, or will be, improperly cancelled, rescinded, or not renewed, You have the right to file a grievance with Us and/or the Department of Managed Health Care.

Option 1. You may submit a grievance to Anthem.

- You may submit a grievance to Anthem by calling 800-365-0609 or at the TDD line 866-333-4823, online at www.anthem.com/ca, or by mailing Your written grievance to:

  Anthem Blue Cross
  Attn: Termination Grievance/AB 2470
  P.O. Box 60007
  Los Angeles, CA 90060-0007

- You may want to submit Your grievance to Anthem first if You believe Your cancellation, rescission, or nonrenewal is the result of a mistake. Grievances should be submitted as soon as possible.
- Anthem will resolve Your grievance or provide a pending status within three (3) calendar days. If You do not receive a response from Us within three (3) calendar days, or if You are not satisfied in any way with Our response, You may submit a grievance to the Department of Managed Health Care (DMHC) as detailed under Option 2 below.

Option 2. You may submit a grievance directly to the Department of Managed Health Care.

- You may submit a grievance to the DMHC without first submitting it to Us or after You have received Our decision on Your grievance.
- You may submit a grievance to the DMHC online at www.dmhc.ca.gov.

- You may submit a grievance to the DMHC by mailing Your written grievance to:

  Help Center
  Department of Managed Health Care
  980 Ninth Street, Suite 500
  Sacramento, CA 95814-2725

- You may contact the DMHC for more information on filing a grievance at:

  Phone: 888-466-2219
  TDD: 877-688-9891
  FAX: 916-255-5241

Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If You have a grievance against Your health plan, You should first telephone Your health plan at **1-800-365-0609** or at the TDD line **1-866-333-4823** for the hearing and speech impaired and use Your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to You. If You need help with a grievance involving an Emergency, a grievance that has not been satisfactorily resolved by Your health plan, or a grievance that has remained unresolved for more than thirty (30) days, You may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If You are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in nature and payment disputes for Emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

Independent Medical Review

If a Member has had coverage denied because proposed treatment is determined by Us to be Investigational or Experimental, that Member may ask for review of that denial by an external, independent medical review organization contracting with the Department of Managed Health Care. A request for review may be submitted to the Department of Managed Health Care in accordance with the procedures described below in "Independent Medical Review of Grievances Involving a Disputed Healthcare Service."

To qualify for independent medical review, all of the following conditions must be satisfied:

- The Member has a life-threatening or seriously debilitating condition.
  - A life-threatening condition is a condition or disease where the likelihood of death is high unless the course of the condition or disease is interrupted and/or a condition or disease with a potentially fatal outcome where the end-point of clinical intervention is survival.
  - A seriously debilitating condition is a disease or condition that causes major, irreversible morbidity.
- The Member's doctor certifies that the Member has a life-threatening or seriously debilitating condition which:
  - Standard therapies have not been effective in improving the condition of the Member, or
  - Standard therapies would not be medically appropriate for the Member, or
  - There is no more beneficial standard therapy covered by the Agreement than the therapy proposed, and
  - Who has provided the supporting evidence.

- The proposed treatment must be recommended by the Member, an In Network doctor, or a board certified or board eligible doctor qualified to treat the Member, who has certified in writing that the proposed treatment is likely to be more beneficial to the Member than available standard therapy.
- If independent medical review is requested by the Member or by a qualified Out of Network doctor, as described above, the requester must supply two (2) items of acceptable medical and scientific evidence (as defined below).

Within three (3) business days of Our receipt from the Department of Managed Health Care of a request by a qualified Member for an independent medical review (and within twenty-four (24) hours of approval of the request for review involving an imminent and serious threat to the health of the Member), We will provide the independent medical review organization designated by the Department with: A copy of all relevant medical records and documents for review, and any information submitted by the Member or the Member's doctor. Additionally, any newly developed or discovered relevant medical records identified by Us or Our In Network Providers after the initial documents are provided will immediately be forwarded to the independent medical review organization.

The independent medical review organization will render its determination within thirty (30) days of the request (if the Member's doctor determines that the proposed therapy would be significantly less effective if not promptly initiated, the analyses and recommendations of the experts on the panel shall be rendered within seven (7) days of the request for expedited review), except the reviewer may ask for three (3) more days if there was any delay in receiving the necessary records.

"Acceptable medical and scientific evidence" means the following sources:

- Peer reviewed scientific studies published in medical journals with national recognized standards;
- Medical journals recognized by the Secretary of Health and Human Services under the Social Security Act;
- The American Hospital Formulary Service's Drug Information and the American Dental Association Accepted Dental Therapeutics;
- Any of the following reference compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen:
    - The Elsevier Gold Standard's Clinical Pharmacology
    - The National Comprehensive Cancer Network Drug and Biologics Compendium
    - The Thomson Micromedex DrugDex
- Medical literature meeting the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline, MEDLARS database Health Services Technology Assessment Research;
- Finding, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes; and
- Peer reviewed abstracts accepted for presentation at major medical association meetings.

Independent Medical Review of Grievances involving a Disputed Healthcare Service

You may request an Independent Medical Review ("IMR") of disputed healthcare services from the Department of Managed Health Care (DMHC) if You believe that We have improperly denied, modified, or delayed healthcare services. A "disputed healthcare service" is any healthcare service eligible for coverage and payment under Your Agreement that has been denied, modified, or delayed by Us, in whole or in part, because the service is not Medically Necessary.

The IMR process is in addition to any other procedures or remedies that may be available to You. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. We must provide You with an IMR application form with any grievance disposition letter that denies, modifies, or delays healthcare services. A decision not to participate in the IMR process may cause You to forfeit any statutory right to pursue legal action against Us regarding the disputed healthcare service.

Eligibility

The DMHC will review Your application for IMR to confirm that:

1. a. Your Provider has recommended a healthcare service as Medically Necessary, or
   b. You have received Urgent Care or Emergency Services that a Provider determined was Medically Necessary, or
   c. You have been seen by an In Network Provider for the diagnosis or treatment of the medical condition for which You seek independent review;
2. The disputed healthcare service has been denied, modified, or delayed by Us based in whole or in part on a decision that the healthcare service is not Medically Necessary; and
3. You have filed a grievance with Us and the disputed decision is upheld or the grievance remains unresolved after thirty (30) days. If Your grievance requires expedited review You may bring it immediately to the DMHC's attention. The DMHC may waive the requirement that You follow Our grievance process in extraordinary and compelling cases.

If Your case is eligible for IMR, the dispute will be submitted to a medical Specialist who will make an independent determination of whether or not the care is Medically Necessary. You will receive a copy of the assessment made in Your case. If the IMR determines the service is Medically Necessary, We will provide benefits for the healthcare service.

For non-urgent cases, the IMR organization designated by the DMHC must provide its determination within thirty (30) days of receipt of Your application and supporting documents. For urgent cases involving an imminent and serious threat to Your health, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of Your health, the IMR organization must provide its determination within three (3) business days.

For more information regarding the IMR process, or to request an application form, please call 800-365-0609.

Binding Arbitration

ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS, INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE AGREEMENT OR ANY OTHER ISSUES RELATED TO THE AGREEMENT AND CLAIMS OF MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. For claims that exceed the jurisdiction of the small claims court that are subject to binding arbitration under this Agreement, California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 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 Agreement 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.

Please send all Binding Arbitration demands in writing to:

Anthem Blue Cross

21215 Burbank Blvd.
Woodland Hills, CA 91367

Legal Action

No lawsuit or legal action of any kind related to a benefit decision may be filed by You in a court of law or in any other forum, unless it is commenced no earlier than sixty (60) days after We receive the claim or other request for benefits and within three (3) Years of Our final decision on the claim or other request for benefits. If We decide an Appeal is untimely, Our latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust Our internal Appeals process before filing a lawsuit or other legal action of any kind against Us.

WHEN MEMBERSHIP CHANGES (ELIGIBILITY)

The benefits, terms and conditions of this Agreement are applicable to individuals who are determined by the Exchange to be Qualified Individuals for purposes of enrollment in a Qualified Health Plan (QHP).

Subscriber Eligibility

To be eligible for membership as a Subscriber under this Agreement, the applicant must:

1. Be determined by the Exchange to be a Qualified Individual for enrollment in a QHP.
2. Be qualified by the Exchange as eligible, if applying to purchase a Catastrophic Plan.
3. Be a United States citizen or national, or
4. Be a lawfully present non-citizen for the entire period for which coverage is sought, and
5. Be a resident of the State of California and meet the following applicable residency requirements:
    - For a Qualified Individual age 21 and over, the applicant must:
        - Not be living in an institution,
        - Be capable of indicating intent,
        - Not be receiving optional State supplementary payments (SSP), and
        - Reside in the Service Area applicable to this Agreement.
    - For a Qualified Individual under age 21, the applicant must:
        - Not be living in an institution,
        - Not be emancipated,
        - Not be eligible for Medicaid or Medi-Cal based on receipt of federal payments for foster care and adoption assistance under Social Security,
        - Not be receiving optional State supplementary payments (SSP), and
        - Reside in the Service Area applicable to this Agreement.
6. Agree to pay for the cost of the Premium that Anthem requires,
7. Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective,
8. Not be incarcerated (except pending disposition of charges),
9. Not be entitled to or enrolled in Medicare Parts A/B, C and/or D,
10. Not be covered by any other group or individual health benefit plan.

For purposes of eligibility, a Qualified Individual's Service Area is the area in which the Qualified Individual:

1. Resides, intends to reside (including without a fixed address), or
2. Is seeking employment (whether or not currently employed), or
3. Has entered with a job commitment.

For Qualified Individuals under age 21, the Service Area is that of the parent or caretaker with whom the Qualified Individual resides.

For tax households with Members in multiple Exchange Service Areas:

1. If all of the members of a tax household are not living within the same Exchange Service Area, any member of the tax household may enroll in a QHP through any of the Exchanges for which one of the Tax Filers meets the residency requirements.
2. If both spouses or domestic partners in a tax household enroll in a QHP through the same Exchange, a Tax Dependent may only enroll in a Qualified Health Plan through that Exchange or through the Exchange that services the area in which the Dependent meets residency requirements.

Dependent Eligibility

To be eligible for coverage to enroll as a Dependent, You must be listed on the enrollment form completed by the Subscriber, be determined by the Exchange to be a Qualified Individual, meet all Dependent eligibility criteria established by the Exchange and be:

1. The Subscriber's legal spouse.
2. The Subscriber's domestic partner - domestic partners are two (2) adults who meet the qualifications of State law. For purposes of this Agreement, a domestic partner shall be treated the same as a spouse.
3. The Subscriber's or the Subscriber's spouse's or the Subscriber's domestic partner's children who are under age 26, including stepchildren, newborn and legally adopted children.
4. Children for whom the Subscriber, the Subscriber's spouse or Subscriber's domestic partner is a legal guardian until age 26.
5. A parent or stepparent who meets the definition of a qualifying relative under federal law and who lives or resides within the Service Area. This includes a parent or stepparent who has an in-law relationship with the Subscriber. The Subscriber's spouse or domestic partner must be enrolled in this Agreement for the parent in-law or stepparent in-law to be covered.

An enrolled Dependent child who reaches age 26 during a Benefit Period may remain enrolled as a Dependent until the end of that Benefit Period. The Dependent coverage shall end on the last day of the Benefit Period during which the Dependent child becomes ineligible.

Eligibility will be continued past the age limit only for those already enrolled Dependents who meet and continue to meet both of the following criteria:

1. Is incapable of self-sustaining employment by reason of physical or mental impairment, injury, illness, or condition and
2. Is chiefly dependent upon the Subscriber for support and maintenance.

The Dependent's impairment must start before the end of the period he or she would become ineligible for coverage.

The Exchange or Anthem Blue Cross acting on the Exchange's behalf must certify the Dependent's eligibility. The Exchange or Anthem Blue Cross acting on the Exchange's behalf must be informed of the Dependent's eligibility for continuation of coverage within sixty (60) days after the date the Dependent would normally become ineligible. You must notify the Exchange if the Dependent's status changes and if he or she is no longer eligible for continued coverage. The Exchange may require the Subscriber to submit proof of continued eligibility for any Dependent to the Exchange or to Anthem Blue Cross acting on the Exchange's behalf. Your failure to provide this information could result in termination of a Dependent's coverage.

Temporary custody is not sufficient to establish eligibility under this Agreement.

Open Enrollment

As established by the rules of the Exchange, Qualified Individuals are only permitted to enroll in a Qualified Health Plan (QHP), during the annual open enrollment period or as an enrollee to add a Qualified Individual to the current QHP during a special enrollment period for which the Qualified Individual has experienced a qualifying event.

An annual open enrollment period is provided for Qualified Individuals and enrollees. Qualified Individuals may enroll in a QHP, and enrollees may change QHPs at that time according to rules established by the Exchange

American Indians are authorized to move from one QHP to another QHP once per month.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Qualified Individual or enrollee who experiences certain qualifying events or changes in eligibility may enroll in or change a QHP through the Exchange, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Qualified Individual or enrollee has sixty (60) calendar days from the date of a triggering event to select a QHP.

The following are triggering events for a special enrollment period:

- A Qualified Individual or Dependent loses Minimum Essential Coverage.
- A Qualified Individual gains a Dependent or becomes a Dependent through marriage or entry into domestic partnership, birth, adoption, placement for adoption, placement in foster care, or through a child support court order (see "Court Ordered Health Coverage" below).
- An individual is mandated to be covered as a Dependent pursuant to a valid State or federal court order (see "Court Ordered Health Coverage" below).
- An individual has been released from incarceration.
- A Qualified Individual loses a Dependent or is no longer considered a Dependent through divorce, legal separation, or dissolution of domestic partnership as defined by State law in the State in which the divorce, legal separation, or dissolution of domestic partnership occurs, or if the individual, or his or her Dependent, dies.
- A Qualified Individual or Dependent newly meets the following requirements:
    - An applicant shall be a citizen or national of the United States, or a non-citizen who is lawfully present in the United States, and is reasonably expected to be a citizen, or not previously a citizen, national, or lawfully present gains such status or a non-citizen who is lawfully present for the entire period for which enrollment is sought.
    - An applicant shall not be incarcerated, other than incarceration pending the disposition (judgment) of charges.
- An individual receiving services from a contracting Provider under another health benefit plan where that Provider is no longer participating in the health benefit plan may qualify for special enrollment.
- A Qualified Individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of an error of the Exchange or the Department of Health and Human Services (HHS), or its instrumentalities as determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error.
- An enrollee or Dependent adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.
- A Qualified Individual, or Dependent enrolled in the same QHP, is determined newly eligible or newly ineligible for Advance Payments of the Premium Tax Credit or has a change in eligibility for Cost Sharing reductions, regardless of whether such individual is already enrolled in a QHP.
- Individuals whose existing coverage through an eligible employer sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan Year are permitted to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan.
- A Qualified Individual, enrollee, or Dependent gains access to new QHPs as a result of a permanent move; provided he or she had Minimum Essential Coverage in effect for one (1) or more days of the sixty (60) days prior to the move.
- A Qualified Individual or enrollee demonstrates to the Exchange, in accordance with HHS guidelines, that the individual meets other exceptional circumstances as the Exchange may provide.
- An individual is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty (also see "Reinstatement of Coverage for Members of the Military" below).
- A Qualified Individual or Dependent is enrolled in any non-calendar Year group health plan or individual health insurance coverage, or qualified small employer health reimbursement arrangement even if the Qualified Individual or their Dependent has the option to renew or re-enroll in such coverage (the date of the loss of coverage is the last day of the plan or policy

Year).

- A Qualified Individual or Dependent who loses pregnancy-related coverage or loses access to healthcare services through coverage provided to a pregnant woman's unborn child may qualify for a special enrollment (the date of the loss of coverage is the last day the Qualified Individual would have pregnancy-related coverage or access to healthcare services through the unborn child coverage).
- An individual who loses medically needy coverage may qualify for a special enrollment only once per calendar Year (the date of the loss of coverage is the last day the consumer would have medically needy coverage).
- A Qualified Individual or enrollee who is a victim of domestic abuse or spousal abandonment or is a Dependent or unmarried victim within a household, is enrolled in Minimum Essential Coverage, and sought to enroll in coverage separate from the perpetrator of the abuse or abandonment may qualify for a special enrollment.
- A Qualified Individual who is a Dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, may enroll in coverage at the same time as the victim.
- The Qualified Individual or enrollee, or their Dependent, adequately demonstrates to the Exchange that a material error related to plan benefits, Service Area, or Premium influenced the Qualified Individual's or enrollee's decision to purchase a QHP through the Exchange.
- A member of a federally recognized American Indian tribe may enroll at any time and may change plans once per month.
- A Qualified Individual newly gains access to an Individual Coverage Health Reimbursement Arrangement (ICHRA) or is newly provided a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA).

If You cannot find Your situation or if You have questions regarding qualification for a special enrollment period, contact Your agent/broker or call Us. We can only enroll based on events defined by State and/or federal law.

Newborn and Adopted Child Coverage

Newborn (recently born infants within thirty-one (31) days of birth) and adopted (children whose birth parent or appropriate legal authority have signed a written document granting the Subscriber, enrolled spouse or enrolled domestic partner the right to control healthcare for or, absent this document, other evidence exists of this right) children of the Subscriber, the Subscriber's spouse or the Subscriber's domestic partner will be covered for an initial period of thirty-one (31) days from the date of birth or adoption. To continue coverage beyond the first thirty-one (31) days, please contact the Exchange within sixty (60) days of the date of birth to add the child to the Subscriber's Agreement and You must pay Anthem timely for any additional Premium due.

A child will be considered adopted from the earlier of: 1) placement for adoption; or 2) the date the court enters a decree granting the adoption. The child will continue to be considered adopted unless the child is removed from Your home prior to issuance of a legal decree of adoption.

Please contact the Exchange within sixty (60) days of the placement for adoption or date of adoption to add the child to the Subscriber's Agreement and You must pay Anthem timely for any additional Premium due.

Newborn and adopted children of the Subscriber's Dependent children, newborn and adopted children of the Subscriber's spouse's Dependent children, or newborn and adopted children of the Subscriber's domestic partner's Dependent children are not covered under this Agreement, unless they are eligible for coverage under another provision of this Agreement.

Adding a Child due to Award of Court-Appointed Guardianship

If a Subscriber or the Subscriber's spouse or the Subscriber's domestic partner files an application for appointment of guardianship of a child, an application to cover the child under the Subscriber's Agreement must be submitted to the Exchange within sixty (60) days of the date the appointment of guardianship is granted. Coverage will be effective on the date the appointment of guardianship is

awarded by the court.

Court Ordered Health Coverage

If You are required by a court order, as defined by applicable State or federal law, to enroll Your child under this Agreement, and the child is otherwise eligible for the coverage, You must request permission from the Exchange for Your child to enroll under this Agreement and once approved by the Exchange, We will provide the benefits of this Agreement in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond any Dependent age limit. Any claims payable under this Agreement will be paid to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent or legal guardian. We will make information available to the child, custodial parent or legal guardian on how to obtain benefits and submit claims to Us directly.

Reinstatement of Coverage for Members of the Military

Members who are members of the United States Military Reserve and National Guard who terminate their coverage of this Agreement as a result of being ordered to active duty on or after January 1, 2007, may have their coverage reinstated. Please contact Member Services at the phone number on Your ID Card for information on how to apply for reinstatement of coverage following active duty as a reservist.

Effective Date of Coverage

The earliest Effective Date for the annual open enrollment period is the first day of the following Benefit Period for a Qualified Individual who has made a QHP selection during the annual open enrollment period. The applicant’s Effective Date is determined by the Exchange based on the receipt of the completed enrollment form. The Effective Date of coverage for plan selection made from November 1 to December 31, inclusive, shall be January 1. The Effective Date of coverage for plan selection made from January 1 to January 31, inclusive, shall be February 1. Benefits will not be provided until the applicable Premium is paid to Anthem.

Effective Dates for special enrollment periods:

1. In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption unless the Subscriber timely requests a different Effective Date. Advance Payments of the Premium Tax Credit and Cost Sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month.
2. In the case of marriage or domestic partnership, coverage is effective on the first day of the month after receipt of the application, as long as the application is received within sixty (60) days of the event.
3. In the case where a Qualified Individual loses Minimum Essential Coverage, coverage is effective on the first day of the month after receipt of the application, as long as the application is received within sixty (60) days of the event.
4. In the case of new access to an ICHRA or new provision of a QSEHRA, if the plan selection is made before the day of the triggering event, coverage is effective on the first (1st) day of the month following the date of the triggering event or, if the triggering event is on the first (1st) day of a month, on the date of the triggering event. If the plan selection is made on or after the day of the triggering event, coverage is effective on the first (1st) day of the month following the plan selection.

Effective Dates for special enrollment due to loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1. Legal separation, dissolution of domestic partnership or divorce,
2. Cessation of Dependent status, such as attaining the maximum age,
3. Death of an employee,
4. Termination of employment,

5. Reduction in the number of hours of employment,
6. Individual who no longer resides, lives or works in the Agreement's Service Area,
7. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
8. Termination of employer contributions, or
9. Exhaustion of COBRA benefits.

Effective Dates for special enrollment due to loss of Minimum Essential Coverage do not include termination or loss due to:

1. Failure to pay Premiums on a timely basis, including COBRA Premiums prior to expiration of COBRA coverage or
2. Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Notice of Changes

The Subscriber is responsible to notify the Exchange of any changes that will affect his or her eligibility or that of Dependents for services or benefits under: this Agreement. The Exchange must be notified of any changes as soon as possible but no later than within sixty (60) days of the event. This includes changes in address, marriage, divorce, domestic partnership, dissolution of domestic partnership, death, changes in income, change of Dependent's impairment or dependency status. Failure to notify the Exchange of persons no longer eligible for services will not obligate Us to pay for such services. Acceptance of Premium for persons no longer eligible for services will not obligate Us to pay for such services.

A family plan will be changed to an individual plan when only the Subscriber is eligible. When notice is provided within sixty (60) days of the event, the Effective Date of coverage is the event date causing the change to an individual plan. The Exchange must be notified when the Member becomes eligible for or enrolled in Medicare.

All notifications must be in writing and on approved forms or as otherwise required by the Exchange. Such notifications must include all information required to effect the necessary changes.

Statements and Forms

Subscribers or applicants for membership shall complete and submit to the Exchange applications or other forms or statements the Exchange may request. Subscribers or applicants for membership represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the Exchange is true, correct and complete and understand that all rights to benefits under this Agreement are subject to the condition that all such information is accurate. Any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact by the Member may result in termination or rescission of coverage.

Moving out of the Service Area

Coverage under this Agreement will end if the Member moves out of the Service Area. You will be eligible for a special enrollment to change to the plans available in the new Service Area to which You have moved to in California. You will need to find a new plan with an In Network Provider in Your new Service Area.

Monthly Premiums

Premiums are due monthly and are the charges You must pay Anthem to establish and maintain coverage. We determine and establish the required Premiums based on the Subscriber's age, number of Members and the specific regional area in which the Subscriber resides.

When You initiate changes to the Agreement that result in a change to the Premiums, the changes to the Premiums will be reflected on the next billing statement. When Anthem initiates a change to this Agreement, We will provide You sixty (60) days advance written notification of the changes.

Monthly Premiums can be found in the "Subscriber and Premium Information" and on Your monthly

billing statement. All monthly Premium payments and administrative fees are payable in advance and due on the monthly Premium due date (the first day of the Agreement period for which the Premium is paid).

If the Subscriber changes residence, he or she may be subject to a change in Premiums. Such change in Premiums will be effective on the next billing statement following notification of the change of residence. We will recalculate the Premiums to the new rate of Your regional area of residence. If the Subscriber does not notify Us of a change in residence and We later learn of the change in residential address, We may bill the Subscriber for the difference in Premiums from the date the address changed.

How to Pay Your Premium

After making Your initial Premium payment, You can make future payments by the following methods:

- Online at www.anthem.com/ca
- By mail using the address on Your Premium notice
- By authorizing Us to automatically deduct Your Premium payment from Your financial institution account every month
- By using Our mobile application
- Pay in person at any approved retailer found on the mobile application

To learn more about any of these options, please contact Member Services at the number on the back of Your Identification Card.

Electronic Funds Transfer

If You submit a personal check for Premiums Payment, You automatically authorize Us to convert that check into an electronic payment. We will store a copy of the check and destroy the original paper check. Your payment will be listed on the financial institution account statement as an Electronic Funds Transfer (EFT). Converting Your paper check into an electronic payment does not authorize Us to deduct Premiums from Your account on a monthly basis unless You have given Us prior authorization to do so.

Non-sufficient Funds

An administrative fee of $20 will be charged for any check, automatic deduction or EFT which is returned or dishonored by the financial institution as non-payable to Anthem for any reason.

WHEN MEMBERSHIP ENDS (TERMINATION)

This section describes how coverage for a Member can be terminated, cancelled, rescinded, suspended, or not renewed.

Termination of the Member

Unless prohibited by law, the Member's coverage will terminate if any of the following occurs:

1. The Member terminates his or her coverage with appropriate notice to the Exchange,
2. The Member no longer meets eligibility requirements for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, move outside the Service Area, etc.). In this case, the Exchange will send a notice to the Member. Coverage ends on the last day of the month following the month in which the Exchange notifies the Member (unless the Member requests an earlier termination date),
3. The Member no longer meets eligibility requirements for coverage in a QHP through the Exchange as a Dependent child because of reaching age 26. Coverage for Dependent children ends on the last day of the Benefit Year in which the child turns age 26. For a Dependent child eligibility past the age limit, please see subsection "Dependent Eligibility" under the section "WHEN MEMBERSHIP CHANGES (ELIGIBILITY)."
4. The Member fails to pay his or her Premium, and the grace period has been exhausted,
5. Rescission of the Member's coverage,
6. The QHP terminates or is decertified,
7. The Member changes to another QHP,
8. The Member was enrolled in a QHP without his or her knowledge or consent by a third party, including by a third party with no connection with the Exchange, or
9. The QHP Issuer may terminate coverage as permitted by the Exchange. The Member will be notified by the QHP Issuer as required by law.

Effective Dates of Termination

"Reasonable notice" is defined as fourteen (14) days prior to the requested Effective Date of termination.

Termination of coverage is effective on the following date(s):

1. In the case of termination initiated by the Member, the last day of coverage is:
    a. The termination date specified by the Member, if reasonable notice is provided,
    b. Fourteen (14) days after the termination is requested, if the Member does not provide reasonable notice, or
    c. On a date determined by the Member's QHP Issuer, if the Member's QHP Issuer is able to implement termination in fewer than fourteen (14) days and the Member requests an earlier termination Effective Date.
2. If the Member is newly eligible for Medicaid, Children's Health Insurance Program (CHIP), or the Basic Health Plan, the last day of coverage is the day before such coverage begins.
3. In the case where a Member is no longer eligible for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, move outside the Service Area, etc.), the last day of coverage is the last day of the month following the month in which notice is sent by the Exchange, unless the Member requests an earlier termination Effective Date.
4. In the case where a Member is no longer eligible for coverage in a QHP through the Exchange as a Dependent child because of reaching age 26, coverage for the Dependent child ends on the last day of the Benefit Year in which the child turns age 26. For a Dependent child eligibility past the age limit, please see subsection "Dependent Eligibility" under the section "WHEN MEMBERSHIP CHANGES (ELIGIBILITY)."
5. In the case of a termination for non-payment of Premium and the three (3) month federal grace period for Members receiving Advance Payments of the Premium Tax Credit (APTC) or

California Premium Subsidy (CAPS) has been exhausted, the last day of coverage will be the last day of the first month of the three (3) month federal grace period.

6. In the case of a termination for non-payment of Premium, and the individual is not receiving APTC or CAPS, the last day of coverage is the last day of the grace period.
7. In the case of a termination when a Member changes QHPs, the last day of coverage in a Member's prior QHP is the day before the Effective Date of coverage in his or her new QHP.
8. The day following the Member's death. When a Subscriber dies, the surviving spouse or domestic partner of the deceased Subscriber, if covered under the Agreement, shall become the Subscriber.

Termination for Non-Payment of Premium

"Grace period" means the period of at least thirty (30) consecutive days beginning the day the Notice of Start of Grace Period is dated to allow a Member who does not receive APTC or CAPS to pay an unpaid Premium amount without losing healthcare coverage.

"Notice of Start of Grace Period" means the notice sent by Us to You that Your coverage will be terminated unless the Premium amount due is received by Us no later than the last day of the grace period.

"APTC Member" is an enrollee who is currently a recipient of APTC payments pursuant to federal laws.

"CAPS Member" is an enrollee who is currently a recipient of CAPS payments pursuant to State laws.

"Federal grace period" means the period of three (3) consecutive months to allow a Member who receives APTC or CAPS to pay an unpaid Premium amount without losing healthcare coverage prior to terminating the Member's coverage for non-payment of Premium. To qualify for the federal grace period, the APTC or CAPS Member must have paid at least one (1) full month's Premium during the Benefit Period.

"Notice of Start of Federal Grace Period" means notice sent by Us to You that Your coverage will be terminated unless the Premium amount due is received by Us no later than the last day of the federal grace period.

If You fail to make a Premium payment by the due date, We will send You a Notice of Start of Grace Period or Notice of Start of Federal Grace Period notifying You that a payment delinquency has triggered a grace period starting from the day the Notice of Start of Grace Period or the Notice of Start of Federal Grace Period is dated.

If You believe that Your coverage has been improperly terminated or not renewed, You may file a grievance in accordance with the grievance process outlined in "If You Have a Compliant or Appeal." You should file Your grievance as soon as possible after You receive notice that Your coverage will end. You may also send a grievance to the Director of the Department of Managed Health Care (DMHC). If Your coverage is still in effect when You submit a grievance, We will continue to provide coverage to You under the terms of Your coverage until a final determination of Your grievance has been made, including any review by the Director of the DMHC (this does not apply if Your coverage is cancelled for non-payment of Premium). If Your coverage is maintained in force pending outcome of the review, Your Premium must still be paid to Us. If, however, Your coverage was terminated or not renewed, and the Director of the DMHC finds that the termination or non-renewal failed to comply with legal requirements, We will reinstate Your coverage.

Guaranteed Renewable

Coverage under this Agreement is guaranteed renewable, except as permitted to be terminated, cancelled, rescinded or not renewed under applicable State and federal law, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Agreement by payment of the renewal Premium by the end of the grace period or federal grace period, as applicable, of the Premium due date, provided the following requirements are satisfied:

1. Eligibility criteria as a Qualified Individual continue to be met.
2. There are no fraudulent or intentional misrepresentations of material fact on the application or

under the terms of this Agreement.

3. This Agreement has not been terminated by the Exchange.

Loss of Eligibility

Coverage ends for a Member when he or she no longer meets the eligibility requirements for coverage. You must timely furnish to the Exchange or the QHP Issuer any information requested regarding Your eligibility and the eligibility of Your Dependents. Failure to give timely notification of a loss of eligibility will not obligate Us to provide benefits for ineligible persons, even if We have accepted Premiums or paid benefits.

Rescission

IF WITHIN TWO (2) YEARS AFTER THE EFFECTIVE DATE OF THIS AGREEMENT, WE DISCOVER ANY ACT, PRACTICE OR OMISSION THAT CONSTITUTES FRAUD OR AN INTENTIONAL MISREPRESENTATION OF MATERIAL FACTS THAT YOU OR YOUR DEPENDENTS KNEW, BUT DID NOT DISCLOSE ON YOUR APPLICATION, WE MAY TERMINATE OR RESCIND THIS AGREEMENT AS OF THE ORIGINAL EFFECTIVE DATE. ADDITIONALLY, IF WITHIN TWO (2) YEARS AFTER ADDING ADDITIONAL DEPENDENTS (EXCLUDING ELIGIBLE NEWBORN CHILDREN ADDED WITHIN SIXTY (60) DAYS AFTER BIRTH), WE DISCOVER ANY ACT, PRACTICE OR OMISSION THAT CONSTITUTES FRAUD OR AN INTENTIONAL MISREPRESENTATION OF MATERIAL FACTS THAT YOU OR YOUR DEPENDENTS KNEW, BUT DID NOT DISCLOSE IN YOUR APPLICATION, WE MAY RESCIND COVERAGE FOR THE ADDITIONAL DEPENDENT AS OF THE DATE HE OR SHE ORIGINALLY BECAME EFFECTIVE.

By signing the application, every Member age 18 or older acknowledged they had provided true and complete answers to all questions in the application to the best of their knowledge and understood that all answers were important and would be considered in the acceptance or denial of the application. Every Member age 18 or older further acknowledged that all information responsive to a question on the application was required to be provided in their answers consistent with California law. If Anthem discovers that You committed an act, practice, or omission that constitutes fraud, or intentional misrepresentation of material fact is found in the application, Anthem may rescind this Agreement within the first twenty-four (24) months from Your Effective Date. This means that Anthem will revoke Your Agreement as if it never existed back to the original Effective Date.

By signing the application, You additionally acknowledged that all of Your Dependents listed on the application who were 18 years of age or older read the application and provided true and complete information on the application to the best of Your knowledge. You further acknowledged that to the best of Your knowledge and belief, that You had done everything necessary to be able to assure Anthem that all information about all applicants, including Your children under the age of 18 listed on the application, was true and complete. Anthem may rescind the entire Agreement, within the first twenty-four (24) months from Your Effective Date if it discovers that You committed an act, practice or omission that constitutes fraud or intentional misrepresentation of material fact is found in the application. Members other than the individual whose information led to the rescission may be able to obtain coverage as set forth below in Eligibility following Rescission.

This Agreement may also be terminated if You knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Agreement. Termination for any act, practice or omission that constitutes fraud or any intentional misrepresentation of material fact will be effective as of the Effective Date of coverage in the case of rescission. We will give You at least thirty (30) days written notice prior to rescission of this Agreement. After the two (2) Years following Your Effective Date, We may not rescind Your Agreement for any reason.

If rescinded, You will have the option to submit a new application in the future to be considered for benefits. You, consistent with California law, will be required to pay for any services Anthem paid on Your behalf and Anthem will refund any Premium paid by You, less Your medical and Pharmacy expenses that Anthem paid.

If Your Agreement is rescinded, You will be sent thirty (30) days written notice that will explain the basis for the decision and Your Appeal rights including the right to request review by Us or the Department of

Managed Health Care if You believe that this Agreement has or will be improperly rescinded.

Eligibility following Rescission. For an Agreement that has been rescinded, eligible Members on such Agreement may continue coverage in one of the following ways:

- Enroll in a new plan that provides same benefits or
- Remain covered under the plan that was rescinded.

In either instance, Premiums may be revised to reflect the number of persons on the Agreement.

We will notify in writing all Members of the right to coverage under an Agreement, at a minimum, when We rescind the Agreement.

We will provide sixty (60) days for Members to accept the offered new Agreement and the contract shall be effective as of the Effective Date of the original Agreement and there shall be no lapse in coverage.

Discontinuation of Coverage

We can refuse to renew Your Agreement if We decide to discontinue a health coverage product that We offer in the individual market. If We discontinue a health coverage product, We will provide You such advance notice of the discontinuation as required by applicable law with at least ninety (90) days' notice of the discontinuation and with at least one-hundred and eighty (180) days' notice if We are discontinuing all individual products in the State. In addition, You will be given the option to purchase any health coverage plan that We currently offer without regard to claims status or health history. Non-renewal will not affect an existing claim.

Grace Period

If the Subscriber does not pay the full amount of the Premium by the Premium due date, the grace period is triggered. The grace period is an additional period of time during which coverage may remain in effect and refers to either the three (3) month grace period required for individuals receiving APTC or CAPS or for individuals not receiving either APTC or CAPS, it refers to any other applicable grace period.

If the Subscriber does not pay the required Premium by the end of the grace period, the Agreement is terminated. In order for a Premium to be considered paid during the grace period, We must receive it by the last day of the grace period. The application of the grace period to claims is based on the date of service and not on the date the claim was submitted.

Subscriber Receives APTC or CAPS

If the Subscriber receiving the APTC or CAPS has previously paid at least one (1) month's Premium in a Benefit Period, We must provide a federal grace period of at least three (3) consecutive months. During the federal grace period, We must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC or CAPS. If full Premium payment is not received during the federal grace period, the last day of coverage will be the last day of the first month of the three (3) month federal grace period. We must pay claims incurred during the first month of the three (3) month federal grace period. During the second and third month of the grace period Your coverage will be suspended and You will be ineligible for benefits under Your health benefit Plan unless You pay all Premiums due before the end of the federal grace period. You may be required by Your healthcare Providers to pay for any healthcare services You need.

Please note, that if Your full Premium payment is not received during the grace period You will have no coverage for claims incurred after the first month of the three (3) month federal grace period and this means You will be liable for the full cost of any services You receive after the first month of the three (3) month federal grace period. If You do not pay Your full Premium during the federal grace period, You will be liable to Us for the Premium payment due for the period through the last day of the first month of the three (3) month federal grace period. You will also be liable to Us for any claims payments made for services incurred after the last day of the first month of the three (3) month federal grace period.

Subscriber Does Not Receive APTC or CAPS

If the Subscriber is not receiving an APTC or CAPS, this Agreement has a grace period of thirty-one (31) days. This means if any Premium payment, except the first, is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the Agreement will stay in force unless prior to the date Premium payment is due You give timely written notice to Us that the Agreement is to be terminated. If You do not make the full Premium payment during the grace period, the Agreement will be terminated on the last day of the grace period. You will be liable to Us for the Premium payment due including for the grace period. You will also be liable to Us for any claims payments made for services incurred after the last day of the grace period.

After Termination

Once this Agreement is terminated, the former Members cannot reapply until the next annual open enrollment period unless they experience an event that qualifies for a special enrollment period prior to the annual open enrollment period.

Removal of Members

A Subscriber may terminate the enrollment of any Member from the Agreement. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

Refund of Premium

Upon termination, We shall return promptly the unearned portion of any Premium paid.

IMPORTANT INFORMATION ABOUT YOUR COVERAGE

Changes in Premium

The Premium for this Agreement may change subject to, and as permitted by, applicable law. You will be notified of a Premium change at the address in Our records sixty (60) days prior to the renewal of this Agreement. Any such change will apply to Premiums due on or after the renewal date. If advance Premiums have been paid beyond the renewal date, such Premiums will be adjusted as of that renewal date to comply with the rate change. Additional Premiums may be billed, if necessary, for future periods.

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 Agreement 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 Agreement. We reserve the right to discontinue a pilot or test program at any time.

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 Agreement are not part of the Agreement between the parties and do not give rise to contractual obligations.

Right to Receive and Release Needed Information

Certain facts are needed to apply these rules. We have the right to decide which facts We need. Subject to applicable privacy restrictions, We may obtain needed facts from, or give them to, any other organization or person. We need not tell You or obtain Your consent to do this. Each person claiming benefits under this Agreement must give Us any facts We need to pay the claim.

Notice of Privacy Practices

You have the right to receive a copy of the Notice of Privacy Practices. You may obtain a copy by calling Member Services at the phone number on Your ID Card or by accessing Our website at www.anthem.com/ca.

Catastrophic Events

In case of fire, flood, war, civil disturbance, court order, strike, an act of terrorism or other cause beyond Our control, We may be unable to process Your claims on a timely basis. No legal action or lawsuit may be taken against Us due to a delay caused by any of these events. In such an event, however, We shall use reasonable efforts to perform Our respective obligations.

Coordination of Dental Benefits

Coordination of Benefits (COB) provisions apply when You or members of Your family have other coverage through another plan that offers dental benefits. When You have other dental coverage, both plans will work together to provide the maximum dental benefits for which You are entitled. Coordinated benefits will never be less than those normally provided under this Agreement. This provision is only applicable to the dental benefits found in the benefit “Child Dental Care” under “What is Covered.”

If You are eligible for dental benefits through two (2) or more plans, one (1) of the plans will be responsible for "primary coverage." This means full benefits will be provided by the primary coverage before benefits of the other plan will be provided.

A plan determined to be secondary shall pay the lesser of either the amount that it would have paid in the absence of any other dental benefit coverage, or the enrollee's total Out of Pocket cost payable under the primary dental benefit plan for benefits covered under the secondary plan.

- If You have Pediatric essential health benefits that are included as part of Your medical plan, the medical plan will be the primary coverage and any standalone dental plan will be secondary coverage.
- If the spouses or domestic partners both have separate dental plans, each offering coverage for spouse or domestic partner and family the plan that covers the person other than as a Dependent (for example, as an employee, Member, Subscriber, policyholder or retiree) is the primary plan and the plan that covers the person as a Dependent is the secondary plan.
- If the Subscriber is the same person on each plan, the plan under which he or she has been enrolled for the longer period of time will be primary.
- If one of the plans does not have a COB provision, it will be primary carrier.
- As required by law, if a covered Member of Your family also has coverage under Medicaid, this plan is always primary.
- If Dependent children are covered under both plans, one of the following rules will apply, unless there is a court order stating otherwise:
    - The plan covering the parent with the earlier birthday in the Year will be primary. If both parents have the same birthday, the plan covering the Dependent for the longer period of time will be primary OR
    - Some insurance companies always designate the father's plan as the primary carrier for children. If Anthem must coordinate benefits with a company that has that rule, the father's plan will be primary. You will be asked to complete questionnaires from time to time asking about other dental coverage. Please complete and return the questionnaire quickly and let Us know when other insurance coverage changes or is terminated to avoid possible claims denials.

Coordination with Medicare

Unless federal law requires the plan to be the primary payor, the benefits under this Agreement for Members entitled to Medicare Part A or enrolled in Medicare Part B, do not duplicate any benefit Members are entitled to under Medicare. Where Medicare is the responsible payor, all amounts for services that have been paid for by Us that should have been paid for by Medicare shall be reimbursed to Us by or on behalf of the Members.

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.

Duplication of Anthem Benefits

If, while covered under this Agreement, You are also covered by another Anthem Individual Agreement:

- You will be entitled only to the benefits of the Agreement with the greater benefits and
- We will refund any Premiums received under the Agreement with the lesser benefits, covering the time period both Agreements were in effect. However, any claims payments made by Us under the Agreement with the lesser benefits will be deducted from any such refund of Premiums.

Notice

Except for notices that are required to be sent by mail, any notice required may be sent by any reasonable method of transmission, including paper, electronic, or another method of transmission specifically agreed to by You. For notice required to be sent by mail, written notice will be officially given by Us when it is mailed to Your address as it appears on Our records. You may review Your EOC online at www.anthem.com/ca or request a hard copy be mailed to You.

You will meet any notice requirements by mailing the notice to:

Anthem Blue Cross
P.O. Box 60007
Los Angeles, California 90060-0007

Terms of Coverage

- In order for You to be entitled to benefits under this Agreement on a specific date, Your coverage under this Agreement must be in effect on the date You received services or supplies except as specifically stated in "Continuation of Care After Termination of a Provider" this section.
- This Agreement, including all terms, benefits, conditions, limitations and exclusions, may be changed by Us as provided in "Right to Change Agreement" below.
- The benefits to which You may be entitled will depend on the terms of coverage as set out in the Agreement in effect on the date You receive the service or supply.

Physical Examinations and Autopsy

We, at Our own expense, shall have the right and opportunity to examine the Member when and as often as it may reasonably be required during the pendency of a claim and to make an autopsy in case of death where it is not prohibited by law.

Receipt of Information

We are entitled to receive from any Provider of service information about You that is necessary to administer claims on Your behalf according to federal/State law. This right is subject to all applicable confidentiality requirements. You agree to assist in obtaining this information if needed. Failure to assist Us in obtaining the necessary information when requested may result in the delay or rejection of Your claims until the necessary information is received by Us.

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. Contact Us at the phone number on Your ID Card for a copy of Our policies and procedures for preserving Your medical record confidentiality.

Anthem shall neither increase the subscription charges payable by You, nor decrease in any manner the benefits and coverage provided hereunder, except after at least thirty (30) days prior written notice to You.

Anthem shall provide, within a reasonable period of time, written notice to You of any In Network Provider's termination or breach of, or inability to perform under, any Provider contract if Anthem determines that You or Your Family Members may be materially and adversely affected thereby.

Your Medical Group will provide You notice of termination of a PCP to whom You are assigned or from whom You are receiving a course of treatment. To select a new PCP, call Member Services at the phone number on Your ID Card.

Upon termination of the contract or other agreement with any In Network Provider, Anthem shall be liable to pay the cost of Covered Services (other than applicable Copayments/Coinsurance) rendered by that Provider to a Member who retains eligibility under this Agreement, or by operation of law, and who is under the care of that Provider at the time of such termination. That Provider shall continue to provide such services to the Member, in accordance with the terms of this Agreement, until the services being rendered are completed, unless reasonable and medically appropriate provision is made for the

assumption of such services by another Provider.

Third Party Liability

These provisions apply when We pay benefits as a result of injuries or illness You sustained and You have a right to a recovery or have received a recovery as a result of actions or omissions of a third party. We will automatically have a lien upon any recovery. Our lien will equal the amount of benefits We pay on Your behalf for injuries, disease, condition or loss You sustained as a result of any act or omission for which a third party is liable. Our lien will not exceed the amount We actually paid for those services. 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.

In this section, "recovery" means money You (or Your estate, parent, trustee or legal guardian) receive, are entitled to receive, or have a right to receive, whether by judgment, award, settlement or otherwise as a result of injury or illness caused by the third party, regardless of whether liability is contested. In this section "third party" refers to any person or entity who is legally responsible in relation to the injuries or illnesses sustained by You for which We paid benefits, including but not limited to the party(ies) who caused the injury or illness ("tortfeasor"), the tortfeasor's insurer, the tortfeasor's indemnifier, the tortfeasor's guarantor, the tortfeasor's principal or any other person or entity responsible or liable for the tortfeasor's acts or omissions, Your own insurer (underinsured or uninsured motorist benefits, medical payments, no fault benefits, personal injury protection, etc.), or any other person, entity, policy or plan that may be liable or responsible in relation to the injuries or illness, to the extent permitted by law.

Subrogation and Right of Reimbursement

- 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.
- We, or Our designee, have first priority for the full amount of Our lien and shall be entitled to payment, reimbursement and/or subrogation to the extent of the total amount of Our lien regardless of whether the total amount of the recovery on account of the injury or illness is less than the actual loss suffered by You (or Your estate, parent, trustee or legal guardian).
- Our rights are not limited by any allocation or characterization made in a settlement agreement or court order.
- If You fail to repay Us, fail to cooperate or Our lien is otherwise not recovered by Us, We shall be entitled to deduct any of the unsatisfied portion of Our lien or the amount of Your recovery, whichever is less, from any future benefit under the Agreement.
- In the event that You fail to disclose to Us the amount of Your settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Agreement.
- We shall also be entitled to recover any of the unsatisfied portion of Our lien or the amount of Your settlement, whichever is less, directly from the Providers to whom We have made payments. In such a circumstance, it may then be Your obligation to pay the Provider the full billed amount, and We would not have any obligation to pay the Provider.

Member's Duties

- Your signed application for coverage and/or Your receipt of benefits under this Agreement authorizes and/or acknowledges each of Our rights set forth in this section.
- You, or Your attorney, must notify Us promptly of how, when and where an accident or incident resulting in personal injury or illness to You occurred and all information regarding the parties

involved.

- You agree to advise Us, directly or through Your attorney, in writing of Your claim against a third party, or a claim against Your own insurance, within sixty (60) days of making such claim, unless a shorter period of time is prescribed by law, and that You or Your attorney will take such action, furnish such information and assistance, and execute such papers as We may require to facilitate enforcement of Our lien rights.
- Relevant information includes, but is not limited to, police reports, pleadings, settlement agreements, and communications with any party regarding the accident, incident, injury or illness.
- Neither You, nor Your attorney, shall take any action that may prejudice Our rights or interests under this section.
- You and/or Your attorney must cooperate with Us in the investigation, settlement and protection of Our rights.
- You and/or Your attorney must immediately notify Us if a trial is commenced, if a settlement occurs or is consummated, or if potentially dispositive motions are filed in a case.
- You and/or Your attorney must hold in trust the extent of Our lien that is recoverable by Us under the law and the recovery must not be dissipated or disbursed until such time as We have been repaid in accordance with these provisions.
- If You, or Your attorney, fail to give Us notice, fail to cooperate with Us, or intentionally take any action that prejudices Our rights, You will be in material breach of this 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.

Nothing in this Agreement shall be construed to limit Our right to utilize any remedy provided by law to enforce Our rights to recover Our lien.

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

Severability

In the event that any provision in this Agreement is declared legally invalid by a court of law or determined to be illegal due to the enactment of new legislation or regulations, such provision will be severable and all other provisions of the Agreement will remain in force and effect.

Unauthorized Use of Identification Card

If You permit Your Identification Card to be used by someone else or if You use the card before coverage is in effect or after coverage has ended, You will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Right to Change Agreement

This Agreement, including any endorsements or attached paper, is the entire contract of insurance. Its terms can only be changed by a written endorsement signed by one of Our authorized officers. NO AGENT OR EMPLOYEE OF OURS IS AUTHORIZED TO CHANGE THE TERMS OR WAIVE ANY OF THE PROVISIONS OF THIS AGREEMENT.

Workers' Compensation Insurance

This Agreement does not take the place of or affect any requirement for or coverage by workers' compensation insurance. Additionally, as stated under "What is Not Covered (Exclusions)," this Agreement does not cover any condition for which benefits are covered by any worker's compensation law or similar law.

Care Coordination

We pay In Network Providers in various ways to provide Covered Services to You. For example,

sometimes We may pay In Network Providers a separate amount for each Covered Service they provide. We may also pay them one (1) amount for all Covered Services related to treatment of a medical condition. Other times, We may pay a periodic, fixed pre-determined amount to cover the costs of Covered Services. In addition, We may pay In Network Providers financial incentives or other amounts to help improve quality of care and/or promote the delivery of healthcare services in a cost-efficient manner, or compensate In Network Providers for coordination of Member care. In some instances, In Network Providers may be required to make payment to Us because they did not meet certain standards. You do not share in any payments made by In Network Providers to Us under these programs.

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its Medical Directors. Technology assessment criteria are used to determine the Experimental/Investigational status or Medical Necessity of new technology. Guidance and external validation of Anthem medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately twenty (20) doctors from various medical specialties including Anthem's Medical Directors, doctors in academic medicine, and doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

Program Incentives

We may offer incentives from time to time in order to introduce You to covered programs and services available under this Agreement. 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, encouraging You to update Member-related information and encouraging You to enroll automatically to pay Premiums electronically. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and discounts on fees or Member Cost Shares. Acceptance of these incentives is voluntary as long as Anthem offers the incentives program. Motivational rewards, awards or points for achieving certain milestones may be a feature of the program. We may discontinue an incentive or a program for a particular covered program or service at any time. If You have any questions about whether receipt of an incentive or retailer coupon results in taxable income to You, We recommend that You consult Your tax advisor.

Value-Added Programs

We may offer health or fitness related programs and products to Our Members, through which You may access discounted rates from certain vendors for products and services available to the general public. We may also offer value-added services that include discounts on Pharmacy products (over-the-counter drugs, consultations and biometrics). In addition, You may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

The products and services available under this program are not Covered Services under the Agreement but are in addition to Agreement benefits and may include giveaways that promote a healthy lifestyle. As such, program features are not guaranteed under Your Agreement 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 Agreement. 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 test for immediate results or collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may also be offered a home visit appointment to collect such specimens and complete biometric screenings. You may need to pay any Cost Shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit or the home visit. (If You have any questions about whether receipt of a gift card or retailer coupon results in taxable income to You, We recommend that You consult Your tax advisor.)

Members' Rights and Responsibilities

The delivery of quality healthcare requires cooperation between patients, their Providers and their healthcare benefit Plan. One of the first steps is for patients and Providers to understand Member rights and responsibilities. Therefore, Anthem has adopted a Members' Rights and Responsibilities statement.

It can be found on Our website FAQs. To access, go to www.anthem.com/ca and select "Member Support". Under the Support column select "FAQs" > "Laws and Rights That Protect You" > "What are my rights as a member?". Members or Providers who do not have access to the website can request copies by contacting Anthem, or by calling the number on the back of the Member ID Card.

DEFINITIONS

The following terms, defined in this section, are capitalized throughout the Agreement so they are easy to identify.

Advance Payments of the Premium Tax Credit (APTC)

Payment of the tax credits which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an Exchange.

Agreement

This Anthem Individual HMO Evidence of Coverage and Disclosure Form issued to You by Anthem.

Ambulatory Surgical Center

A freestanding Outpatient surgical Facility. It must be licensed as an Outpatient clinic according to State and local laws and must meet all requirements of an Outpatient clinic providing surgical services. It must also meet accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations or the Accreditation Association of Ambulatory Health Care.

American Indian

An individual who is a member of a federally recognized Indian tribe. A tribe is defined as any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation which is recognized as eligible for the special programs and services provided by the United States because of their status as Indians.

Anthem Blue Cross ("Anthem")

Blue Cross of California, doing business as Anthem Blue Cross, a healthcare service plan regulated by the Department of Managed Health Care. In this Agreement, the words "We," "Us," "Our" and "Anthem" refer to Anthem Blue Cross.

Appeal

A formal request by You or Your representative for reconsideration of a decision not resolved to Your satisfaction. See the "If You Have a Complaint or an Appeal" section of this Agreement.

Authorized Referral

Occurs when a Member, because of his or her medical needs, requires the services of a Specialist who is an Out of Network doctor, or requires special services or Facilities not available at a contracting Hospital, but only when the Referral has been authorized ***before*** services are rendered and when the following conditions are met:

- There is no In Network doctor who practices in the appropriate specialty, or
- There is no contracting Hospital which provides the required services or has the necessary Facilities that meet the adequacy and accessibility requirements of State or federal law, and
- The Member is referred to Hospital or doctor that does not have an agreement with Anthem for a Covered Service by an Anthem In Network doctor

If there is a shortage of one or more types of Providers to ensure timely access to Covered Services, Anthem will also assist covered individuals to locate available and accessible contract Providers in neighboring Service Areas for obtaining healthcare services in a timely manner appropriate to the Member's health needs.

Authorized Service(s)

A Covered Service You get from an Out of Network Provider that We have agreed to cover at the In Network level. Anthem may authorize such service(s) when a service is not available from an In Network Provider within the Agreement's applicable access standards.

You will have to pay any In Network Deductible, Coinsurance, and/or Copayment(s) that apply, and may also have to pay the difference between the Reasonable and Customary Value and the Out of Network Provider's charge. See Your "Schedule of Cost Share and Benefits" and "How Your Claims are Paid" for more details.

Benefit Period

The period of time that We pay benefits for Covered Services. Generally, the Benefit Period is a calendar Year for this Agreement, as listed in the "Schedule of Cost Share and Benefits." If Your coverage ends earlier, the Benefit Period ends at the same time.

Biosimilar/Biosimilars

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 Drugs (Brand Name Drugs)

Prescription Drugs that We classify as Brand Name Drugs or Our PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

California Premium Subsidy (CAPS)

Payment of assistance which is provided from the state on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an Exchange.

Coinsurance

The percentage of the Negotiated Fee Rate that You pay for some Covered Services.

Compounded (Combination) Medications (Compound Drugs)

When all the active ingredients of the Compound Drug are FDA-approved in the form in which they are used in the Compound Drug, require a Prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer.

Controlled Substances

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

Copayment

A fixed amount You pay for a Covered Service, usually when You receive the service. The amount can vary by the type of Covered Service.

Cost Share (Cost Sharing)

The amount which the Member is required to pay for Covered Services. Where applicable, Cost Share can be in the form of Copayments, Coinsurance and/or Deductibles.

Covered Services

Services, supplies or treatments which are:

- Medically Necessary or otherwise specifically included as a benefit and that is listed under the "What is Covered" section,
- Within the scope of the Provider's license,
- Rendered while coverage under this Agreement is in force,
- Not Experimental or Investigational or not covered by this Agreement, and
- Authorized in advance if such preauthorization is required in this Agreement.

Deductible

The amount of charges You must pay for any Covered Services before any benefits are available to You under this coverage. Your Deductible is stated in Your "Schedule of Cost Share and Benefits".

Dependent

A member of the Subscriber's family who meets the rules listed in the "When Membership Changes (Eligibility)" section and who has enrolled in the Agreement.

Designated Pharmacy Provider

An In Network Pharmacy that has executed a Designated Pharmacy Provider agreement with Us or an In Network Provider that is designated to provide Prescription Drugs, including Specialty Drugs, to treat certain conditions.

Effective Date

The date when a Member's coverage begins under this Agreement.

Emergency Medical Condition (Emergency)

A medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following conditions:

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

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

Emergency Services (Emergency Care)

With respect to an Emergency Medical Condition:

- A medical or behavioral health screening examination that is within the capability of the Emergency department of a Hospital, including ancillary services routinely available to the Emergency department to evaluate such Emergency Medical Condition and
- Within the capabilities of the staff and Facilities available at the Hospital, such further medical examination and treatment to stabilize the patient.

The term "stabilize" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a Facility. With respect to a pregnant woman who is having contractions, the term "stabilize" also means to deliver (including the placenta), if there is inadequate time to affect a safe transfer to another Hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Exchange

The Health Benefit Exchange of California also known as Covered California.

Experimental and Experimental Procedures

Any medical, surgical and/or other procedures, services, products, drugs, or devices, including implants used for research, except as specified in "Clinical Trials" in the "What is Covered" section.

Facility

A Facility including but not limited to, a Hospital, freestanding ambulatory surgical Facility, Residential Treatment Center, or Skilled Nursing Facility, as defined in this Agreement. The Facility must be

licensed as required by law, satisfy Our accreditation requirements, and approved by Us.

Generally Accepted Standards of Mental Health and Substance Use Disorder Care

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

Gender Identity Disorder (Gender Dysphoria) (GID)

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

The process of changing one's outward appearance, including physical sex characteristics, to accord with his or her actual gender identity.

Generic/Generic Drugs

Prescription Drugs that We classify as Generic Drugs or that Our PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

Habilitative Services

Healthcare services and devices that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings.

Home Delivery Pharmacy

A service where You get Prescription Drugs (other than Specialty Drugs) through a mail order service.

Home Healthcare Agency

An entity, licensed in the state in which it is located, which:

- Provides skilled nursing and other services on a visiting basis in the Member’s home and
- Is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending doctor.

Hospital

A Facility licensed as a Hospital as required by law that must satisfy Our accreditation requirements and be approved by Us.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial care
6. Educational care
7. Subacute care

Identification Card/ID Card

A card issued by Anthem that bears the Member's name, identifies the membership by number, and may contain information about Your coverage. It is important to carry this card with You.

In Network Pharmacy

An In Network Pharmacy is a Pharmacy that has an In Network Pharmacy agreement in effect with or for Our benefit at the time services are rendered. In Network Pharmacies may be based on a restricted network, and may be different than the network of In Network Pharmacies for Our other products. To find an In Network Pharmacy near You, call Pharmacy Member Services at the telephone number on the back of Your Identification Card.

In Network Provider

In Network Provider means any Provider as defined in California law, located inside or outside of the network Service Area of a designated network, meeting all of the following criteria:

A. The Provider is available to provide covered services to all Members using the designated network.

B. The Provider is one or more of the following:

    1. An Anthem employee;
    2. An individual health professional or health facility contracted directly with Anthem, consistent with California law;
    3. An individual health professional or health facility contracted with Anthem through an association, Provider group, or other entity, consistent with California law;
    4. An individual health professional or health facility designated to deliver Covered Services to enrollees in the network through a plan-to-plan contract, as defined in California law; or
    5. An individual health professional or health facility required to be part of Anthem's network under any of the following circumstances;
        a. A corrective action plan submitted to the DMHC by Anthem or its delegated entity;
        b. As required by the DMHC pursuant to California law; or
        c. As otherwise required by order of the DMHC.

C. The Provider is accessible to Members of the designated network without limitations other than established:

    1. In Network referral or authorization processes; or
    2. Processes for changing Provider groups consistent with California law, in networks where enrollees are assigned to a Provider group.

Inpatient

A Member who receives care as a registered bed patient in a Hospital or other Facility where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than twenty-four (24) hours.

Intensive Outpatient Program

Structured, multidisciplinary treatment for Mental Health and Substance Use Disorders that provides a combination of individual, group and family therapy to Members who require a type or frequency of treatment that is not available in a standard Outpatient setting.

Interchangeable Biological Product

A type of biological product that is licensed (approved) by the 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. 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 and Investigational Procedures

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

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

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

Maintenance Medication

A drug You take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If You are not sure if the Prescription Drug You are taking is a Maintenance Medication, please call Pharmacy Member Services at 833-236-6196 or check Our website at www.anthem.com/ca for more details.

Medicaid

Title XIX of the United States Social Security Act, Grants to States for Medical Assistance Programs.

Medical Emergency

A psychiatric Emergency Medical Condition or a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity including, without limitation, sudden and unexpected severe pain that the absence of immediate medical or psychiatric attention could reasonably be expected to result in:

- Permanently placing the Member's health in jeopardy,
- Causing other serious medical or psychiatric consequences,
- Causing serious impairment to bodily functions,
- Causing serious and permanent dysfunction of any bodily organ or part,
- Rendering the patient an immediate danger to himself or herself or others, or
- Immediately unable to provide for, or utilize food, shelter or clothing due to the mental disorder.

Medical Group

A group of physicians, organized as a legal entity, which has an agreement in effect with Anthem HMO to furnish medical care to Members. The Medical Group may be organized as an In Network Medical Group (PMG) or Independent Practice Association (IPA). The Subscriber is required, at the time of enrollment, to select a Medical Group and/or PCP to provide services covered under this Agreement. However, in the event the Subscriber does not indicate his or her selection on the enrollment form, Anthem will assign the Subscriber to a Medical Group.

Medically Necessary (Medical Necessity)

Healthcare services that a medical practitioner, exercising professional clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, or disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice

- Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease
- Not primarily for the convenience of the patient, doctor or other healthcare Provider, and
- Not more costly than an alternative service, including the same service in an alternative setting, or sequence of services that is medically appropriate and is likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's injury, disease, illness or condition

For example, We will not provide coverage for an Inpatient admission for surgery if the surgery could have been performed on an Outpatient basis, or an infusion or injection of a Specialty Drug provided in the Outpatient department of a Hospital if the drug could be provided in a doctor's office or the home setting.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, National Physician Specialty Society recommendations and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors. In evaluating new technology and whether to consider it as eligible for coverage under Our Agreement, We consider peer-reviewed medical literature, consultations with doctors, Specialists and other healthcare professionals, policies and procedures of government agencies and study results showing the impact of the new technology on long-term health.

For purposes of treatment of Mental Health and Substance Use Disorder, Medically Necessary means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following:

1. In accordance with the Generally Accepted Standards of Mental Health and Substance Use Disorder care
2. Clinically appropriate in terms of type, frequency, extent, site, and duration
3. Not primarily for the economic benefit of Anthem and the Member or for the convenience of the patient, treating doctor, or other healthcare Provider

Medically Necessary Orthodontic Care

A service for pediatric Members used to treat malocclusion of teeth and associated dental and facial disharmonies. Certain criteria must be met in order for Medically Necessary Orthodontic Care to be covered. See the "Medically Necessary Orthodontic Care" benefit description in the "Child Dental Care" section for more information.

Medicare

The programs of healthcare for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Member

The Subscriber and enrolled Dependent.

Mental Health and Substance Use Disorder

A Mental Health Condition or Substance Use Disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of Mental Health and Substance Use Disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this Agreement as long as a condition is commonly understood to be a Mental Health Condition or Substance Use Disorder by healthcare Providers practicing in relevant clinical specialties.

Minimum Essential Coverage

The term Minimum Essential Coverage means any of the following: Government sponsored programs (Medicare, Medicaid, CHIP, TRICARE for Life, veteran's healthcare program); coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a State; coverage under a grandfathered health plan, and such other health benefits coverage, such as State high risk pool coverage, or as the Secretary of HHS recognizes.

Negotiated Fee Rate

The dollar amount allowed for the Covered Service that Anthem has negotiated with the In Network Medical Group, Anthem has negotiated with the In Network Provider, or the In Network Medical Group has negotiated with the In Network Provider. This dollar amount may vary based on the terms that have been negotiated. (For more information, see “How Your Claims are Paid”.)

Other Practitioners

Practitioners that include nurse practitioners, certified nurse midwives, physical therapists, occupational therapists, respiratory therapists, clinical psychologists, speech and language therapists, licensed clinical social workers, marriage and family therapists, applied behavior analysis therapists, podiatrists, acupuncture practitioners, registered dieticians and other nutrition advisors, and Other Practitioners designated by law.

Out of Network Pharmacy

A Pharmacy that does not have an In Network Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered.

Out of Network Provider

A Provider that does **not** have an agreement or contract with Us or Our subcontractor(s) to give services to Our Members through negotiated payment arrangements under this Agreement. There are no benefits provided when using an Out of Network Provider and You may be responsible for the total amount billed by an Out of Network Provider. Services received from an Out of Network Provider as a result of a Medical Emergency, Urgent Care or an Authorized Referral are exceptions. Also, if You receive Covered Services at an In Network Facility in California at which, or as a result of which, You receive services provided by an Out of Network Provider, You will pay no more than the same Cost Sharing that You would pay for the same Covered Services received from an In Network Provider.

Out of Pocket Maximum

The most You pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out of Pocket Maximum does not include Your Premium, amounts over the Negotiated Fee Rate or charges for healthcare that Your Agreement does not cover. When the Out of Pocket Maximum is reached, no additional Deductible, Copayment or Coinsurance is required unless otherwise specified in this Agreement. Please see the “Schedule of Cost Share and Benefits” for details.

Outpatient

A Member who receives services or supplies when not an Inpatient.

Partial Hospitalization Program

Structured, multidisciplinary treatment for Mental Health and Substance Use Disorders, including nursing care and active individual, group and family treatment for Members who require more care than is available in an Intensive Outpatient Program.

Pharmacy

A place licensed by State law where You can get Prescription Drugs and other medicines from a licensed pharmacist when You have a Prescription from Your doctor.

Pharmacy and Therapeutics (P&T) Process

Process to make clinically based recommendations that will help You access quality, low cost medicines

within Your benefit program. The process includes healthcare professionals such as nurses, pharmacists, and doctors. The committees of the Anthem National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for Our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the Prescription Drug List. Our programs may include, but are not limited to, drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and drug profiling initiatives.

Pharmacy Benefits Manager (PBM)

A Pharmacy benefits management company that manages Pharmacy benefits on Anthem's behalf. Anthem's PBM has a nationwide network of Retail Pharmacies, a Home Delivery Pharmacy, and clinical services that include Prescription Drug List management.

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

The set of benefits, conditions, exclusions and limitations described in this document.

Precertification

Please see the section "Requesting Approval for Benefits" for details.

Premium

The monthly charge You must pay Anthem to establish and maintain coverage under this Agreement.

Prescription Drug

Under the Federal Food, Drug and Cosmetic Act, such substances must bear a message on their original packing label that says, "Caution: Federal law prohibits dispensing without a Prescription." This includes the following:

1. Compounded (Combination) Medications, when all of the ingredients are FDA-approved, require a Prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer
2. Insulin, diabetic supplies, and syringes

Prescription Drug List

Listing of Prescription Drugs that are determined by Anthem to be designated as covered drugs. The list of approved Prescription Drugs developed by Anthem in consultation with doctors and pharmacists has been reviewed for their quality and cost effectiveness. This Prescription Drug List contains a limited number of Prescription Drugs and may be different than the formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Prescription Drug coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Prescription Drug List from time to time. A description of the Prescription Drugs that are listed is available upon request at www.anthem.com/ca.

Prescription Order (Prescription)

A written request by a Provider, as permitted by law, for a drug or medication and each authorized refill for same.

Primary Care Physician (PCP)

An In Network Provider who is a practitioner that specialized in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other In Network Provider as allowed by Us. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Provider

A professional or Facility licensed by law that gives healthcare services within the scope of that license, that must satisfy Our accreditation requirements and be approved by Us. Details on Our accreditation requirements can be found at https://www.anthem.com/provider/credentialing/. This includes any Provider that State law says We must cover when they give You services that State law says We must cover. Providers that deliver Covered Services are described throughout this Agreement. If You have a question about a Provider not described in this Agreement please call the number on the back of Your Identification Card.

Psychiatric Emergency Medical Condition

A mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

- An immediate danger to himself or herself or to others, or
- Immediately unable to provide for, or utilize, food, shelter or clothing, due to the mental disorder

Qualified Health Plan or QHP

A health plan that has in effect a certification issued or recognized by each Exchange through which such health plan is offered.

Qualified Health Plan Issuer or QHP Issuer

A health plan insurance issuer that offers a QHP in accordance with the certification from an Exchange.

Qualified Individual

With respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

Reasonable and Customary Value

1. For professional Out of Network Providers, the Reasonable and Customary Value is determined by using a percentile of billed charges from a database of a third party that takes into consideration various factors, such as the amounts billed for same or similar services, and the geographic locations in which the services were rendered.
2. For Facility Out of Network Providers, the Reasonable and Customary Value is determined by using a percentile of billed charges from a database of Anthem's actual claims experience, subject to certain thresholds based on each Provider's cost-to-charge ratio as reported by the Provider to a California governmental agency and the actual claim submitted to Us.

Referral

A specific recommendation by a Member's PCP that the Member should receive evaluation or treatment from a specific Provider. A recommendation from a Provider is a Referral only to the extent of the specific services approved by the PCP on the written Referral form or by other notification methods prescribed by Anthem for use by PCPs. A general statement by a PCP that a Member should seek a particular type of service or Provider does not constitute a Referral under this Agreement.

Rehabilitative Services

Healthcare services that help a person get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric Rehabilitation Services in a variety of Inpatient and/or Outpatient settings.

Reproductive or Sexual Healthcare Services

Services as described in California State law which are the following:

- Medical care related to the prevention or treatment of pregnancy
- Medical care related to the diagnosis or treatment of an infectious, contagious, or communicable

disease, if such disease is required for reporting to a local health officer, or is a related sexually-transmitted disease

- Medical care related to the prevention of a sexually-transmitted disease
- For alleged rape or sexual assault, medical care related to the diagnosis or treatment of the condition, and the collection of medical evidence after an alleged rape or sexual assault
- HIV testing

Residential Treatment Center

An Inpatient Facility that provides multidisciplinary treatment for Mental Health and Substance Use Disorders. 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 term Residential Treatment Center does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial care
6. Educational care

Retail Pharmacy

An establishment licensed to dispense Prescription Drugs and other medications (other than Specialty Drugs) through a licensed pharmacist or Home Delivery Pharmacy service upon an authorized healthcare professional's order.

Self-Administered Drugs

Drugs that are administered which do not require a medical professional to administer.

Service Area

The geographic area within the State of California within which this Agreement is offered and issued where Anthem is approved by the DMHC to arrange healthcare services consistent with network adequacy requirements.

Skilled Nursing Facility

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, satisfy Our accreditation requirements, and be approved by Us.

A Skilled Nursing Facility is not a place mainly for care of the aged, custodial care or domiciliary care; or a place for rest, educational, or similar services.

Specialist (Specialty Care Physician or SCP)

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. Specialists include doctors with specialties in allergy, anesthesiology, dermatology, cardiology and other internal medicine Specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, a surgical specialty, otolaryngology, urology and others designated by law.

Specialty Drugs

Drugs that are high-cost, injectable, infused, oral or inhaled drugs that generally require close supervision, training and monitoring of their effect on the patient's drug therapy by a medical professional. These drugs often require special handling, such as temperature-controlled packaging and overnight delivery, and are often unavailable at Retail Pharmacies. Specialty Drugs are required to be

obtained through the PBM's Specialty Pharmacy unless stated otherwise. Specialty Drugs may be placed on drug tiers 1, 2, 3 or 4.

Specialty Pharmacy

A Pharmacy that is designated by Us, other than a Retail Pharmacy or Home Delivery Pharmacy that provides high cost, biotech drugs which are used for the treatment of acute or chronic diseases.

State

The State of California.

Subscriber

The Member who applied for coverage and in whose name this Agreement is issued.

Surprise Billing Claims

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

- Emergency Services provided by Out of Network Providers;
- Covered Services provided by an Out of Network Provider at an In Network Facility; and
- Out of Network air ambulance services.

Tax Dependent

Tax Dependent has the same meaning as the term dependent under the Internal Revenue Code.

Tax Filer

Tax Filer means an individual, or a married couple, who indicates that he, she or they expect:

1. To file an income tax return for the benefit Year,
2. If married, per IRS guidelines, to file a joint tax return for the benefit Year,
3. That no other taxpayer will be able to claim him, her or them as a Tax Dependent for the benefit Year, and
4. That he, she, or they expects to claim a personal exemption deduction on his or her tax return for one or more applicants, who may or may not include himself or herself and his or her spouse or domestic partner.

Urgent Care

Healthcare for a condition which requires prompt attention, consistent with California law.

Urgent Care Center

A licensed healthcare Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for Urgent Care.

Utilization Review

Evaluation of the necessity, quality, effectiveness or efficiency of medical or behavioral health services, Prescription Drugs (as set forth in the section Prescription Drugs Administered by a Medical Provider), procedures and/or Facilities.

We, Us and Our

Anthem Blue Cross (Anthem).

Year and Yearly

A twelve (12) month period.

You and Your

The Member, Subscriber and each covered Dependent.

SUBSCRIBER AND PREMIUM INFORMATION

Issued by

Anthem Blue Cross

PLAN NAME:
CONTRACT CODE:
SUBSCRIBER'S NAME:
[DEPENDENT'S NAME:]
[DEPENDENT'S NAME:]
[DEPENDENT'S NAME:]
[DEPENDENT'S NAME:]
[DEPENDENT'S NAME:]
SUBSCRIBER'S RESIDENTIAL ADDRESS
MONTHLY PREMIUM RATE:
PREMIUM RATE EFFECTIVE DATE:
Please review this information carefully and if it is incorrect please inform Your agent or Anthem immediately.

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