UNIVERSITY OF CALIFORNIA

Effective July 1, 2023

UC Medical Residents and Fellows

Benefit Booklet

SPD281636-1 2023 (Approved 6/6/23)

This Benefit Booklet provides a complete explanation of your Benefits, limitations and other Plan provisions that apply to you. Your Plan is a Preferred Provider Medical Plan. Be sure you understand the Benefits offered under this Plan before receiving services.

Benefits of this Plan are available only for Covered Services and supplies furnished during the term the Plan is in effect and while the Individual claiming Benefits is actually covered by this Plan.

Benefits may be modified during the term of this Plan as specifically provided under the terms of the Plan or upon renewal. If Benefits are modified, the revised Benefits (including any reduction in Benefits or the elimination of Benefits) apply for the Covered Services or supplies furnished on or after the effective date of the modification. There is no vested right to receive the Benefits of this Plan.

Many words used in this Benefit Booklet have special meanings (e.g., Covered Services and Medically Necessary). 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 Benefit Booklet you may also see references to “we,” “us,” “our,” “you,” and “your.” The words “we,” “us,” and “our” refers to Anthem, the Claims Administrator. The Plan Administrator is the University of California Executive Steering Committee on Health Benefits Programs, which has delegated certain duties to Anthem Blue Cross Life and Health Insurance Company (Anthem). The words “you” and “your” mean the Member, Employee and each covered Dependent. **All capitalized words in this benefit booklet are in the DEFINITIONS section starting at page 110.**

Please read this Benefit Booklet carefully so that you understand all the Benefits your Plan offers. Keep this Benefit Booklet handy in case you have any questions about your coverage. This booklet, the University of California Group Insurance Regulations (Medical-related portions), and applicable fact sheets, constitute both the Plan document and summary for the Plan.

Important: The Regents of the University of California is the Employer and may change or terminate the Plan by action of the Plan Administrator. Anthem Blue Cross Life and Health Insurance Company has been appointed the Claims Administrator. On behalf of Anthem Blue Cross Life and Health Insurance Company, Anthem Blue Cross processes and reviews the claims submitted under this Plan. This is not an insured benefit plan. The Benefits described in this Benefit Booklet or any rider or amendments are funded by, and paid out of the assets of, the Employer who is responsible for their payment and employee contributions. Anthem Blue Cross Life and Health Insurance Company provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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

COMPLAINT NOTICE

All complaints and disputes relating to coverage under this Plan must be resolved in accordance with the Plan's grievance procedures. Grievances may be made by telephone (please call the number described on your Identification Card) or in writing (write to Anthem Blue Cross Life and Health Insurance Company, 21215 Burbank Blvd., Woodland Hills, CA 91367 marked to the attention of the Member Services Department named on your identification card). If you wish, Anthem will provide a Complaint Form which you may use to explain the matter.

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

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SUMMARY OF BENEFITS

Note: The following SUMMARY OF BENEFITS contains the Benefits and applicable Copayments of your Plan. The SUMMARY OF BENEFITS represents only a brief description of the Benefits. Please read this booklet carefully for a complete description of Covered Services and exclusions of the Plan.

See the end of this SUMMARY OF BENEFITS for important Benefit information.

Many words or phrases in this Benefit Booklet have special meanings. Whenever any key terms are shown, the first letter of each word will be capitalized. When you see these capitalized words, you should refer to this DEFINITIONS section starting at page 110.

UC PPO Plan

Member Benefit Year Deductible Responsibility	**Deductible Amount**		
	Services by UCMC (In-Network)	Services by Anthem Preferred Providers (In-Network)	Services by Out-of-Network Providers*
	*For Covered Services from Out-of-Network Providers, you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount.		
Benefit Year Deductible Deductible amounts do not cross accumulate. Please refer to the Member Deductible in the "Medical Benefit Summary Notes" section for information on how your Benefit Year Deductible works. For additional details about how Deductibles work, please refer to the "Deductibles, Copayments, Out-of-Pocket Amounts and Medical Benefit Maximums" section.	None	$100 Individual / $200 family	$200 Individual / $500 family

Member Benefit Year Out-of-Pocket Responsibility	Out-of-Pocket Amount		
	Services by UCMC (In-Network)	Services by Anthem Preferred Providers (In-Network)	Services by Out-of-Network Providers*
	*For Covered Services from Out-of-Network Providers, you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount.		
Benefit Year Out-of-Pocket Maximum When you meet your Out-of-Pocket Maximum amount, you will no longer have to pay for cost shares during the remainder of your Benefit Year. UCMC, UC and Anthem Preferred Provider Out-of-Pocket Maximum amounts cross accumulate. UCMC, UC and Anthem Preferred Provider (In-Network) and Out-of-Network Provider Out-of-Pocket Maximum amounts do not cross accumulate. Pharmacy Copayments will apply towards your Out-of-Pocket Maximum. Please refer to Member Out-of-Pocket Maximum in the "Medical Benefit Summary Notes" section for information on how your Out-of-Pocket Maximum works. For additional details about how Out-of-Pocket Maximums work, please refer to the "Deductibles, Copayments, Out-of-Pocket Amounts and Medical Benefit Maximums" section.	$1,000 per Individual / $2,000 per family	$1,000 per Individual / $2,000 per family	$2,000 per Individual / $4,000 per family

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

Member Maximum Lifetime Benefits	Maximum Anthem Payment		
	Services by UCMC (In-Network)	Services by Anthem Preferred Providers (In-Network)	Services by Out-of-Network Providers
Lifetime Benefit Maximum	No maximum		

Note: Please refer to the section Medical Care That Is Covered for additional details regarding your Benefits.

Benefit	Member Copayment/Coinsurance		
	Services by UCMC Providers (In-Network)	Services by Anthem Preferred Providers (In-Network)	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount.		
Acupuncture Benefits			
• Acupuncture services – office location The Plan will pay for up to 24 visits per Member during a Benefit Year. Please refer to "Medical Benefit Maximums in the Medical Benefit Summary Notes" section for maximums that apply to your Plan. Since your Plan has a Benefit Year Deductible, the number of visits will start counting toward the maximum when services are first provided even if the Benefit Year Deductible has not been met.	Not applicable Services covered under Anthem Preferred Providers	$15 per visit (not subject to the Benefit Year Deductible)	30%
Advanced Imaging Procedure Benefits			
Advanced imaging procedure services are subject to pre-service review to determine whether Medically Necessary. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.			
• Physician services - office location	No charge	10%	30%
• Freestanding Facility	No charge	10%	30%
• Outpatient Hospital Advanced imaging procedures, when performed by an Out-of-Network Provider, will have a maximum payment of **$350** per visit. Please refer to "Medical Benefit Maximums in the Medical Benefit Summary Notes" section for maximums that apply to your Plan.	No charge	10%	30%

Benefit	Member Copayment/Coinsurance		
	Services by UCMC Providers (In-Network)	Services by Anthem Preferred Providers (In-Network)	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount.		
Allergy Testing and Treatment Benefits			
• Testing and treatment, includes serum and serum injections (office visit Copayment will apply when billed with an office visit).	$15 per visit (not subject to the Benefit Year Deductible)	10% up to a maximum Copayment of $250 per Drug	30% up to a maximum Copayment of $250 per Drug
• Allergy serum purchased separately for treatment (billed separately from an office visit)	10% up to a maximum Copayment of $250 per Drug	10% up to a maximum Copayment of $250 per Drug	30% up to a maximum Copayment of $250 per Drug
Ambulance Benefits			
• Emergency or authorized transport (ground, air or water)	Not applicable Services covered under Anthem Preferred Providers	10%	10%
Ambulatory Surgery Center Benefits Ambulatory Surgical Center services are subject to pre-service review to determine whether Medically Necessary. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.			
• Outpatient services (Hospital or freestanding surgical center) For the services of an Out-of-Network Provider, the Plan's maximum payment is limited to **$350** per visit. Please refer to "Medical Benefit Maximums in the Medical Benefit Summary Notes" section for maximums that apply to your Plan.	No charge	10%	30%
• Physician services	No charge	10%	30%

Benefit	Member Copayment/Coinsurance		
	Services by UCMC Providers (In-Network)	Services by Anthem Preferred Providers (In-Network)	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount.		
Bariatric Surgery Benefits Services and supplies in connection with Medically Necessary surgery for weight loss, only for morbid obesity. These procedures are covered only when performed at a BDCSC. See page 42 under "Medical Care That Is Covered" section for details. You must obtain pre-service review for all bariatric surgical procedures. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.			
• Hospital inpatient services	$250 per admission	10%	Not covered
• Hospital outpatient surgery services	No charge	10%	Not covered
• Physician inpatient services	No charge	10%	Not covered
• Bariatric Travel Expense The Plan's maximum payment will not exceed **$3,000** per surgery. Please refer to Medical Benefit Maximums in the "Medical Benefit Summary Notes" section for maximums that apply to your Plan. The Benefit Year Deductible will not apply to Bariatric Travel Expense in connection with an authorized bariatric surgical procedure provided at a designated BDCSC.	No charge	No charge	Not covered
Cardiac Rehabilitation If rendered in Outpatient Hospital setting, for services of an Out-of-Network Provider, the Plan's maximum payment is limited to **$350** per visit.	$15 per visit (not subject to the Benefit Year Deductible)	10%	30%

Benefit	Member Copayment/Coinsurance		
	Services by UCMC Providers (In-Network)	Services by Anthem Preferred Providers (In-Network)	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount.		
Chiropractic Benefits			
• Chiropractic Services – office location The Plan will pay for up to 60 visits per Member during a Benefit Year. Please refer to "Medical Benefit Maximums in the Medical Benefit Summary Notes" section for maximums that apply to your Plan. Since your Plan has a Benefit Year Deductible, the number of visits will start counting toward the maximum when services are first provided even if the Benefit Year Deductible has not been met.	Not applicable Services covered under Anthem Preferred Providers	$15 per visit (not subject to the Benefit Year Deductible)	30%
Clinical Trial of Cancer and Other Life Threatening Conditions Benefits			
Coverage is provided for routine patient costs you receive as a Member in an approved clinical trial. The services must be those that are listed as covered by this Plan for Members who are not enrolled in a clinical trial.	$15 per visit (not subject to the Benefit Year Deductible)	10%	30%
Contraceptive Benefits			
Certain contraceptives are covered under the "Preventive Care Benefits". Please see that provision for further details. The Benefit Year Deductible will not apply to services provided by Anthem Preferred Providers. See page 44 under "Medical Care That Is Covered" for details for information about your "Contraceptives Benefits"			

Benefit	Member Copayment/Coinsurance		
	Services by UCMC Providers (In-Network)	Services by Anthem Preferred Providers (In-Network)	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount.		
• Diaphragm fitting procedure	$15 per visit (not subject to the Benefit Year Deductible)	$15 per visit (not subject to the Benefit Year Deductible)	30%
• Implantable and injectable contraceptives	No charge	No charge	30%
• Insertion and/or removal of intrauterine device (IUD)	No charge	No charge	30%
• Intrauterine device (IUD)	No charge	No charge	30%
Diabetes Care Benefits			
• Devices, equipment and supplies	10%	10%	30%
• Diabetes self-management training – office location	$15 per visit (not subject to the Benefit Year Deductible)	$15 per visit (not subject to the Benefit Year Deductible)	30%
Durable Medical Equipment Benefits			
• Other Durable Medical Equipment Specific durable medical equipment is subject to pre-service review to determine whether Medically Necessary. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.	Not applicable Services covered under Anthem Preferred Providers	10%	30%
Emergency Room Benefits			
• Emergency room Facility services *The Benefit Year Deductible and Copayment will not apply if you are admitted to the Hospital from the Emergency Room.	No charge	$100 per visit*	$100 per visit*
• Physician services	No charge	No charge (not subject to the Benefit Year Deductible)	No charge (not subject to the Benefit Year Deductible)
Family Planning Benefits Certain contraceptives are covered under the “Preventive Care Benefits”. Please see that provision for further details.			

Benefit	Member Copayment/Coinsurance		
	Services by UCMC Providers (In-Network)	Services by Anthem Preferred Providers (In-Network)	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount.		
The Benefit Year Deductible will not apply to services provided by Anthem Preferred Providers. See page 47 under "Medical Care That Is Covered" for details for information about your "Family Planning Benefits"			
• Counseling and consulting (including Physician office visits for diaphragm fitting, injectable contraceptives, or implantable contraceptives)	$15 per visit (not subject to the Benefit Year Deductible)	$15 per visit (not subject to the Benefit Year Deductible)	30%
• Tubal ligation (an additional Facility Copayment may apply when services are rendered in a Hospital)	No charge	No charge	No charge
Family Planning Benefits			
• Vasectomy (an additional Facility Copayment may apply when services are rendered in a Hospital or outpatient surgery center)	No charge	10%	30%
Hearing Aid Benefits			
• Hearing aids and ancillary equipment up to a maximum of **$2,000** every three years. Please refer to "Medical Benefit Maximums in the Medical Benefit Summary Notes" section for maximums that apply to your Plan.	Not applicable Services covered under Anthem Preferred Providers	10%	30%

Benefit	Member Copayment/Coinsurance		
	Services by UCMC Providers (In-Network)	Services by Anthem Preferred Providers (In-Network)	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount.		
Home Health Care Benefits			
• Home health care agency services Benefits are provided for up to a maximum of 100 visits per Benefit Year. Please refer to "Medical Benefit Maximums in the Medical Benefit Summary Notes" section for maximums that apply to your Plan. Since your Plan has a Benefit Year Deductible, the number of visits will start counting toward the maximum when services are first provided even if the Benefit Year Deductible has not been met. **Please refer to Copayments in the "Medical Benefit Summary Notes" section for additional Benefit information. Home health care services are subject to pre-service review to determine whether Medically Necessary. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.	Not applicable Services covered under Anthem Preferred Providers	10%	30%**
• Medical supplies	Not applicable Services covered under Anthem Preferred Providers	10%	30%**
Hospice Care Benefits			
The services and supplies are covered when provided by a Hospice for the palliative treatment of pain and other symptoms associated with a terminal disease. **Please refer to Copayments in the "Medical Benefit Summary Notes" section for additional Benefit information.	Not applicable Services covered under Anthem Preferred Providers	10%	30%**

Benefit	Member Copayment/Coinsurance		
	Services by UCMC Providers (In-Network)	Services by Anthem Preferred Providers (In-Network)	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount.		
Hospital Benefits			
• Inpatient services – resulting from an Emergency	No charge	No charge	No charge
• Inpatient services and supplies, provided by a Hospital, including services in Special Care Units. For the services of an Out-of-Network Provider, there is an additional **$250** Copayment if prior authorization is not obtained. For the services of an Out-of-Network Provider, the Plan's maximum payment is limited to **$600** per day. Please refer to "Medical Benefit Maximums in the Medical Benefit Summary Notes" section for maximums that apply to your Plan. Hospital services are subject to pre-service review to determine whether Medically Necessary. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.	$250 per admission	10%	30%
• Inpatient Physician services	No charge	10%	30%
• Outpatient surgery including freestanding facilities For the services of an Out-of-Network Provider, the Plan's maximum payment is limited to **$350** per visit. Please refer to "Medical Benefit Maximums in the Medical Benefit Summary Notes" section for maximums that apply to your Plan. Hospital services are subject to pre-service review to determine whether Medically Necessary. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.	No charge	10%	30%

Benefit	Member Copayment/Coinsurance		
	Services by UCMC Providers (In-Network)	Services by Anthem Preferred Providers (In-Network)	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount.		
• Outpatient Physician services	No charge	10%	30%
• Outpatient diagnostic services and other outpatient services not listed elsewhere, included but not limited to: chemotherapy, infusion therapy, radiation and services at freestanding facilities For the services of an Out-of-Network Provider, the Plan's maximum payment is limited to **$350** per visit. Please refer to "Medical Benefit Maximums in the Medical Benefit Summary Notes" section for maximums that apply to your Plan. **Note:** Professional (Physician) reading charge may apply. Hospital services are subject to pre-service review to determine whether Medically Necessary. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.	No charge	10%	30%
Infertility Benefits			
Diagnosis of cause of Infertility provided you are under the direct care and treatment of a Physician.	10%	10%	30%
Infusion / Injectable Therapy Benefits			
Services and supplies when provided by an Infusion Therapy Provider/Injectable Therapy Provider in your home or in any other outpatient setting by a qualified health care Provider. Please refer to Copayments in the "Medical Benefit Summary Notes" section for additional Benefit information.	Not applicable Services covered under Anthem Preferred Providers	10%	30%

Benefit	Member Copayment/Coinsurance		
	Services by UCMC Providers (In-Network)	Services by Anthem Preferred Providers (In-Network)	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount.		
Infusion/Injection therapy services are subject to pre-service review to determine whether Medically Necessary. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.			
Jaw Joint Disorder Benefits			
• Inpatient Hospital services For the services of an Out-of-Network Provider, there is an additional **$250** Copayment if prior authorization is not obtained. For the services of an Out-of-Network Provider, the Plan's maximum payment is limited to **$600** per day. Please refer to Medical Benefit Maximums in the "Medical Benefit Summary Notes" section for maximums that apply to your Plan. Hospital services are subject to pre-service review to determine whether Medically Necessary. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.	$250 per admission	10%	30%
• Outpatient surgery Facility services For the services of an Out-of-Network Provider, the Plan's maximum payment is limited to **$350** per visit. Please refer to "Medical Benefit Maximums in the Medical Benefit Summary Notes" section for maximums that apply to your Plan. Hospital services are subject to pre-service review to determine whether Medically Necessary. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.	No charge	10%	30%
• Physician services	No charge	10%	30%

Benefit	Member Copayment/Coinsurance		
	Services by UCMC Providers (In-Network)	Services by Anthem Preferred Providers (In-Network)	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount.		
Mental Health and Substance Use Disorder			
The Benefit Year Deductible will not apply to services provided by Anthem Preferred Providers.			
• Inpatient Hospital services For the services of an Out-of-Network Provider, there is an additional **$250** Copayment if prior authorization is not obtained. For the services of an Out-of-Network Provider, the Plan's maximum payment is limited to **$600** per day. Please refer to "Medical Benefit Maximums in the Medical Benefit Summary Notes" section for maximums that apply to your Plan. Hospital services are subject to pre-service review to determine whether Medically Necessary. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.	$250 per admission	10%	30%
• Outpatient Facility services	No charge	10%	30%
• Physician services including Bereavement services	$15 per visit (not subject to the Benefit Year Deductible)		30%
Physical Therapy, Physical Medicine, Occupational and Speech Therapy Services including Habilitation and Rehabilitation			
• Physician services – office location	$15 per visit (not subject to the Benefit Year Deductible)	10%	30%

Benefit	Member Copayment/Coinsurance		
	Services by UCMC Providers (In-Network)	Services by Anthem Preferred Providers (In-Network)	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount.		
• Outpatient Hospital For the services of an Out-of-Network Provider, the Plan's maximum payment is limited to **$350** per visit. Please refer to Medical Benefit Maximums in the "Medical Benefit Summary Notes" section for maximums that apply to your Plan.	$15 per visit (not subject to the Benefit Year Deductible)	10%	30%
Pregnancy and Maternity Care Benefits			
• Inpatient Hospital services For the services of an Out-of-Network Provider, there is an additional **$250** Copayment if prior authorization is not obtained. For the services of an Out-of-Network Provider, the Plan's maximum payment is limited to **$600** per day. Please refer to "Medical Benefit Maximums in the Medical Benefit Summary Notes" section for maximums that apply to your Plan. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.	$250 per admission	10%	30%
• Prenatal and postnatal Physician office visits	$15 per visit (not subject to the Benefit Year Deductible)	$15 per visit (not subject to the Benefit Year Deductible)	30%
Preventive Care Benefits			
Preventive Care Services and Preventive Care for Chronic Conditions (per IRS guidelines) See page 54 under "Medical Care That Is Covered" for details for information about your Preventive Care Services. The Benefit Year Deductible will not apply to services provided by Anthem Preferred Providers.	No charge (not subject to the Benefit Year Deductible)	No charge (not subject to the Benefit Year Deductible)	30%
• Travel Immunizations Benefits			

Benefit	Member Copayment/Coinsurance		
	Services by UCMC Providers (In-Network)	Services by Anthem Preferred Providers (In-Network)	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount.		
- ACA Travel Vaccinations	No charge	No charge	30%
- Hepatitis A	No charge	No charge	30%
- Hepatitis B	No charge	No charge	30%
- Meningitis	No charge	No charge	30%
- Polio	No charge	No charge	30%
• Other Travel Vaccinations			
- Japanese Encephalitis	No charge	No charge	30%
- Rabies	No charge	No charge	30%
- Typhoid	No charge	No charge	30%
- Yellow Fever	No charge	No charge	30%
Professional (Physician) Benefits			
• Inpatient Physician services	No charge	10%	30%
• Outpatient Physician services, other than an office setting	No charge	10%	30%
• Physician home visits This Copayment applies only to the charge for the visit itself. It does not apply to any other charges made during that visit, such as testing procedures, etc.	$15 per visit (not subject to the Benefit Year Deductible)	$15 per visit (not subject to the Benefit Year Deductible)	30%
• Physician office visit This Copayment applies only to the charge for the visit itself. It does not apply to any other charges made during that visit, such as testing procedures, surgery, etc.	$15 per visit (not subject to the Benefit Year Deductible)	$15 per visit (not subject to the Benefit Year Deductible)	30%
• Virtual visits (LiveHealth Online) The Benefit Year Deductible will not apply to services provided by Anthem Preferred Providers. LiveHealth Online provides access to U.S. board-certified doctors 24/7/365 via phone or online video consults for urgent, non-Emergency medical assistance, including the ability to write prescriptions, when you are unable to see your primary care Physician. This service is available by registering and going to www.anthem.com/ca.	Services covered under Anthem Preferred Providers $15 per visit (not subject to the Benefit Year Deductible)		Not covered

Benefit	Member Copayment/Coinsurance		
	Services by UCMC Providers (In-Network)	Services by Anthem Preferred Providers (In-Network)	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount.		
• Chemotherapy and radiation therapy services	$15 per visit (not subject to the Benefit Year Deductible)	10%	30%
• Hemodialysis services	$15 per visit (not subject to the Benefit Year Deductible)	10%	30%
• Office based injectable service	10%	10%	30%
• Retail Health Clinic	Not applicable Services covered under Anthem Preferred Providers	$15 per visit (not subject to the Benefit Year Deductible)	30%
• Urgent Care services	$15 per visit (not subject to the Benefit Year Deductible)	$15 per visit (not subject to the Benefit Year Deductible)	30%
Prosthetic Devices Benefits			
• Physician services	$15 per visit (not subject to the Benefit Year Deductible)	10%	30%
• Prosthetic and Devices	Not applicable Services covered under Anthem Preferred Providers	10%	30%

Benefit	Member Copayment/Coinsurance		
	Services by UCMC Providers (In-Network)	Services by Anthem Preferred Providers (In-Network)	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount.		
Skilled Nursing Facility Benefits			
• Inpatient Hospital services Benefits are provided for up to a maximum of 100 visits per Benefit Year. Please refer to "Medical Benefit Maximums in the Medical Benefit Summary Notes" section for maximums that apply to your Plan. Since your Plan has a Benefit Year Deductible, the number of visits will start counting toward the maximum when services are first provided even if the Benefit Year Deductible has not been met. Please refer to Copayments in the "Medical Benefit Summary Notes" section for additional benefit information. Skilled Nursing Facility services are subject to pre-service review to determine whether Medically Necessary. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.	Not applicable Services covered under Anthem Preferred Providers	10%	30%
Transgender Benefits			
Transgender services are subject to prior authorization in order for coverage to be provided. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.			
• Hospital inpatient services For the services of an Out-of-Network Provider, there is an additional **$250** Copayment if prior authorization is not obtained.	$250 per admission	10%	30%

Benefit	Member Copayment/Coinsurance		
	Services by UCMC Providers (In-Network)	Services by Anthem Preferred Providers (In-Network)	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount.		
For the services of an Out-of-Network Provider, the Plan's maximum payment is limited to **$600** per day. Please refer to "Medical Benefit Maximums in the Medical Benefit Summary Notes" section for maximums that apply to your Plan.			
• Hospital outpatient surgery services For the services of an Out-of-Network Provider, the Plan's maximum payment is limited to **$350** per visit. Please refer to "Medical Benefit Maximums in the Medical Benefit Summary Notes" section for maximums that apply to your Plan. Hospital services are subject to pre-service review to determine whether Medically Necessary. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.	No charge	10%	30%
• Physician services	No charge	10%	30%
• Covered Transgender Travel Expenses The Plan's maximum payment will not exceed **$10,000** per surgery or series of surgeries. Please refer to "Medical Benefit Maximums in the Medical Benefit Summary Notes" section for maximums that apply to your Plan. The Benefit Year Deductible will not apply to transgender travel expense in connection with an approved transgender surgery.			

Benefit	Member Copayment/Coinsurance		
	Services by UCMC Providers (In-Network)	Services by Anthem Preferred Providers (In-Network)	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount.		
Transplant Benefits			
Services and supplies provided in connection with a non-Investigative organ or tissue transplant. These procedures are covered only when performed at a CME or BDCSC. See page 57 under "Medical Care That Is Covered" for details. Transplant services are subject to pre-service review to determine whether Medically Necessary. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.			
• Hospital inpatient services For the services of an Out-of-Network Provider, there is an additional **$250** Copayment if prior authorization is not obtained.	$250 per admission	10%	Not covered
• Hospital outpatient surgery services Hospital services are subject to pre-service review to determine whether Medically Necessary. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.	No charge	10%	Not covered
• Physician services	No charge	10%	Not covered

Benefit	Member Copayment/Coinsurance		
	Services by UCMC Providers (In-Network)	Services by Anthem Preferred Providers (In-Network)	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount.		
• Transplant Travel Expenses The Plan's maximum payment will not exceed **$10,000** per surgery. Please refer to Medical Benefit Maximums in the "Medical Benefit Summary Notes" section for maximums that apply to your Plan. The Benefit Year Deductible will not apply to transplant travel expenses authorized by Anthem in connection with a specified transplant procedure provided at a designated CME or a BDCSC.	No charge	No charge	Not covered
• Unrelated Donor Search service The Plan's maximum payment will not exceed **$30,000** per transplant. Please refer to Medical Benefit Maximums in the "Medical Benefit Summary Notes" section for maximums that apply to your Plan.			

SUMMARY OF PRESCRIPTION DRUG BENEFITS

Member Benefit Year Drug Deductible Responsibility	Deductible Amount	
	In-Network	Out-of-Network
Benefit Year Deductible	None	None

Member Maximum Benefit Year Out-of-Pocket Responsibility	Out-of-Pocket Amount	
Benefit Year Out-of-Pocket Maximum	In-Network	Out-of-Network
Combined with the medical Out-of-Pocket Maximum	$1,000 per Individual / $2,000 per family	$2,000 per Individual / $4,000 per family

Prescription Drug Benefits
Each Prescription Drug will be subject to a cost share (e.g., Copayment / Coinsurance) as described below. If your Prescription order includes more than one Prescription Drug, a separate cost share will apply to each covered Drug. You will be required to pay the lesser of your scheduled cost share or the Maximum Allowed Amount. If the retail price for a covered Prescription and/or refill is less than the applicable Copayment amount, you will not be required to pay more than the retail price. This Plan uses the National 4-Tier Drug List. Drugs not on the list are not covered. Please refer to the drug list at www.anthem.com/ca/pharmacyinformation/ to determine which Tier(s) apply to your prescription(s). Please note, *prescription drugs* that are required to be covered by federal law under the "Preventive Care Services" benefit will be covered with no deductible, copayments or coinsurance when you use a *participating pharmacy*.

Pharmacy Copayments / Coinsurance	In-Network	Out-of-Network
Retail Pharmacies – up to a 30-day supply		
– Tier 1 Typically Generic Drugs	$10 Copayment per Prescription Drug	$10 Copayment plus 50% of the remaining Prescription Drug Maximum Allowed Amount per Prescription Drug up to a maximum of $250 per prescription
– Tier 2 Typically Preferred Drugs	$20 Copayment per Prescription Drug	$20 Copayment plus 50% of the remaining Prescription Drug Maximum Allowed Amount per Prescription Drug up to a maximum of $250 per prescription

Pharmacy Copayments / Coinsurance	In-Network	Out-of-Network
– Tier 3 Typically Non-Preferred Drugs	$40 Copayment per Prescription Drug	$40 Copayment plus 50% of the remaining Prescription Drug Maximum Allowed Amount per Prescription Drug up to a maximum of $250 per prescription
UCMC or UC Pharmacies– 31 to 90 day supply You pay additional copays or coinsurance on all tiers for fills that exceed 30 days as noted.		
– Tier 1 Typically Generic Drugs	$10 Copayment per Prescription Drug	Not covered
– Tier 2 Typically Preferred Drugs	$20 Copayment per Prescription Drug	Not covered
– Tier 3 Typically Non-Preferred Drugs	$40 Copayment per Prescription Drug	Not covered
Home Delivery Pharmacy – up to 90 day supply You pay additional copays or coinsurance on all tiers for fills that exceed 30 days as noted.		
– Tier 1 Typically Generic Drugs	$10 Copayment per Prescription Drug	Not covered
– Tier 2 Typically Preferred Drugs	$30 Copayment per Prescription Drug	Not covered
– Tier 3 Typically Non-Preferred Drugs	$50 Copayment per Prescription Drug	Not covered
Retail90 Pharmacies – 31 to 90 day supply When you get a 90-day supply, three (3) retail Pharmacy Copayments (one for each 30 day period) per prescription order will apply.		
– Tier 1 Typically Generic Drugs	$30 Copayment per Prescription Drug	Not covered
– Tier 2 Typically Preferred Drugs	$60 Copayment per Prescription Drug	Not covered
– Tier 3 Typically Non-Preferred Drugs	$120 Copayment per Prescription Drug	Not covered

Pharmacy Copayments / Coinsurance	In-Network	Out-of-Network
CarelonRx Specialty Pharmacy and Select UC Pharmacies – up to 30 days*		
– Tier 4 Typically Specialty Drugs	$40 Copayment per Prescription Drug *See additional information in the "Specialty Drug Copayments / Coinsurance" section below	$40 Copayment plus 50% of the remaining Prescription Drug Maximum Allowed Amount per Prescription Drug up to a maximum of $250 per prescription (retail pharmacy only)
Contraceptive Drugs and Devices Up to a 12-month supply of contraceptive drugs when dispensed or furnished at one time.	$0 Copayment per Prescription (Retail, Home Delivery, UC Pharmacies, and Retail90)	$0 Copayment per Prescription (Retail only)
Smoking Cessation Products Over-the-Counter Drugs with prescription and Prescription Drugs	$0 Copayment per Prescription	Not covered
Diabetic Supplies Including lancets, alcohols swabs, and formulary test strips. (Syringes, needles, insulin, and non-formulary test strips are covered at the applicable copay or coinsurance.)	$0 Copayment per Prescription	50% Coinsurance per Prescription
Travel Immunizations – ACA Travel Vaccinations – Hepatitis A – Hepatitis B – Meningitis – Polio Other Travel Vaccinations – Japanese Encephalitis – Rabies – Typhoid – Yellow Fever	$0 Copayment per Prescription	50% Coinsurance per Prescription

The Prescription Drug Formulary is a list of outpatient prescription drugs which may be particularly cost-effective, therapeutic choices. Your Copayment amount for non-Formulary Drugs is higher than for Formulary Drugs. Any participating pharmacy can assist you in purchasing a Formulary Drug. You may also get information about covered Formulary Drugs by calling the Anthem Health Guide toll free at **(833) 674-9256** or by going to the website www.anthem.com/ca. Anthem Health Guide is available Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) but you can receive prescription related support after hours by calling **(833) 674-9256** and pressing 2.

What is allowed for Prescription Drug Covered Expense for out-of-network pharmacies is usually significantly lower than what those providers customarily charge, so you will almost always have a higher out-of-pocket expense for your drugs when you use an Out-of-Network Pharmacy to fill your prescription.

Preferred Generic Program

Prescription Drugs will always be dispensed by a pharmacist as prescribed by your Physician. Your Physician may order a Drug in a higher or lower Drug Copayment tier for you. You may request your Physician to prescribe a Drug in a higher Drug Copayment tier instead of a Drug in a lower Copayment tier or you may request the pharmacist to give you a Drug in a higher Copayment tier instead of a Drug in a lower Copayment tier. Under this Plan, if a Drug is available in a lower Copayment Drug tier, and it is not determined that a Drug in a higher Copayment Drug tier is Medically Necessary for you to have (see "Prescription Drug Formulary - Prior Authorization" below), you will have to pay the Copayment for the lower tier Drug plus the difference in cost between the Prescription Drug Maximum Allowed Amount for the lower Copayment drug tier and the higher Copayment drug tier.

Special Programs

From time to time, Anthem may initiate various programs to encourage you to utilize more cost-effective or clinically-effective Drugs including, but, not limited to, Generic Drugs, home delivery Drugs, over-the-counter Drugs or preferred Drug products. If Anthem initiates such a program, and determines that you are taking a Drug for a medical condition affected by the program, you will be notified in writing of the program and how to participate in it.

Half-tab Program

The Half-Tablet Program allows you to pay a reduced Copayment on selected "once daily dosage" medications. The Half-Tablet Program allows you to obtain a 30-day supply (15 tablets) of a higher strength version of your medication when the prescription is written by the Physician to take "½ tablet daily" of those medications on a list approved by Anthem. The Pharmacy and Therapeutics Process will determine additions and deletions to the approved list. The Half-Tablet Program is strictly voluntary and your decision to participate should follow consultation with and the concurrence of your Physician. To obtain a list of the products available on this program, contact the Anthem Health Guide toll free at **(833) 674-9256** or go to the website www.anthem.com/ca. Anthem Health Guide is available Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) but you can receive prescription related support after hours by calling **(833) 674-9256** and pressing 2.

Split Fill Dispensing Program

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

The Drugs that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and potential reactions or side-effects. This program allows you to get your Prescription Drug in a smaller quantity and at a prorated Copayment so that if your dose changes or you have to stop taking the Prescription Drug, you can save money by avoiding costs for Prescription Drugs you may not use. You can access the list of these Prescription Drugs by calling the Anthem Health Guide toll free at **(833) 674-9256** or by going to the website www.anthem.com/ca. Anthem Health Guide is available Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) but you can receive prescription related support after hours by calling **(833) 674-9256** and pressing 2.

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Prescription Drug Copayments" and "Prescription Drug Conditions of Service" sections of this Plan. In most cases, you must use a certain amount of your Prescription before it can be refilled. In some cases Anthem may let you get an early refill. For example, Anthem may let you refill your Prescription early if it is decided that you need a larger dose. Anthem 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 the Pharmacy Benefits Manager and ask for an override for one early refill. If you need more than one early refill, please call the Anthem Health Guide toll free at **(833) 674-9256** or go to the website www.anthem.com/ca. Anthem Health Guide is available Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) but you can receive prescription related support after hours by calling **(833) 674-9256** and pressing 2.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells you and your physicians about alternatives to certain Prescription Drugs. Anthem may contact you and your Physician to make you aware of these choices. Only you and your Physician can determine if the therapeutic substitute is right for you. For questions or issues about therapeutic Drug substitutes, please call the Anthem Health Guide toll free at **(833) 674-9256** or go to the website www.anthem.com/ca. Anthem Health Guide is available Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) but you can receive prescription related support after hours by calling **(833) 674-9256** and pressing 2.

Specialty Drug Copayments / Coinsurance

Specialty drugs are specific drugs used to treat complex or chronic conditions which usually require close monitoring such as multiple sclerosis, hepatitis, rheumatoid arthritis, cancers and other conditions that are difficult to treat with traditional therapies. Specialty Drugs may be self-administered in the home by injection by the patient or family member (subcutaneously or intramuscular), by inhalation, orally or topically. Specialty Drugs may also require special handling, special manufacturing processes, and may have limited prescribing or limited pharmacy availability. Specialty Drugs must be considered safe for self-administration and be obtained from CarelonRx or select UC Pharmacies and may require prior authorization for Medical Necessity. Infused or Intravenous (IV) medications are not included as Specialty Drugs. Specialty Drugs are covered only when dispensed through CarelonRx and certain UC pharmacies unless Medically Necessary for a covered Emergency. Specialty Drugs are limited to a quantity not to exceed a 30-day supply; however initial prescriptions for select specialty medications may be limited to a quantity not to exceed a 15-day supply through CarelonRx. In such circumstances the applicable specialty drug will be pro-rated based upon the number of day supply.

Retail90 Drugs

You can get a 90-day supply of medication. Through Retail90, you can choose to get a 90-day supply of medication from a participating local retail pharmacy for three (3) copays. The Retail90 network includes major retail chains like Rite Aid and Wal-Mart. Please call Anthem Health Guide toll free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) to obtain a list of Retail90 pharmacies or visit the website www.anthem.com/ca.

Medical Benefit Summary Notes

Member Deductible

The Benefit Year Deductible per Individual, and per family amounts are shown on the SUMMARY OF BENEFITS. Deductible amounts do not cross accumulate and only apply to Covered Services received from Anthem Preferred Providers and Out-of-Network Providers.

There is no Benefit Year Deductible for Covered Services received from UCMC Providers.

For additional information about Deductibles please see the "Deductibles, Copayments, Out-of-Pocket Amounts and Medical Benefit Maximums" section of this booklet.

Member Out-of-Pocket Maximum

1. The per Individual and per family Out-of-Pocket Maximum responsibility each Benefit Year for Covered Services rendered by UCMC Providers is shown on the SUMMARY OF BENEFITS.
2. The per Individual and per family Out-of-Pocket Maximum responsibility each Benefit Year for Covered Services rendered by any combination of UCMC Providers and Anthem Preferred Providers is shown on the SUMMARY OF BENEFITS.
3. The per Individual and per family Out-of-Pocket Maximum responsibility each Benefit Year for Covered Services rendered by Out-of-Network Providers is shown on the SUMMARY OF BENEFITS.

UCMC Provider and Anthem Preferred Provider Out-of-Pocket Maximum amounts cross accumulate. UCMC/Anthem Preferred Provider and Out-of-Network Maximum amounts do not cross accumulate.

After a Member has made the total out-of-pocket payments for covered medical and Prescription Drug services and supplies during a Benefit Year, the Member will no longer be required to pay a Copayment for the remainder of that Year, but will remain responsible for non-Covered Services and out-of-network costs in excess of the Maximum Allowed Amount.

Note: Expenses and Copayments you make for non-Covered Services or supplies or which is in excess of the maximum allowable amount provided by an Out-of-Network Provider will not be applied to your Out-of-Pocket Maximum. For additional information about Out-of-Pocket Maximums please see the "Deductibles, Copayments, Out-of-Pocket Amounts and Medical Benefit Maximums" section of this booklet.

Copayments

The Member Copayment amounts for Covered Services are shown in the SUMMARY OF BENEFITS. The SUMMARY OF BENEFITS also contains information on Benefit and Copayment maximums and restrictions. In addition to your Copayment, you will be required to pay any amount in excess of the Maximum Allowed Amount for the services of Out-of-Network Providers.

- Your Copayment for Out-of-Network Providers will be the same as for Anthem Preferred Providers for the following services if services are authorized. You may be responsible for charges which exceed the Maximum Allowed Amount. See UTILIZATION REVIEW PROGRAM.

  a. Home health care
  b. Infusion/Injection therapy
  c. Hospice
  d. Skilled Nursing Facility

- Skilled Nursing Facility day limit does not apply to Mental Health and Substance Use Disorder.

Medical Benefit Maximum. The Plan will pay for Covered Services and supplies, up to the maximum amounts, or for the maximum number of days or visits as shown on the SUMMARY OF BENEFITS. The Plan will not make Benefit payments for any Member in excess of any of the Medical Benefit Maximums.

Complete Benefit descriptions may be found in the "Medical Care That Is Covered" section. Plan exclusions and limitations may be found in the " Medical Care That Is NOT Covered" section.

INTRODUCTION TO YOUR UC PLAN

Your UC Plan is a PPO Plan created just for UC. You can get care from UC physicians and medical centers as well as the Prudent Buyer network of Providers — the choice is yours. You also have coverage for services provided by Out-of-Network Providers.

How the Plan works

1. You may choose any doctor or care Facility, worldwide.
2. You have two options for In-Network care:
    a. You generally pay set dollar amount Copayments as shown in the SUMMARY OF BENEFITS for Covered Services and there is no Deductible when you use Providers in the UCMC network.
    b. You also can choose a Provider in the Anthem Preferred network and pay applicable Copayments as shown in the SUMMARY OF BENEFITS. There is a $100 Deductible for Individual coverage and $200 Deductible for a family of three or more.
3. Or, you can choose a non-preferred or Out-of-Network Provider and pay applicable Copayments as shown in the SUMMARY OF BENEFITS. There is a $200 Deductible for Individual coverage and $500 Deductible for a family of three or more.
    a. When an In-Network Provider is not available, you may access Out-of-Network Providers for Medically Necessary services covered by the Plan. You will be responsible for any applicable Deductible and Copayment amounts and all charges in excess of the maximum allowable amount. Please refer to the SUMMARY OF BENEFITS for Covered Services and the "Maximum Allowed Amount" in the YOUR MEDICAL BENEFITS section for additional information. If you have questions about accessing an Out-of-Network Provider, please contact the Anthem Health Guide toll free at **(833) 674-9256,** Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific).

Your Employer has agreed to be subject to the terms and conditions of Anthem's Provider agreements which may include pre-service review and utilization management requirements, coordination of Benefits, timely filing limits, and other requirements to administer the Benefits under this Plan.

The Benefits of this Plan are provided only for those services that are considered to be Medically Necessary. The fact that a Physician prescribes or orders a service does not, in itself, mean that the services is Medically Necessary or that the service is covered under this Plan. Consult this Benefit Booklet or contact the Anthem Health Guide toll free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) if you have any questions regarding whether services are covered.

This Plan contains many important terms (such as "Medically Necessary" and "Maximum Allowed Amount") that are defined in the DEFINITIONS section starting at page 110. When reading through this booklet, consult the DEFINITIONS section to be sure that you understand the meaning of these words.

This Plan is designed to reduce the cost of health care to you, the Member. In order to reduce your costs, much greater responsibility is placed on you.

If you have questions about your Benefits, contact Anthem before Hospital or medical services are received.

You should read your Benefit Booklet carefully. Your booklet tells you which services are covered by your health Plan and which are excluded. It also lists your Copayment and Deductible responsibilities.

When you need health care, present your ID card to your Physician, Hospital, or other licensed healthcare Provider. Your ID card has your Member and group numbers on it. Be sure to include these numbers on all claims you submit to Anthem.

In order to receive the highest level of Benefits, you should assure that your Provider is an In-Network Provider.

You are responsible for following the provisions as described in the UTILIZATION REVIEW section of this booklet, including:

1. You or your Physician must obtain Anthem's approval at least 5 working days before Hospital or Skilled Nursing Facility admissions for all non-Emergency inpatient Hospital or Skilled Nursing Facility services.
2. You or your Physician must notify Anthem within 24 hours or by the end of the first business day following Emergency admissions, or as soon as it is reasonably possible to do so.
3. You or your Physician must obtain prior authorization in order to determine if contemplated services are covered. See "Types of Reviews" in the UTILIZATION REVIEW section for a listing of services requiring prior authorization.

Failure to meet these responsibilities may result in your incurring a substantial financial liability. Some services may not be covered unless prior review and other requirements are met.

Note: Anthem will render a decision on all requests for prior authorization within 5 business days from receipt of the request. The treating Provider will be notified of the decision within 24 hours followed by written notice to the Provider and Member within 2 business days of the decision. For urgent services in situations in which the routine decision making process might seriously jeopardize the life or health of a Member or when the Member is experiencing severe pain, Anthem will respond as soon as possible to accommodate the Member's condition not to exceed 72 hours from receipt of the request.

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

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

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

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

You may also refer to the following website for more information, The Mental Health Parity and Addiction Equity Act (MHPAEA) - CMS.gov.

Second Opinions. If you have a question about your condition or about a plan of treatment which your Physician has recommended, you may receive a second medical opinion from another Physician. This second opinion visit will be provided according to the Benefits, limitations, and exclusions of this Plan. If you wish to receive a second medical opinion, remember that greater Benefits are provided when you choose a UCMC Provider or an Anthem Preferred Provider. You may also ask your Physician to refer you to a UCMC Provider or an Anthem Preferred Provider to receive a second opinion.

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 by telephone. Triage or screening services are the evaluation of your health by a Physician 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 the telephone number listed on your identification card 24 hours a day, 7 days a week.

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

All benefits are subject to coordination with benefits. Please refer to the COORDINATION OF BENEFITS section of this booklet for details.

The Benefits of this Plan are subject to the SUBROGATION AND REIMBURSEMENT section.

Consolidated Appropriations Act of 2021 Notice

Consolidated Appropriations Act of 2021 (CAA)

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

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

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 Providers at an In-Network Facility; and
- Out-of-Network air ambulance services.

No Surprises Act Requirements

Emergency Services

As required by the CAA, *emergency medical conditions* are covered under your *plan*:

- Without the need for pre-certification;
- Whether the provider is an In-Network Provider or Out-of-Network Provider;

If the *emergency medical conditions* 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, Out-of-Network Provider cost-shares (i.e., Copayments, Deductibles and/or Coinsurance) will apply to your claim if the treating Out-of-Network Provider determines you are stable, meaning you have been provided necessary *emergency* care such that your condition will not materially worsen and the Out-of-Network Provider determines: (i) that you are able to travel to a *participating provider* Facility by non-emergency transport; (ii) the Out-of-Network Provider complies with the notice and consent requirement; and (iii) you are in condition to receive the information and provide informed consent. If you continue to receive services from the Out-of-Network Provider after you are stabilized, you will be responsible for the Out-of-Network Provider cost-shares, and the Out-of-Network Provider will also be able to charge you any difference between the maximum allowable amount and the Out-of-Network Provider's billed 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.

Non-Participating Services Provided at an In-Network Provider Facility

When you receive covered services from an Out-of-Network Provider at an In-Network Provider Facility, your claims will be paid at the Out-of-Network Provider benefit level 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 out-of-network cost-shares for those services and the Out-of-Network Provider can also charge you any difference between the maximum allowable amount and the Out-of-Network Provider's billed charges. This requirement does not apply to ancillary services. Ancillary services are one of the following services: (A) *emergency* care; (B) anesthesiology; (C) laboratory and pathology services; (D) radiology; (E) neonatology; (F) diagnostic services; (G) assistant surgeons; (H) hospitalists; (I) intensivists; and (J) any services set out by the U.S. Department of Health & Human Services. In addition, Anthem will not apply this

notice and consent process to you if Anthem does not have an In-Network Provider in your area who can perform the services you require.

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

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

How Cost-Shares Are Calculated

Your cost shares for *emergency* care services or for covered services received by an Out-of-Network Provider at an In-Network Provider Facility, will be calculated using the median Plan an In-Network Provider 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 Provider Facility will be applied to your In-Network Provider Out-of-Pocket Limit.

Appeals

If you receive Emergency care services from an Out-of-Network Provider, covered services from an Out-of-Network Provider at an In-Network Provider 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 "YOUR RIGHT TO APPEALS" section of this Benefit Book.

Provider Directories

The Claims Administrator is required to confirm the list of In-Network Providers in its Provider Directory every 90 days. If you can show that you received inaccurate information from The Claims Administrator 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 Provider cost shares will be calculated based upon the Maximum Allowed Amount.

Transparency Requirements

Anthem provides the following information on its website (i.e., 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 The Claims Administrator's website or by calling Member Services at the phone number on the back of your ID Card:

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

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

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

TYPES OF PROVIDERS

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

Introduction
Your Plan is a PPO Plan. The Plan has two sets of Benefits: In-Network and Out-of-Network. If you choose an In-Network Provider as described below, you will pay less in out-of-pocket costs, such as Copayments and Deductibles. If you use an Out-of-Network Provider, you will have to pay more out-of-pocket costs. Cost sharing for services with Copayments is the lesser of the Copayment amount or the Maximum Allowed Amount.

UCMC Providers. Anthem has established a network of Providers and facilities in the UCMC network. This network includes facility and professional services only throughout California. Covered Services received from a UCMC Provider may be subject to lower Copayments than services received from other Providers and there is no Deductible when you use these Providers. Providers and facilities in the UCMC network have agreed to a rate they will accept as reimbursement for Covered Services.

Anthem Preferred Providers in California. Anthem has made available to Members a network of various types of In-Network Providers. UCMC Providers as described above and Anthem Preferred Providers are called 'participating' because they have agreed to participate in Anthem's preferred provider organization program (PPO), called the Prudent Buyer Plan. Anthem Preferred Providers have agreed to a rate they will accept as reimbursement for Covered Services. The amount of Benefits payable under this Plan will be different for Out-of-Network Providers than for UCMC Providers and Anthem Preferred Providers. See the definition of "Anthem Preferred Providers" in the DEFINITIONS section starting at page 110, for a complete list of the types of Providers which may be participating Providers.

A directory of UCMC Providers and Anthem Preferred Providers is available upon request. The directories list In-Network Providers in your area, including health care facilities such as Hospitals and skilled nursing facilities, physicians, laboratories, and diagnostic x-ray and imaging providers. You may call Anthem Health Guide toll free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) and request for a directory to be sent to you. You may also search for an UCMC Providers and Anthem Preferred Providers using the "Find a Doctor" function on Anthem's website at www.anthem.com/ca. The listings include the credentials of UCMC Providers and Anthem Preferred Providers such as specialty designations and board certification.

If you need details about a Provider's license or training, or help choosing a Physician who is right for you, call Anthem Health Guide toll free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific).

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.

How to Access Primary and Specialty Care Services

Your health plan covers care provided by primary care physicians and specialty care providers. To see a primary care physician, simply visit any UCMC Provider or Anthem Preferred Provider Physician who is a general or family practitioner, internist or pediatrician. Your health plan also covers care provided by any UCMC Provider and Anthem Preferred Provider specialty care provider you choose (certain Providers' services are covered only upon referral of an M.D. (medical doctor) or D.O. (doctor of osteopathy) see "Physician," below). Referrals are never needed to visit any In-Network specialty care provider including a behavioral health care provider.

To make an appointment call your Physician's office:

- Tell them you are a UC PPO Plan Member.
- Have your Member ID card handy. They may ask you for your group number, Member ID number, or office visit Copayment.
- Tell them the reason for your visit.

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

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

In-Network Providers Outside of California

The Blue Cross and Blue Shield Association, of which Anthem is a member, has a program (called the "BlueCard Program") which allows our Members to have the reciprocal use of In-Network Providers contracted under other states' Blue Cross and/or Blue Shield Licensees (the Blue Cross and/or Blue Shield Plan).

If you are outside of the California service areas, please call the toll free BlueCard Provider Access number on your ID card to find an In-Network Provider in the area you are in visit the website www.provider.bcbs.com. A directory of PPO Providers for outside of California is available upon request.

Certain categories of Providers defined in this Benefit Booklet as Anthem Preferred Providers may not be available in the Blue Cross and/or Blue Shield Plan in the service area where you receive services. See "Medical Benefit Summary Notes" section and "Maximum Allowed Amount" in the YOUR MEDICAL BENEFITS section for additional information on how health care services you obtain from such Providers are covered.

Out-of-Network Providers. Out-of-Network Providers are providers which have not agreed to participate in the Prudent Buyer Plan network or the Blue Cross and/or Blue Shield Plan. They have not agreed to the reimbursement rates and other provisions of a Prudent Buyer Plan contract nor the Blue Cross and/or Blue Shield Plan.

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

Telehealth Provider Visits. Seeing a Physician 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 Physician in your Plan's In-Network Provider 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 a right to review the medical records from your telehealth visit.

- You have the right to have the medical records from your telehealth visit given to or shared with your primary care doctor, unless you tell us not to share them.

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

Physicians. "Physician" means more than an M.D. Certain other practitioners are included in this term as it is used throughout the Plan. This doesn't mean they can provide every service that a medical doctor could; it just means that the plan will cover expense you incur from them when they're practicing within their specialty the same as if the care were provided by a medical doctor. As with the other terms, be sure to read the definition of "Physician" to determine which Providers' services will be covered. Only Providers listed in the definition are covered as physicians. Please note also that certain providers' services are covered only upon referral of an M.D. (medical doctor) or D.O. (doctor of osteopathy). Providers for whom referral is required are indicated in the definition of "Physician" by an asterisk (*).

Reproductive Health Care Services. Some Hospitals and other Providers do not provide one or more of the following services that may be covered under your Plan and that you or your 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 Physician or clinic, or call Anthem Health Guide toll free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) to ensure that you can obtain the health care services that you need.

In-Network and Out-of-Network Pharmacies. "Network Pharmacies" agree to charge only the Prescription Drug Maximum Allowed Amount to fill the Prescription. You pay only your Copayment amount.

"Out-of-Network Pharmacies" have not agreed to the Prescription Drug Maximum Allowed Amount. The amount that will be covered as Prescription Drug Covered Expense is significantly lower than what these Providers customarily charge.

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

- **Transplant Facilities.** Transplant facilities have been organized to provide services for the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. Subject to any applicable Copayments or Deductibles, CME and BDCSC have agreed to a rate they will accept as payment in full for Covered Services. **These procedures are covered only when performed at a CME or BDCSC.**

- **Bariatric Facilities.** Hospital facilities have been organized to provide services for bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss programs. **These procedures are covered only when performed at a BDCSC.**

A UCMC Provider or an Anthem Preferred Provider in the Prudent Buyer Plan or the Blue Cross and/or Blue Shield Plan network is not necessarily a CME or BDCSC Facility. For additional information, please see the DEFINITIONS section of this book or call Anthem Health Guide toll free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific).

YOUR MEDICAL BENEFITS

Maximum Allowed Amount

General

This section describes the term Maximum Allowed Amount as used in this Benefit Booklet, and what the term means to you when obtaining Covered Services under this Plan. The Maximum Allowed Amount is the total reimbursement payable under your Plan for Covered Services you receive from UCMC Providers, Anthem Preferred Providers and Out-of-Network Providers. It is the Plan's payment towards the services billed by your Provider combined with any Deductible or Copayment owed by you. In some cases, you may be required to pay the entire Maximum Allowed Amount. For instance, if you have not met your Benefit Year Deductible under this Plan, then you could be responsible for paying the entire Maximum Allowed Amount for Covered Services. Except for *surprise billing claims*, when you receive services from an Out-of-Network Provider, you may be responsible for paying any difference between its charges and the Maximum Allowed Amount and the Provider's actual charges. In many situations, this difference could be significant.

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

Below are two examples, which illustrate how the Maximum Allowed Amount works. These examples are for illustration purposes only.

Example: The Plan has a Member Copayment of 20% for Anthem Preferred Provider services after the Benefit Year Deductible has been met.

- The Member receives services from a participating surgeon. The charge is $2,000. The Maximum Allowed Amount under the Plan for the surgery is $1,000. The Member's Copayment responsibility when a participating surgeon is used is 20% of $1,000, or $200. This is what the Member pays. The Plan pays 80% of $1,000, or $800. The participating surgeon accepts the total of $1,000 as payment for the surgery regardless of the charges.

Example: The Plan has a Member Copayment of 50% for Out-of-Network Provider services after the Benefit Year Deductible has been met.

- The Member receives services from an out-of-network surgeon. The charge is $2,000. The Maximum Allowed Amount under the Plan for the surgery is $1,000. The Member's Copayment responsibility when an out-of-network surgeon is used is 50% of $1,000, or $500. The Plan pays the remaining 50% of $1,000, or $500. In addition, the out-of-network surgeon could bill the Member the difference between $2,000 and $1,000. So the Member's total out-of-pocket charge would be $500 plus an additional $1,000, for a total of $1,500.

When you receive Covered Services, Anthem will, to the extent applicable, apply claim processing rules to the claim submitted. Anthem uses these rules to evaluate the claim information and determine the accuracy and appropriateness of the procedure and diagnosis codes included in the submitted claim. Applying these rules may affect the Maximum Allowed Amount if Anthem determines that the procedure and/or diagnosis codes used were inconsistent with procedure coding rules and/or reimbursement policies. For example, if your Provider submits a claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed, the Maximum Allowed Amount will be based on the single procedure code.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is a UCMC Provider, an Anthem Preferred Provider or an Out-of-Network Provider.

UCMC Providers and Anthem Preferred Providers. For Covered Services performed by a UCMC Provider or an Anthem Preferred Provider, the Maximum Allowed Amount for this Plan will be the rate the UCMC Provider or Anthem Preferred Provider has agreed with Anthem to accept as reimbursement for the Covered Services. Because UCMC Providers and Anthem Preferred Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or

collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Benefit Year Deductible or have a Copayment. Please call Anthem Health Guide toll free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) for help in finding a UCMC Provider or an Anthem Preferred Provider or visit www.anthem.com/ca.

If you go to a Hospital which is a UCMC Provider or an Anthem Preferred Provider, you should not assume all Providers in that Hospital are also Anthem Preferred Providers. To receive the greater Benefits afforded when Covered Services are provided by a UCMC Provider or an Anthem Preferred Provider, you should request that all your Provider services (such as services by an anesthesiologist) be performed by In-Network Providers whenever you enter a Hospital.

If you are planning to have outpatient surgery, you should first find out if the Facility where the surgery is to be performed is an Ambulatory Surgical Center. An Ambulatory Surgical Center is licensed as a separate Facility even though it may be located on the same grounds as a Hospital (although this is not always the case). If the center is licensed separately, you should find out if the Facility is a UCMC Provider or an Anthem Preferred Provider before undergoing the surgery.

Note: If a Provider defined in this Benefit Booklet as a UCMC Provider or an Anthem Preferred Provider is of a type not represented in the local Blue Cross and/or Blue Shield Plan at the time you receive services, such Provider will be considered an Out-of-Network Provider for the purposes of determining the Maximum Allowed Amount.

Out-of-Network Providers.*

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

Providers who are not contracted for this Plan, but are contracted for other products, are also considered Out-of-Network Providers. For this Plan, the Maximum Allowed Amount for services from these Providers will be determined under one of the methods shown above unless the Provider's contract specifies a different amount or if your claim involves a *surprise billing claim*.

For Covered Services rendered outside the Anthem Blue Cross service area by Out-of-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan's Out-of-Network Provider fee schedule / rate or the pricing arrangements required by applicable state or federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing we would use if the healthcare services had been obtained within the Anthem Blue Cross service area, or a special negotiated price.

Unlike a UCMC Provider or an Anthem Preferred Provider, Out-of-Network Providers may send you a bill and collect for the amount of the Out-of-Network Provider's charge that exceeds the Maximum Allowed Amount under this Plan. Except for *surprise billing claims*, you may be responsible for paying the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges. This amount can be significant. Choosing an Anthem Preferred Provider will likely result in lower out of pocket costs to you. Please call Anthem Health Guide toll free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) for help in finding a UCMC Provider or an Anthem Preferred Provider or visit the website www.anthem.com/ca. Member Services is also available to assist you in determining this Plan's Maximum Allowed Amount for a particular Covered Service from an Out-of-Network Provider.

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

***Exceptions:**

- **Clinical Trials of Cancer and Other Life Threatening Conditions Benefits.** The Maximum Allowed Amount for services and supplies provided in connection with clinical trials will be the lesser of the billed charge or the amount that ordinarily applies when services are provided by a UCMC Provider or an Anthem Preferred Provider.

- **If Medicare is the primary payor, the Maximum Allowed Amount does not include any charge:**

  1. By a Hospital, in excess of the approved amount as determined by Medicare; or

  2. By a Physician who is a UCMC Provider or an Anthem Preferred Provider who accepts Medicare assignment, in excess of the approved amount as determined by Medicare; or

  3. By a Physician who is an Out-of-Network Provider who accepts Medicare assignment, in excess of the lesser of Maximum Allowed Amount stated above, or the approved amount as determined by Medicare; or

  4. By a Physician who does not accept Medicare assignment, in excess of the lesser of the Maximum Allowed Amount stated above, or the limiting charge as determined by Medicare.

You will always be responsible for expense Incurred which is not covered under this Plan.

Member Cost Share

For certain Covered Services, and depending on your Plan design, you may be required to pay all or a part of the Maximum Allowed Amount as your cost share amount (Deductibles or Copayments). Your cost share amount and the Out-Of-Pocket Amounts may be different depending on whether you received Covered Services from a UCMC Provider, an Anthem Preferred Provider or Out-of-Network Provider. Specifically, you may be required to pay higher cost-sharing amounts or may have limits on your Benefits when using Out-of-Network Providers. Please see the SUMMARY OF BENEFITS section for your cost share responsibilities and limitations, or call Anthem Health Guide toll free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) to learn how this Plan's Benefits or cost share amount may vary by the type of Provider you use. For additional details about Deductibles or Copayments please refer to the "Deductibles, Copayments, Out-of-Pocket Amounts and Medical Benefit Maximums" section.

Anthem will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by a UCMC Provider, an Anthem Preferred Provider or Out-of-Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your plan and services received after Benefits have been exhausted. Benefits may be exhausted by exceeding, for example, Medical Benefit Maximums or day/visit limits.

Authorized Referrals

In some circumstances Anthem may authorize a UCMC Provider or Anthem Preferred Provider cost share amounts (Deductibles or Copayments) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstance, you or your Physician must contact Anthem in advance of obtaining the Covered Service. It is your responsibility to ensure that Anthem has been contacted. If Anthem authorizes a UCMC Provider or an Anthem Preferred Provider cost share amount to apply to a Covered Service received from an Out-of-Network Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please call Anthem Health Guide toll-free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) for Authorized Referral information or to request authorization.

Deductibles, Copayments, Out-of-Pocket Amounts and Medical Benefit Maximums

After any applicable Deductible and your Copayment are subtracted, the Plan will pay Benefits up to the Maximum Allowed Amount, not to exceed any applicable Medical Benefit Maximum. The Deductible amounts, Copayments, Out-Of-Pocket Amounts and Medical Benefit Maximums are set forth in the SUMMARY OF BENEFITS.

Deductibles

Each Deductible under this Plan is separate and distinct from the other. Only the covered charges that make up the Maximum Allowed Amount will apply toward the satisfaction of any Deductible except as specifically indicated in this booklet. **The Deductibles explained below do not apply to Covered Services and supplies provided by UCMC.**

Benefit Year Deductible. Each year, you will be responsible for satisfying the Member's Benefit Year Deductible before Benefits are paid. If Members of an enrolled family pay Deductible expense in a Year equal to the family Deductible, the Benefit Year Deductible for all Family Members will be considered to have been met

Anthem Preferred Providers, In-Network Pharmacies and Home Delivery Pharmacies. Only covered charges up to the Maximum Allowed Amount for the services of Anthem Preferred Providers, In-Network Pharmacies and Home Delivery Pharmacies will be applied to the Anthem Preferred Provider, In-Network Pharmacy and Home Delivery Pharmacy Benefit Year Deductibles. When these Deductibles are met, the Plan will pay Benefits only for the services of Anthem Preferred Providers, In-Network Pharmacies and Home Delivery Pharmacies. The Plan will not pay any Benefits for Out-of-Network Providers and Out-of-Network Pharmacies unless the separate Out-of-Network Provider and Out-of-Network Pharmacy Benefit Year Deductibles (as applicable) are met.

Out-of-Network Providers and Out-of-Network Pharmacies. Only covered charges up to the Maximum Allowed Amount for the services of Out-of-Network Providers and Out-of-Network Pharmacies will be applied to the Out-of-Network Provider and Out-of-Network Pharmacy Benefit Year Deductibles. The Plan will pay Benefits for the services of Out-of-Network Providers and Out-of-Network Pharmacies only when the applicable Out-of-Network Provider Deductibles and Out-of-Network Pharmacies are met.

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

Copayments

After you have satisfied any applicable Deductible, your Copayment will be subtracted from the remaining Maximum Allowed Amount.

Depending on the type of service rendered, your Copayment will either be a percentage or a set-dollar Copayment. If your Copayment is a percentage, the Plan will apply the applicable percentage to the Maximum Allowed Amount remaining after any Deductible has been met. If your Copayment is a set-dollar Copayment, the Plan will apply the applicable set-dollar Copayment, such as an office visit or an emergency room visit.

UCMC Provider and Anthem Preferred Provider Out-of-Pocket Amounts

Satisfaction of the UCMC Provider Out-Of-Pocket Amount. If, after you pay Copayments equal to your UCMC Provider Out-of-Pocket Amount per Member during a Benefit Year, you will no longer be required to make Copayments for any additional Covered Services or supplies during the remainder of that Year, except as specifically stated below under Charges Which Do Not Apply Toward the UCMC Provider Out-of-Pocket Amount.

If enrolled Members of a family pay Copayments in a year equal to the UCMC Provider Out-of-Pocket Amount per family, the UCMC Provider Out-of-Pocket Amount for all Family Members will be considered to have been met. Once the family UCMC Provider Out-of-Pocket Amount is satisfied, no Family Member will be required to make Copayments for any additional Covered Services or supplies during the remainder of that year, except as specifically stated under "Charges Which Do Not Apply Toward the UCMC Provider Out-of-Pocket Amount" below. However, the Plan will not credit any expense previously applied to the UCMC Provider Out-of-Pocket Amount per Member in the same year for any other Family Member.

Note: Any Copayments you make toward covered charges for the services of an Anthem Preferred Provider will be applied to the UCMC Provider Out-of-Pocket Amount.

Satisfaction of the Anthem Preferred Provider Out-Of-Pocket Amount. If, after you have met your Benefit Year Deductible, you pay Copayments equal to your Out-of-Pocket Amount per Member during a Benefit Year, you will no longer be required to make Copayments for any additional Covered Services or supplies during the remainder of that year, except as specifically stated below under Charges Which Do Not Apply Toward the Out-of-Pocket Amount.

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

Anthem Preferred Provider, In-Network Pharmacies and Home Delivery Pharmacies. Only covered charges up to the Maximum Allowed Amount for the services of an Anthem Preferred Provider, In-Network Pharmacy and Home Delivery Pharmacy will be applied to the Anthem Preferred Provider, In-Network Pharmacy and Home Delivery Pharmacy Out-of-Pocket Amount.

After this Out-of-Pocket Amount per Member or family has been satisfied during a Benefit Year, you will no longer be required to make any Copayment for the Covered Services provided by an Anthem Preferred Provider, In-Network Pharmacy and Home Delivery Pharmacy for the remainder of that year. You will continue to be required to make Copayments for the Covered Services of an Out-of-Network Provider until the Out-of-Network Provider and Out-of-Network Pharmacy Out-of-Pocket Amount has been met.

Note: Any Copayments you make toward covered charges for the services of a UCMC Provider will be applied to the Anthem Preferred Provider Out-of-Pocket Amount.

Out-of-Network Provider Out-of-Pocket-Amounts

Out-of-Network Providers and Out-of-Network Pharmacies. Only covered charges up to the Maximum Allowed Amount for the services of an Out-of-Network Provider will be applied to the Out-of-Network Provider and Out-of-Network Pharmacy Out-of-Pocket Amount. After this Out-of-Pocket Amount per Member has been satisfied during a Benefit Year, you will no longer be required to make any Copayment for the Covered Services provided by an Out-of-Network Provider for the remainder of that year.

Note: Any covered expense applied to any Deductible or Copayments for Prescription Drugs will apply towards your Out-of-Pocket Amount.

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

- Charges for services or supplies not covered under this Plan.
- Charges which exceed the Maximum Allowed Amount.
- Charges which exceed the Prescription Drug Maximum Allowed Amount.

Medical Benefit Maximums

The Plan does not make Benefit payments for any Member in excess of any of the Medical Benefit Maximums.

Prior Plan Maximum Benefits. If you were covered under the Prior Plan, any Benefits paid to you under the Prior Plan will reduce any maximum amounts you are eligible for under this Plan which apply to the same Benefit for the remainder of the benefit year.

Crediting Prior Plan Coverage

If you were covered by UC's Prior Pan immediately before UC signs up with Anthem, with no lapse in coverage, then you will get credit for any accrued Benefit Year Deductible and, if applicable and approved by Anthem, out-of-pocket amounts under the Prior Plan. This does not apply to Individuals who were not covered by the Prior Plan on the day before UC's coverage with Anthem began, or who join UC later. Credits are applied to the same Individual only.

If UC moves from one of Anthem's plans to another, (for example, changes its coverage from HMO to PPO), and you were covered by the other product immediately before enrolling in this product with no break in coverage, then you may get credit for any accrued Benefit Year Deductible and out-of-pocket amounts, if applicable and approved by the Anthem. Credits are applied to the same Individual only. Any maximums, when applicable, will be carried over and charged against the Medical Benefit Maximums under this Plan.

If UC offers more than one of the Anthem's products, and you change from one product to another with no break in coverage, you will get credit for any accrued Benefit Year Deductible and, if applicable, out-of-pocket amounts and any maximums will be carried over and charged against Medical Benefit Maximums under this Plan. Credits are applied to the same Individual only.

If UC offers coverage through other products or carriers in addition to Anthem's, and you change products or carriers to enroll in this product with no break in coverage, you will get credit for any accrued Benefit Year Deductible, out-of-pocket amount, and any Medical Benefit Maximums under this Plan, if applicable and approved by UC. Credits are applied to the same Individual only.

This Section Does Not Apply To You If:

- UC moves to this Plan at the beginning of a Benefit Year;
- You change from one of Anthem's individual policies to UC's plan;
- You change Employers; or
- You are a new Member of UC who joins after UC's initial enrollment with Anthem.

Conditions of Coverage

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

1. You must incur this expense while you are covered under this Plan. Expense is Incurred on the date you receive the service or supply for which the charge is made.
2. The expense must be for a medical service or supply furnished to you as a result of illness or injury or pregnancy, unless a specific exception is made.
3. The expense must be for a medical service or supply included in Medical Care That Is Covered. Additional limits on covered charges are included under specific Benefits and in the SUMMARY OF BENEFITS.
4. The expense must not be for a medical service or supply listed in Medical Care That Is NOT Covered. If the service or supply is partially excluded, then only that portion which is not excluded will be covered under this Plan.
5. The expense must not exceed any of the maximum Benefits or limitations of this Plan.
6. Any services received must be those which are regularly provided and billed by the Provider. In addition, those services must be consistent with the illness, injury, degree of disability and your medical needs. Benefits are provided only for the number of days required to treat your illness or injury.
7. All services and supplies must be ordered by a Physician.

Contact the Anthem Health Guide toll free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) if you have any questions.

Medical Care That Is Covered

Subject to the Medical Benefit Maximums in the SUMMARY OF BENEFITS, the requirements set forth under Conditions of Coverage and the exclusions or limitations listed under "Medical Care That Is NOT Covered", the Plan will provide Benefits for the following services and supplies:

Abortion Services. Benefits include all abortion and abortion-related services, including pre-abortion and follow-up services. For outpatient abortion services, precertification is not required.

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

Acupuncture Benefits. The services of a Physician for acupuncture treatment to treat a disease, illness or injury, including a patient history visit, physical examination, treatment planning and treatment evaluation, electroacupuncture, cupping and moxibustion. The Plan will pay for up to 24 visits (combined with "Chiropractic Benefits") during a Benefit Year.

Since your Plan has a Benefit Year Deductible, the number of visits will start counting toward the maximum when services are first provided even if the Benefit Year Deductible has not been met.

Advanced Imaging Procedure Benefits. Imaging procedures, including, but not limited to, Magnetic Resonance Imaging (MRI), Computerized Tomography (CT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography and nuclear cardiac imaging are subject to pre-service review to determine whether Medically Necessary. You may call Anthem Health Guide toll free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) to find out if an imaging procedure requires pre-service review. See UTILIZATION REVIEW PROGRAM for details.

Advanced imaging procedures, when performed by an Out-of-Network Provider, will have a maximum payment of **$350** per visit.

Allergy Testing and Treatment Benefits. Allergy testing and treatment, including serum and serum injections.

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

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

All non-Emergency ambulance services (ground, air or water) are subject to medical necessity reviews. Emergency ground ambulance services do not require pre-service review. Pre-service review is required for air ambulance in a non-medical Emergency. When using an air ambulance in a non-Emergency situation, Anthem reserves the right to select the air ambulance provider. If you do not use the air ambulance Anthem

selects in a non-Emergency situation, no coverage will be provided by the Plan and Members will be responsible for the entire cost of transport.

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

Coverage includes Medically Necessary treatment of an illness or injury by medical professionals from an ambulance service, even if you are not transported to a Hospital. Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your Family Members or Physician are not a Covered Service.

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

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

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

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

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

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

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

Ambulatory Surgery Center Benefits. Services and supplies provided by an Ambulatory Surgical Center in connection with outpatient surgery.

For the services of an Out-of-Network Provider Facility only, the Plan's maximum payment is limited to **$350** per visit each time you have outpatient surgery at an Ambulatory Surgical Center.

Ambulatory Surgical Center services are subject to pre-service review to determine whether Medically Necessary. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

Asthma Equipment and Supplies Benefits. The following items and services when required for the Medically Necessary treatment of asthma in a Dependent child:

1. Nebulizers, including face masks and tubing, inhaler spacers, and peak flow meters. These items are covered under the Plan's medical Benefits and are not subject to any limitations or maximums that apply to coverage for durable medical equipment (see "Durable Medical Equipment Benefits").
2. Inhaler spacers and peak flow meters. These items are covered under your Prescription Drug benefits and are subject to the Copayment for Brand Name Drugs (see YOUR PRESCRIPTION DRUG BENEFITS).

3. Education for pediatric asthma, including education to enable the child to properly use the items listed above. This education will be covered under the Plan's Benefits for office visits to a Physician.

Bariatric Surgery Benefits. Services and supplies in connection with Medically Necessary surgery for weight loss, only for morbid obesity and only when performed at a designated BDCSC Facility. See UTILIZATION REVIEW PROGRAM for details.

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

Bariatric Travel Expense Benefits. Certain travel expenses Incurred in connection with an approved, specified bariatric surgery, performed at a designated BDCSC that is fifty (50) miles or more from the Member's place of residence, are covered, provided the expenses are authorized by Anthem in advance. The fifty (50) mile radius around the BDCSC will be determined by the Bariatric BDCSC Coverage Area (See DEFINITIONS). The Plan's maximum payment will not exceed **$3,000** per surgery for the following travel expenses Incurred by the Member and/or one companion:

- Transportation for the Member and/or one companion to and from the BDCSC.
- Lodging, limited to one room, double occupancy.
- Other reasonable expenses. Tobacco, alcohol, drug expenses, and meals are excluded from coverage.

Member Services will confirm if the "Bariatric Travel Expense Benefit" is available in connection with access to the selected bariatric BDCSC. Details regarding reimbursement can be obtained by calling Anthem Health Guide toll free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific). A travel reimbursement form will be provided and will include instructions for submission of legible copies of all applicable receipts in order to obtain reimbursement.

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

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

1. Diagnostic mammogram examinations in connection with the treatment of a diagnosed illness or injury. Routine mammograms will be covered initially under the "Preventive Care Benefits". A follow-up mammogram may be considered diagnostic or treatment of a diagnosed illness or injury. Please talk with your treating Physician to understand what care is being provided so you will know which coverage applies.
2. Breast cancer (BRCA) testing, if appropriate, in conjunction with genetic counseling and evaluation. When done as a Preventive Care Service, BRCA testing will be covered under the "Preventive Care Benefits".
3. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.
4. Reconstructive Surgery of both breasts performed to restore and achieve symmetry following a Medically Necessary mastectomy.
5. Breast prostheses following a mastectomy (see "Prosthetic Devices Benefits").

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

Breast Health Screening (Athena). Covered Members who receive mammography screening are eligible to complete a breast health screening tool which provides additional information on the risk of developing breast cancer. High risk individuals may receive telephonic or in person counseling from an Athena breast health specialist. For further information on the Athena program, please go to the following website: www.wisdomstudy.org**.**

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

Chiropractic Benefits. Chiropractic Services for manual manipulation of the spine to correct subluxation demonstrated by Physician-read x-ray. The Plan will pay for up to 60 visits during a Benefit Year.

Since your plan has a Benefit Year Deductible, the number of visits will start counting toward the maximum when services are first provided even if the Benefit Year Deductible has not been met.

Clinical Trial of Cancer and Other Life Threatening Conditions Benefits. Coverage is provided for routine patient costs you receive as a voluntary participant in an approved clinical trial. The services must be those that are listed as covered by this Plan for Members who are not enrolled in a clinical trial.

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

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

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

Participation in the clinical trial must be recommended by your Physician after determining participation has a meaningful potential to benefit you. All requests for clinical trials services, including requests that are not part of approved clinical trials, will be reviewed according to the Plan's Clinical Coverage Guidelines, related policies and procedures. If you have any questions about the information in this section, please refer to Anthem's clinical guidelines website at www.anthem.com/ca.

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

1. The investigational item, device, or service.

2. Any item or service provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.

3. Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

4. Any item, device, or service that is paid for, by the sponsor of the trial or is customarily provided by the sponsor free of charge for any enrollee in the trial.

Note: You will be financially responsible for the costs associated with non-Covered Services.

Contraceptive Benefits

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

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

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

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

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

Dental Care Benefits

1. **Admissions for Dental Care.** Listed inpatient Hospital services for up to three days during a Hospital Stay, when such Stay is required for dental treatment and has been ordered by a Physician (M.D.) and a dentist (D.D.S. or D.M.D.). Anthem will make the final determination as to whether the dental treatment could have been safely rendered in another setting due to the nature of the procedure or your medical condition. Hospital Stays for the purpose of administering general anesthesia are not considered necessary and are not covered except as specified in #2, below.

2. **General Anesthesia.** General anesthesia and associated Facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a Hospital or Ambulatory Surgical Center. This applies only if (a) the Member is less than seven years old, (b) the Member is developmentally disabled, or (c) the Member's health is compromised and general anesthesia is Medically Necessary. Charges for the dental procedure itself, including professional fees of a dentist, may not be covered.

3. **Dental Injury.** Services of a Physician (M.D.) or dentist (D.D.S. or D.M.D.) solely to treat an Accidental Injury to natural teeth. Coverage shall be limited to only such services that are Medically Necessary to repair the damage done by Accidental Injury and/or restore function lost as a direct result of the Accidental Injury. Damage to natural teeth due to chewing or biting is not Accidental Injury unless the chewing or biting results from a medical or mental condition.

4. **Cleft Palate.** Medically Necessary dental or orthodontic services that are an integral part of Reconstructive Surgery for cleft palate procedures. "Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

5. **Orthognathic Surgery.** Orthognathic surgery for a physical abnormality that prevents normal function of the upper or lower jaw and is Medically Necessary to attain functional capacity of the affected part.

Important: If you decide to receive dental services that are not covered under this Plan, a UCMC Provider or an Anthem Preferred Provider who is a dentist may charge you his or her usual and customary rate for those services. Prior to providing you with dental services that are not a covered Benefit, the dentist should provide a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about the dental services that are covered under this Plan, please call Anthem Health Guide toll free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific). To fully understand your coverage under this Plan, please carefully review this Benefit Booklet document.

Designated Pharmacy Provider Benefits

Anthem may establish one or more Designated Pharmacy Provider programs which provide specific pharmacy services (including shipment of Prescription Drugs) to Members. A participating provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the participating provider must have signed a Designated Pharmacy Provider agreement with the Plan. You or your Physician can contact the Anthem Health Guide toll free at **(833) 674-9256** or go to the website www.anthem.com/ca to learn which Pharmacy or pharmacies are part of a Designated Pharmacy Provider program. The Anthem Health Guide is available Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) but you can receive prescription related support after hours by calling **(833) 674-9256** and pressing 2.

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

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

If you are required to use a Designated Pharmacy Provider and you choose not to obtain your Prescription Drug from a Designated Pharmacy Provider, coverage will be the same as for an Out-of-Network Provider.

You can get the list of the Prescription Drugs covered under this section by calling Anthem Health Guide toll free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) or check Anthem's website at www.anthem.com/ca.

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

1. The following equipment and supplies:

    a. Insulin pumps.

    b. Pen delivery systems for insulin administration (non-disposable).

    c. Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin.

    d. Podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes-related complications.

    Items a. through d. above are covered under your Plan's Benefits for durable medical equipment (see "Durable Medical Equipment Benefits"). Item e. above is covered under your Plan's Benefits for Prosthetic Devices (see "Prosthetic Devices Benefit").

2. Diabetes education program which:

    a. Is designed to teach a Member who is a patient and covered Members of the patient's family about the disease process and the daily management of diabetic therapy;

    b. Includes self-management training, education, and medical nutrition therapy to enable the Member to properly use the equipment, supplies, and medications necessary to manage the disease; and

    c. Is supervised by a Physician.

    Diabetes education services are covered under Plan Benefits for office visits to physicians.

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

    a. Insulin, glucagon, and other Prescription Drugs for the treatment of diabetes.

    b. Insulin syringes, disposable pen delivery systems for insulin administration.

    c. Testing strips, lancets, and alcohol swabs.

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

4. Screenings for gestational diabetes are covered under your “Preventive Care Benefits”. Please see that provision for further details.

Diagnostic Services. Outpatient diagnostic imaging and laboratory services. This does not include services covered under the "Advanced Imaging Procedure Benefits" provision of this section.

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

1. Of no further use when medical needs end;

2. For the exclusive use of the patient;

3. Not primarily for comfort or hygiene;

4. Not for environmental control or for exercise; and

5. Manufactured specifically for medical use.

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

eConsult. The eConsult program provides UCMC Providers with point-of-care decision support on referral appropriateness, and allows your UCMC Provider to receive timely recommendations directly from a UC specialist. You are not subject to a Copayment for this service nor do you physically see the specialist. eConsult is available to all UCMC Providers and UC specialists. Please coordinate these services with your UCMC Provider. For additional information on the eConsult program, please contact the Anthem Health Guide toll free at **(833) 674-9256,** Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific).

Emergency Room. Benefits are provided for Medically Necessary services provided in the emergency room of a Hospital.

Family Planning Benefits. Family planning services, counseling and planning for problems of fertility and Infertility, as Medically Necessary. Artificial insemination, in vitro fertilization, and any related laboratory procedures are not covered.

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

Gene Therapy Services. Your Plan includes benefits for gene therapy services, when the Claims Administrator approves the benefits in advance through precertification. See the "Utilization Review Program" for details on the precertification process. To be eligible for coverage, services must be Medically Necessary and performed by an approved Physician at an approved treatment center. Even if a Physician is an Anthem Preferred Provider for other services it may not be an approved provider for certain gene therapy services. Please call the claims administrator to find out which providers are approved Physicians. (When calling Member Services, ask for the Transplant Case Manager for further details.)

Services Not Eligible for Coverage

Your Plan does not include benefits for the following:

i. Services determined to be Experimental / Investigational;

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

iii. Services not approved in advance through precertification.

Hearing Aid Benefits. The following hearing aid services are covered when provided by or purchased as a result of a written recommendation from an otolaryngologist or a state-certified audiologist. The Plan's payment will not exceed of **$2,000** every three years.

1. Audiological evaluations to measure the extent of hearing loss and determine the most appropriate make and model of hearing aid. These evaluations will be covered under Plan Benefits for office visits to physicians.

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

3. Visits for fitting, counseling, adjustments and repairs for a one year period after receiving the covered hearing aid.

No Benefits will be provided for the following:

1. Charges for a hearing aid which exceeds specifications prescribed for the correction of hearing loss, or for more than one hearing aid per ear every three years.

2. Surgically implanted hearing devices (i.e., cochlear implants, audient bone conduction devices). Medically Necessary surgically implanted hearing devices may be covered under your Plan's Benefits for Prosthetic Devices (see "Prosthetic Devices Benefits").

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

The following renal dialysis services are covered:

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

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

1. Services of a registered nurse or licensed vocational nurse under the supervision of a registered nurse or a Physician.
2. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy, or respiratory therapy.
3. Services of a medical social service worker.
4. Services of a health aide who is employed by (or who contracts with) a Home Health Agency. Services must be ordered and supervised by a registered nurse employed by the Home Health Agency as professional coordinator. These services are covered only if you are also receiving the services listed in 1 or 2 above. Other organizations may give services only when approved by the *claims administrator*, and their duties must be assigned and supervised by a professional nurse on the staff of the *home health agency* or other provider as approved by the *claims administrator*.
5. Medically Necessary supplies provided by the Home Health Agency.

Benefits are also available for intensive in-home behavioral health services. These do not require confinement to the home. Please see the “Mental Health and Substance Use Disorder” for a description of this coverage.

In no event will Benefits exceed 100 visits during a Benefit Year. A visit of four hours or less by a home health aide shall be considered as one home health visit.

Since your Plan has a Benefit Year Deductible, the number of visits will start counting toward the maximum when services are first provided even if the Benefit Year Deductible has not been met.

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

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

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

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

1. Interdisciplinary team care with the development and maintenance of an appropriate plan of care.
2. Short-term inpatient Hospital care when required in periods of crisis or as respite care.
3. Skilled nursing services provided by or under the supervision of a registered nurse. Certified home health aide services and homemaker services provided under the supervision of a registered nurse.
4. Social services and counseling services provided by a qualified social worker.
5. Dietary and nutritional guidance. Nutritional support such as intravenous feeding or hyperalimentation.
6. Physical therapy, occupational therapy, speech therapy, and respiratory therapy provided by a licensed therapist.
7. Volunteer services provided by trained Hospice volunteers under the direction of a Hospice staff member.
8. Pharmaceuticals, medical equipment, and supplies necessary for the management of your condition. Oxygen and related respiratory therapy supplies.

9. Palliative care (care which controls pain and relieves symptoms, but does not cure) which is appropriate for the illness.

Your Physician must consent to your care by the Hospice and must be consulted in the development of your treatment plan. The Hospice must submit a written treatment plan to Anthem every 30 days.

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

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

Hospital Benefits

1. Inpatient services and supplies, provided by a Hospital. The Maximum Allowed Amount will not include charges in excess of the Hospital's prevailing two-bed room rate unless there is a negotiated per diem rate between Anthem and the Hospital, or unless your Physician orders, and Anthem authorizes, a private room as Medically Necessary. For inpatient services and supplies provided by an Out-of-Network Provider Facility, the Plan's maximum payment is limited to **$600*** per day.
2. Services in Special Care Units.
3. Outpatient services and supplies provided by a Hospital, including outpatient surgery. For outpatient services and supplies provided by an Out-of-Network Provider, the Plan's maximum payment is limited to **$350*** per day.

   *The Out-of-Network Provider Facility maximums do not apply to Emergency Services.

Hospital services are subject to pre-service review to determine medical necessity which is based on Anthem's medical policy. Information regarding Anthem's Medical Policy can be obtained by going to www.anthem.com/ca.

Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews. For the inpatient services at an Out-of-Network Provider, there is an additional $250 Copayment if prior authorization is not obtained.

Infertility Treatment Benefits. Diagnosis of cause of Infertility, provided you are under the direct care and treatment of a Physician.

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

1. Medication, ancillary medical supplies and supply delivery, (not to exceed a 14-day supply); however, medication which is delivered but not administered is not covered;
2. Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications (if outpatient prescription drug benefits are provided under this Plan, Compound Medications must be obtained from an In-Network Pharmacy);
3. Hospital and home clinical visits related to the administration of infusion therapy, including skilled nursing services including those provided for: (a) patient or alternative caregiver training; and (b) visits to monitor the therapy;
4. Rental and purchase charges for durable medical equipment; maintenance and repair charges for such equipment;

5. Laboratory services to monitor the patient's response to therapy regimen.

6. Total Parenteral Nutrition (TPN), Enteral Nutrition Therapy, antibiotic therapy, pain management, chemotherapy, and may also include injections (intra-muscular, subcutaneous, or continuous subcutaneous).

Infusion / injectable therapy services are subject to pre-service review to determine whether Medically Necessary. (See UTILIZATION REVIEW PROGRAM.)

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

Mental Health and Substance Use Disorder Benefits. This Plan provides coverage for the Medically Necessary treatment of Mental Health and substance use disorder. This coverage is provided according to the terms and conditions of this Plan that apply to all other medical conditions, except as specifically stated in this section. Medically Necessary services are a benefit only when the procedure is in accordance with Anthem Blue Cross Medical Policy. Information regarding Anthem's Medical Policy can be obtained by going to www.anthem.com/ca

Covered Services shown below for the Medically Necessary treatment of Mental Health and substance use disorder, or to prevent the deterioration of chronic conditions.

1. Inpatient Hospital services and services from a Residential Treatment Center (including crisis residential treatment) as stated in the "Hospital Benefits" provision of this section, for inpatient services and supplies, and Physician visits during a covered inpatient Stay.

2. Outpatient Office Visits for the following:

   - individual and group mental health evaluation and treatment,
   - Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the member's death. Bereavement services are available to the patient and those individuals who are closely linked to the patient, including the immediate family, the primary or designated care giver and individuals with significant personal ties, for one year after the member's death.
   - nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa,
   - drug therapy monitoring,
   - individual and group chemical dependency counseling,
   - medical treatment for withdrawal symptoms,
   - methadone maintenance treatment,
   - Behavioral health treatment for autism spectrum disorders delivered in an office setting.

- Other Outpatient Items and Services:

   - Partial hospitalization, including Intensive Outpatient Programs and visits to a Day Treatment Center. Partial hospitalization is covered as stated in the "Hospital Benefits" provision of this section, for outpatient services and supplies.
   - Psychological testing,
   - Multidisciplinary treatment in an intensive outpatient psychiatric treatment program,
   - Behavioral health treatment for autism spectrum disorders delivered at home.

3. Behavioral health treatment for autism spectrum disorders. Inpatient services, office visits, and other outpatient items and services are covered under this section. See the section BENEFITS FOR AUTISM SPECTRUM DISORDERS for a description of the services that are covered. **Note:** You must obtain pre-service review for all behavioral health treatment services for the treatment of autism spectrum disorders in order for these services to be covered by this Plan (see UTILIZATION REVIEW PROGRAM for details).

Treatment for substance use disorder does not include smoking cessation programs, nor treatment for nicotine dependency or tobacco use. Certain services are covered under the "Preventive Care Benefits". Please see that provision for further details.

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

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

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

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

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

The cost of the necessary formulas and special food products is covered only as it exceeds the cost of a normal diet. "Formula" means an enteral product or products for use at home. The formula must be prescribed by a Physician or nurse practitioner, or ordered by a registered dietician upon referral by a health care provider authorized to prescribe dietary treatments, and is Medically Necessary for the treatment of PKU. Formulas and special food products used in the treatment of PKU that are obtained from a Pharmacy are covered as Prescription Drugs (see YOUR PRESCRIPTION DRUG BENEFITS). Formulas and special food products that are not obtained from a pharmacy are covered under this Benefit.

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

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

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

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

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

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

Pregnancy and Maternity Care Benefits

1. All medical Benefits for an enrolled Member when provided for pregnancy or maternity care, including the following services:
   a. Prenatal, postnatal and postpartum care;
   b. Ambulatory care services (including ultrasounds, fetal non-stress tests, Physician office visits, and other Medically Necessary maternity services performed outside of a Hospital);
   c. Involuntary complications of pregnancy;
   d. Diagnosis of genetic disorders in cases of high-risk pregnancy; and
   e. Inpatient Hospital care including labor and delivery.

   Inpatient Hospital Benefits in connection with childbirth will be provided for at least 48 hours following a normal delivery or 96 hours following a cesarean section, unless the mother and her Physician decide on an earlier discharge. Please see the section entitled FOR YOUR INFORMATION for a statement of your rights under federal law regarding these services.
2. Medical Hospital Benefits for routine nursery care of a newborn child, if the child's natural mother is an enrolled Member. Routine nursery care of a newborn child includes screening of a newborn for genetic diseases, congenital conditions, and other health conditions provided through a program established by law or regulation.
3. Certain services are covered under the "Preventive Care Benefits". Please see that provision for further details.

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

Prescription Drugs Obtained From Or Administered By a Medical Provider. Your Plan includes Benefits for Prescription Drugs, including Specialty Drugs that must be administered to you as part of a Physician visit, services from a Home Health Agency, or at an outpatient Hospital when they are Covered Services. This may include Drugs for infusion therapy / injectable therapy, chemotherapy, blood products, certain injectables and any Drug that must be administered by a Physician. This section describes your Benefits when your Physician orders the medication and administers it to you.

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

Non-duplication of Benefits applies to Pharmacy drugs under this Plan. When Benefits are provided for Pharmacy drugs under the Plan's medical Benefits, they will not be provided under your Prescription Drug Benefits, if included. Conversely, if Benefits are provided for Pharmacy drugs under your Prescription Drug Benefits, if included, they will not be provided under the Plan's medical Benefits.

Prior Authorization. Your Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Physician may be asked to give more details before Anthem can decide if the Drug is eligible for coverage. In order to determine if the Prescription Drug is eligible for coverage, the following criteria has been established.

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

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

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

- Step therapy requiring one *drug*, *drug* regimen, or treatment be used prior to use of another *drug*, *drug* regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated;

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

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

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

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

Your *plan* also covers certain over-the-counter *drugs* that must be covered under federal law, when prescribed by a *physician*, subject to all terms of this *plan* that apply to those benefits. Please see the

"Preventive Care Services" provision of MEDICAL CARE THAT IS COVERED or the "Preventive Prescription Drugs and Other Items" provision under YOUR PRESCRIPTION DRUG BENEFITS for additional details.

Precertification and Step Therapy Exclusions: You or your Physician can get the list of the Prescription Drugs that require prior authorization by calling the Anthem Health Guide toll free at **(833) 674-9256** or by going to the website www.anthem.com/ca. Anthem Health Guide is available Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) but you can receive prescription related support after hours by calling **(833) 674-9256** and pressing 2. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under your Plan. A step therapy exception means a decision to override a generally applicable step therapy protocol in favor of covering the Drug prescribed by your provider. Your Physician may check with the plan to verify Prescription Drug coverage, to find out which Prescription Drug are covered under this section and if any drug edits apply. However, if it is determined through prior authorization that the Drug originally prescribed is Medically Necessary and is cost effective, you will be provided the Drug originally requested. If, when you first become a Member, you are already being treated for a medical condition by a Drug that has been appropriately prescribed and is considered safe and effective for your medical condition, Anthem will not require you to try a Drug other than the one you are currently taking.

In order for you to get a specialty pharmacy Drug that requires prior authorization, your Physician must submit a request to the Plan using the required uniform prior authorization request form. The request may be made by mail, telephone, facsimile, or it may be made electronically. At the time the request is initiated, specific clinical information will be requested from your Physician based on medical policy and/or clinical guidelines, based specifically on your diagnosis and/or the Physician's statement in the request or clinical rationale for the specialty pharmacy Drug.

After the Plan receives the request from your Physician, Anthem will review the request and respond within the following time periods:

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

If you have any questions regarding whether a specialty pharmacy drug requires prior authorization, please call the Anthem Health Guide toll free at **(833) 674-9256** or go to the website www.anthem.com/ca. Anthem Health Guide is available Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) but you can receive prescription related support after hours by calling **(833) 674-9256** and pressing 2.

If a request for prior authorization of a specialty pharmacy Drug is denied, you or your prescribing Physician may appeal the decision by calling Anthem Health Guide toll free at **(833) 674-9256** or by going to the website www.anthem.com/ca. Anthem Health Guide is available Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) but you can receive prescription related support after hours by calling **(833) 674-9256** and pressing 2.

Preventive Care Benefits. Preventive care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA) and applicable state law. This means for Preventive Care Services, the Benefit Year Deductible will not apply to these services or supplies when they are provided by a UCMC Provider or an Anthem Preferred Provider. No Copayment will apply to these services or supplies when they are provided a UCMC Provider or by an Anthem Preferred Provider.

Certain Benefits for Members who have current symptoms or a diagnosed health problem may be covered under a different benefit instead of this benefit, if the coverage does not fall within the state or ACA-recommended Preventive Care Services.

1. A Physician's services for routine physical examinations.
2. Immunizations prescribed by the examining Physician.

3. Radiology and laboratory services and tests ordered by the examining Physician in connection with a routine physical examination, excluding any such tests related to an illness or injury. Those radiology and laboratory services and tests related to an illness or injury will be covered as any other medical service available under the terms and conditions of the provision “Diagnostic Services Benefit”.

4. Health screenings as ordered by the examining Physician for the following: breast cancer, including BRCA testing if appropriate (in conjunction with genetic counseling and evaluation), cervical cancer, including human papillomavirus (HPV), prostate cancer, colorectal cancer screenings, including a required colonoscopy following a positive result on a test or procedure, other than a colonoscopy, and other medically accepted cancer screening tests, blood lead levels, high blood pressure, type 2 diabetes mellitus, cholesterol, obesity, and screening for iron deficiency anemia in pregnant women.

5. Human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis, including screenings for preexposure prophylaxis (PrEP) for prevention of HIV infection.

6. Counseling and risk factor reduction intervention services for sexually transmitted infections, human immunodeficiency virus (HIV), contraception, tobacco use, smoking cessation and tobacco use-related diseases.

7. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:

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

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

        In order to be covered as preventive care, contraceptive prescription drugs must be either generic oral contraceptives or a Brand Name Drug. Brand Name Drugs will be covered as Preventive Care Services when Medically Necessary according to your attending doctor, otherwise they will be covered under your Plan’s prescription drug benefits (see YOUR PRESCRIPTION DRUG BENEFITS).

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

    c. Gestational diabetes screening.

    d. Preventive prenatal care.

8. Preventive services for certain high-risk populations as determined by your Physician, based on clinical expertise.

9. Home test kits for sexually transmitted diseases (STD), including any laboratory costs of processing the kits.

    - Must be deemed Medically Necessary or appropriate and ordered directly by a clinician or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs, when ordered by an 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.

This list of Preventive Care Services is not exhaustive. Preventive tests and screenings with a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF), or those supported by the Health Resources and Services Administration (HRSA) will be covered with no Copayment and will not apply to the Benefit Year Deductible.

See the definition of "Preventive Care Services" in the DEFINITIONS section starting at page 110 for more information about services that are covered by this Plan.

Preventive Care for Chronic Conditions (per IRS guidelines)

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

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

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

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

Professional Services Benefit

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

Prosthetic Devices Benefits

1. Breast prostheses following a mastectomy.
2. Prosthetic Devices to restore a method of speaking when required as a result of a covered Medically Necessary laryngectomy.
3. The Plan will pay for other Medically Necessary Prosthetic Devices, including:
    a. Surgical implants, including but not limited to cochlear implants;
    b. Artificial limbs or eyes;
    c. Therapeutic shoes and inserts only for the prevention and treatment of diabetes-related foot complications; and
    d. Benefits are available for certain types of orthotics, limited to: (1) foot orthotics, orthopedic shoes, footwear or support items used for a systemic illness affecting the lower limbs, such as diabetes, (2) braces, (3) boots and (4) splints. Covered services include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities, or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

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

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

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

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

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

Skilled Nursing Facility Benefits. Inpatient services and supplies provided by a Skilled Nursing Facility, for up to 100 days per Benefit Year. The amount by which your room charge exceeds the prevailing two-bed room rate of the Skilled Nursing Facility is not considered covered under this Plan.

Skilled Nursing Facility services and supplies are subject to pre-service review to determine whether Medically Necessary. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

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

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

After your initial visit to a Physician for speech therapy, pre-service review must be obtained prior to receiving additional services. There is no limit on the number of covered visits for Medically Necessary services. However, visits must be authorized in advance. Please refer to utilization review program for information on how to obtain the proper reviews.

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

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

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

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

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

Transgender Travel Expense Benefits. Certain travel expenses Incurred in connection with an approved transgender surgery, when the Hospital at which the surgery is performed is 75 miles or more from your place of residence, provided the expenses are authorized in advance by Anthem. The Plan's maximum payment will not exceed **$10,000** per transgender surgery, or series of surgeries (if multiple surgical procedures are performed), for the following travel expenses Incurred by you and one companion:

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

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

Details regarding reimbursement can be obtained by calling the Anthem Health Guide toll free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific). A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

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

1. The recipient; or
2. The donor.

Benefits for an organ donor are as follows:

- When both the person donating the organ and the person getting the organ are covered Members under this Plan, each will get Benefits under their plans.
- When the person getting the organ is a Member under this Plan, but the person donating the organ is not, Benefits under this Plan are limited to Benefits not available to the donor from any other source. This includes, but is not limited to, other insurance, grants, foundations, and government programs.
- If a Member covered under this Plan is donating the organ to someone who is **not** a Member, Benefits are not available under this Plan.

The Maximum Allowed Amount for a donor, including donor testing and donor search, is limited to expense Incurred for Medically Necessary medical services only. The Maximum Allowed Amount for services incident to obtaining the transplanted material from a living donor or a human organ transplant bank will be covered. Such charges, including complications from the donor procedure for up to six weeks from the date of procurement, are covered. Services for treatment of a condition that is not directly related to, or a direct result of, the transplant are not covered.

An unrelated donor search may be required when the patient has a disease for which a transplant is needed and a suitable donor within the family is not available. The Plan's payment for unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants will not exceed **$30,000** per transplant.

Covered Services are subject to any applicable Deductibles, Copayments and medical benefit maximums set forth in the SUMMARY OF BENEFITS. The Maximum Allowed Amount does not include charges for services received without first obtaining Anthem's prior authorization or which are provided at a Facility other than a transplant center approved by Anthem. See UTILIZATION REVIEW PROGRAM for details.

Please call the Transplant Department as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation and/or work-up for a transplant.

To get the most benefits under your Plan, you must get certain human organ and tissue transplant services from a participating transplant provider that we have chosen as a *Centers of Medical Excellence* for Transplant Provider and/or a provider designated as a participating transplant provider by the Blue Cross and Blue Shield Association. Even if a *hospital* is an In-Network Provider for other services, it may not be a participating transplant provider for certain transplant services. Please call us to find out which *hospitals* are participating transplant providers. (When calling Member Services, ask for the Transplant Case Manager for further details.)

Anthem will help you maximize your Benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, Centers of Medical Excellence (CME) or Blue Distinction Centers for Specialty Care (BDCSC) rules, or exclusions apply. Call Anthem Health Guide toll free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) and ask for the transplant coordinator.

You or your Physician must call the Transplant Department for pre-service review prior to the transplant, whether it is performed in an inpatient or outpatient setting. Prior authorization is required before Benefits for a transplant will be provided. Your Physician must certify, and Anthem must agree, that the transplant is Medically Necessary. Your Physician should send a written request for prior authorization to Anthem as soon as possible to start this process. Not getting prior authorization will result in a denial of Benefits.

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

Specified Transplant Benefits

You must obtain Anthem's prior authorization for all services including, but not limited to, preoperative tests and postoperative care related to the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. Specified transplants must be performed at Centers of Medical Excellence (CME) or Blue Distinction Centers for Specialty Care (BDCSC). **Charges for services provided for or in connection with a specified transplant performed at a Facility other than a CME or BDCSC will not be considered covered.** Call Anthem Health Guide toll free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) if your Physician recommends a specified transplant for your medical care. A case manager transplant coordinator will assist in facilitating your access to a CME or BDCSC. See UTILIZATION REVIEW PROGRAM for details.

Transplant Travel Expense Benefits

Certain travel expenses Incurred in connection with an approved, specified transplant (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures) performed at a designated CME or BDCSC that is 75 miles or more from the recipient's or donor's place of residence are covered, provided the expenses are authorized by Anthem in advance. The Plan's maximum payment will not exceed **$10,000** per transplant for the following travel expenses Incurred by the recipient and one companion* or the donor:

- Ground transportation to and from the CME or BDCSC when the designated CME or BDCSC is 75 miles or more from the recipient's or donor's place of residence.
- Coach airfare to and from the CME or BDCSC when the designated CME or BDCSC is 300 miles or more from the recipient's or donor's residence
- Lodging, limited to one room, double occupancy
- Other reasonable expenses. Tobacco, alcohol, drug expenses, and meals are excluded.

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

The Benefit Year Deductible will not apply and no Copayments will be required for transplant travel expenses authorized in advance by Anthem. The Plan will provide Benefits for lodging and ground transportation, up to the current limits set forth in the Internal Revenue Code.

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

Details regarding reimbursement can be obtained by calling the Anthem Health Guide toll free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific). A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

Travel Immunization Benefits

1. ACA Travel Vaccinations:
   a. Hepatitis A
   b. Hepatitis B
   c. Meningitis
   d. Polio

2. Other Travel Vaccinations:
   a. Japanese Encephalitis
   b. Rabies
   c. Typhoid
   d. Yellow Fever

Urgent Care Benefits. Services and supplies received to prevent serious deterioration of your health or, in the case of pregnancy, the health of the unborn child, resulting from an unforeseen illness, medical condition, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed. Urgent Care services are not Emergency Services. Services for Urgent Care are typically provided by an Urgent Care Center or other Facility such as a Physician's office. Urgent Care can be obtained from UCMC Providers, Anthem Preferred Providers or Out-of-Network Providers. For Covered Services from Out-of-Network Providers you may be required to pay higher cost-sharing amounts or may have limits on your Benefits.

Virtual Visits (Telemedicine / Telehealth Visits). When available in your area, your coverage will include visits from a LiveHealth Online Provider. Covered Services include medical consultations using the internet via webcam, or voice. Online visits are covered under the Plan only from Providers who contract with LiveHealth Online. Please visit www.anthem.com/ca and choose Resources for more information.

Covered services include virtual Telemedicine / Telehealth visits that are appropriately provided through the internet via video chat or voice.

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

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

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

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

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

Medical Care That Is NOT Covered

No payment will be made under this Plan for services or supplies that are not Medically Necessary or that were Incurred before the Member's Effective Date or after a Member's coverage has ended in connection with any of the items below. (The titles given to these exclusions and limitations are for ease of reference only; they are not meant to be an integral part of the exclusions and limitations and do not modify their meaning.)

Acupuncture. Acupuncture treatment except as specifically stated in the "Acupuncture Benefits" provision of Medical Care That Is Covered. Acupressure, or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

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

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

Clinical Trials. Services and supplies in connection with clinical trials, except as specifically stated in the "Clinical Trial of Cancer and Other Life Threatening Conditions Benefits" provision under the section Medical Care That Is Covered.

Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Plan.

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

This exclusion does not apply to Medically Necessary treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as stated in the "Bariatric Surgery Benefits" provision of Medical Care That Is Covered.

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specifically stated in the "Contraceptive Benefits" provision in Medical Care That Is Covered.

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

Crime or Nuclear Energy. Conditions that result from: (1) your commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a Hospital Stay primarily for environmental change or physical therapy. Custodial Care, rest cures, except as specifically provided under the "Hospice Care Benefits" or "Infusion Therapy / Injectable Therapy Benefits" provision of Medical Care That Is Covered. Services provided by a rest home, a home for the aged, a nursing home or any similar Facility. Services provided by a Skilled Nursing Facility, except as specifically stated in the "Skilled Nursing Facility Benefits" provision of Medical Care That Is Covered.

Dental Devices for Snoring. Oral appliances for snoring.

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

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

This exclusion does not apply to the following:

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

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

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

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

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

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

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

Fraud, Waste, Abuse, and Other Inappropriate Billing. Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.

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

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

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

Hearing Aids or Tests. Hearing aids, including bone-anchored hearing aids, except as specifically stated in the "Hearing Aid Benefits" provision of Medical Care That Is Covered. Routine hearing tests, except as specifically provided as part of a routine exam under the "Preventive Care Benefits" provision of Medical Care That Is Covered.

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

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

Infertility Treatment. Services or supplies furnished in connection with the treatment of Infertility, except as specifically stated in the "Infertility Treatment" or "Fertility Preservation Services" provisions of Medical Care That Is Covered.

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

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

Massage Therapy. Massage, except as specifically stated in the "Physical Therapy, Physical Medicine and Occupational Therapy Benefits" provision of Medical Care That Is Covered

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

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

This exclusion does not apply to the Medically Necessary treatment of specifically stated in "Durable Medical Equipment Benefits" provision of Medical Care That Is Covered.

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

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

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

Not Medically Necessary. Services or supplies that are not Medically Necessary, as defined. See page 114 in the DEFINITIONS section for more information.

This exclusion does not apply to services that are mandated by federal law or listed as covered under "YOUR MEDICAL BENEFITS" and/or "Your Prescription Drug Benefits".

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, except when provided as part of a routine exam under the "Preventive Care Benefits" provision of Medical Care That Is Covered. Eyeglasses or contact lenses, except as specifically stated in the "Prosthetic Devices Benefits" provision of Medical Care That Is Covered.

Orthodontia. Braces and other orthodontic appliances or services, except as specifically stated in the "Reconstructive Surgery Benefits" or "Dental Care Benefits" provisions of Medical Care That Is Covered.

Orthopedic Supplies. Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes, as specifically stated in the "Prosthetic Devices Benefits" provision of Medical Care That Is Covered.

Outpatient Occupational Therapy. Outpatient occupational therapy, except as specifically stated in the "Infusion Therapy / Injectable Therapy Benefits" provision of Medical Care That Is Covered, or when provided by a Home Health Agency or Hospice, as specifically stated in the "Home Health Care Benefits", "Hospice Care Benefits" or "Physical Therapy, Physical Medicine and Occupational Therapy Benefits" provisions of that section. This exclusion also does not apply to the Medically Necessary treatment of , or to the Medically Necessary treatment of autism spectrum disorders, to the extent stated in the section BENEFITS FOR AUTISM SPECTRUM DISORDERS.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specifically stated in the “Infusion Therapy” / Injectable Therapy Benefits”, “Prescription Drug for Abortion Benefits,” or “Preventive Care Benefits” provisions of “Medical Care That Is Covered” or under YOUR PRESCRIPTION DRUG BENEFITS section of this booklet. Non-prescription, over-the-counter patent or proprietary drugs or medicines, except as specified in “Preventive Prescription Drugs or Other Items’ covered under Your Prescription Drug Benefits. Cosmetics, health or beauty aids. However, health aids that are Medically Necessary and meet the requirements for durable medical equipment as specified under the “Durable Medical Equipment Benefits” provision of Medical Care That Is Covered, are covered, subject to all terms of this Plan that apply to that benefit.

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

Physical Therapy or Physical Medicine. Services of a Physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement, or as specifically stated in the "Home Health Care Benefits", "Hospice Care Benefits", "Infusion Therapy / Injectable Therapy" or "Physical Therapy, Physical Medicine and Occupational Therapy Benefits" provisions of Medical Care That Is Covered. This exclusion also does not apply to the Medically Necessary treatment of autism spectrum disorders, to the extent stated in the section BENEFITS FOR AUTISM SPECTRUM DISORDERS.

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

Private Duty Nursing. Private duty nursing services of a registered nurse or licensed vocational nurse under the supervision of a registered nurse or a Physician.

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

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

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

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specifically stated in the "Preventive Care Benefits" provision of “Medical Care That Is Covered”.

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

Services of Relatives. Professional services received from a person who lives in your home or who is related to you by blood or marriage, except as specifically stated in the "Infusion Therapy / Injectable Therapy Benefits" provision of “Medical Care That Is Covered”.

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

Specialty drugs. Specialty Drugs that must be obtained from the specialty pharmacy program through CarelonRx or select UC Pharmacies, but, which are obtained from a retail pharmacy are not covered by this Plan. **You will have to pay the full cost of the Specialty Drugs you get from a retail Pharmacy that you should have obtained from the specialty pharmacy program**.

Speech Therapy. Speech therapy except as stated in the "Speech Therapy and Speech language pathology (SLP) Benefits" provision of Medical Care That Is Covered. BENEFITS FOR AUTISM SPECTRUM DISORDERS.

Sterilization Reversal. Reversal of an elective sterilization.

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

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

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

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

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

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

Waived Cost-Shares Out-of-Network Provider. For any service for which you are responsible under the terms of this Plan to pay a Copayment or Deductible, and the Copayment or Deductible is waived by an Out-of-Network Provider.

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

Work-Related. Work-related conditions if Benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if you do not claim those Benefits.

BENEFITS FOR AUTISM SPECTRUM DISORDERS

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

Behavioral health treatment services covered under this Plan are subject to the same Deductibles and Copayments that apply to services provided for other covered medical conditions. Services provided by Qualified Autism Service Providers, Qualified Autism Service Professionals, and Qualified Autism Service Paraprofessionals (see the "Definitions" below) will be covered under Plan Benefits that apply for outpatient office visits or other outpatient items and services. Services provided in a Facility, such as the outpatient department of a hospital, will be covered under Plan Benefits that apply to such facilities. See also the "Mental Health and Substance Use Disorder Benefits" under "Medical Care That Is Covered".

You must obtain pre-service review for all behavioral health treatment services for the treatment of autism spectrum disorders in order for these services to be covered by this Plan (see UTILIZATION REVIEW PROGRAM for details). No Benefits are payable for these services if pre-service review is not obtained.

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

DEFINITIONS

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

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

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

Qualified Autism Service Provider is either of the following:

- A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for autism spectrum disorders, provided the services are within the experience and competence of the person, entity, or group that is nationally certified; or

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

Anthem's network of UCMC Providers or Anthem Preferred Providers is limited to licensed Qualified Autism Service Providers who contract with Anthem or a Blue Cross and/or Blue Shield Plan and who may supervise and employ Qualified Autism Service Professionals or Qualified Autism Service Paraprofessionals who provide and administer Behavioral Health Treatment.

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

- Provides behavioral health treatment,

- Is employed and supervised by a Qualified Autism Service Provider,

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

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

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

BEHAVIORAL HEALTH TREATMENT SERVICES COVERED

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

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

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

SUBROGATION AND REIMBURSEMENT

These Subrogation and Reimbursement provisions apply when the Plan pays benefits as a result of injuries or illnesses You sustained, and You have a right to a Recovery or have received a Recovery from any source.

Definitions

As used in these Subrogation and Reimbursement provisions, “You” or “Your” includes anyone on whose behalf the plan pays benefits. These Subrogation and Reimbursement provisions apply to all current or former plan participants and plan beneficiaries. The provisions also apply to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the Plan. The Plan’s rights under these provisions shall also apply to the personal representative or administrator of Your estate, Your heirs or beneficiaries, minors, and legally incompetent or disabled persons. If the covered person is a minor, any amount recovered by the minor, the minor’s trustee, guardian, parent, or other representative, shall be subject to these Subrogation and Reimbursement provisions. Likewise, if the covered person’s relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, or because of the death of the covered person, that Recovery shall be subject to this provision, regardless of how any Recovery is allocated or characterized.

As used in these Subrogation and Reimbursement provisions, “Recovery” includes, but is not limited to, monies received from any person or party, any person’s or party’s liability insurance coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, workers’ compensation insurance or fund, premises medical payments coverage, restitution, or “no-fault” or personal injury protection insurance and/or automobile medical payments coverage, or any other first or third party insurance coverage, whether by lawsuit, settlement or otherwise. Regardless of how You or Your representative or any agreements allocate or characterize the money You receive as a Recovery, it shall be subject to these provisions.

Subrogation

Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to, or stand in the place of, all of Your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan has the right to recover payments it makes on Your behalf from any party or insurer responsible for compensating You for Your illnesses or injuries. The Plan has the right to take whatever legal action it sees fit against any person, party, or entity to recover the benefits paid under the Plan. The Plan may assert a claim or file suit in Your name and take appropriate action to assert its subrogation claim, with or without Your consent. The Plan is not required to pay You part of any recovery it may obtain, even if it files suit in Your name.

Reimbursement

If You receive any payment as a result of an injury, illness or condition, You agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of Your recovery. If You obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on Your behalf, the Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on Your behalf. You must promptly reimburse the Plan from any Recovery to the extent of benefits the Plan paid on Your behalf regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.

Secondary to Other Coverage

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy, or personal injury protection policy regardless of any election made by You to the contrary. The Plan

shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies. This provision applies notwithstanding any coordination of benefits term to the contrary.

Assignment

In order to secure the Plan's rights under these Subrogation and Reimbursement Provisions, You agree to assign to the Plan any benefits or claims or rights of recovery You have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim You may have regardless of whether You choose to pursue the claim.

Applicability to All Settlements and Judgments

Notwithstanding any allocation or designation of Your Recovery made in any settlement agreement, judgment, verdict, release, or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery You make. Furthermore, the Plan's rights under these Subrogation and Reimbursement provisions will not be reduced due to Your own negligence. The terms of these Subrogation and Reimbursement provisions shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the terms of any settlement, judgment, or verdict pertaining to Your Recovery identify the medical benefits the Plan provided or purport to allocate any portion of such Recovery to payment of expenses other than medical expenses. The Plan is entitled to recover from any Recovery, even those designated as being for pain and suffering, non-economic damages, and/or general damages only.

Constructive Trust

By accepting benefits from the Plan, You agree that if You receive any payment as a result of an injury, illness or condition, You will serve as a constructive trustee over those funds. You and Your legal representative must hold in trust for the Plan the full amount of the Recovery to be paid to the Plan immediately upon receipt. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Plan. Any Recovery You obtain must not be dissipated or disbursed until such time as the Plan has been repaid in accordance with these Subrogation and Reimbursement provisions.

Lien Rights

The Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of Your illness, injury or condition upon any Recovery related to treatment for any illness, injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds from Your Recovery including, but not limited to, you, your representative or agent, and/or any other source possessing funds from Your Recovery. You and Your legal representative acknowledge that the portion of the Recovery to which the Plan's equitable lien applies is a Plan asset. The Plan shall be entitled to equitable relief, including without limitation restitution, the imposition of a constructive trust or an injunction, to the extent necessary to enforce the Plan's lien and/or to obtain (or preclude the transfer, dissipation or disbursement of) such portion of any Recovery in which the Plan may have a right or interest.

First-Priority Claim

By accepting benefits from the Plan, You acknowledge the Plan's rights under these Subrogation and Reimbursement provisions are a first priority claim and are to be repaid to the Plan before You receive any Recovery for your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any Recovery, even if such payment to the Plan will result in a Recovery which is insufficient to make You whole or to compensate You in part or in whole for the losses, injuries, or illnesses You sustained. The "made-whole" rule does not apply. To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by You, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to Your claim, Your attorney fees, other expenses or costs. The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs You incur. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Cooperation

You agree to cooperate fully with the Plan's efforts to recover benefits paid. The duty to cooperate includes, but is not limited, to the following:

- You must promptly notify the Plan of how, when and where an accident or incident resulting in personal injury or illness to You occurred, all information regarding the parties involved and any other information requested by the Plan.
- You must notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to Your injury, illness or condition.
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- You and your agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation.
- You recognize that to the extent that the Plan paid or will pay benefits under a capitated agreement, the value of those benefits for purposes of these provisions will be the reasonable value of those payments or the actual paid amount, whichever is higher.
- You must not do anything to prejudice the Plan's rights under these Subrogation and Reimbursement provisions. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to You.
- You must promptly notify the Plan if You retain an attorney or if a lawsuit is filed on Your behalf.
- You must immediately notify the Plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its rights under these Subrogation and Reimbursement provisions, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

If You fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of Your Recovery whichever is less, from any future benefit under the Plan if:

1. The amount the Plan paid on Your behalf is not repaid or otherwise recovered by the Plan; or
2. You fail to cooperate.

In the event You fail to disclose the amount of Your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.

The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of Your Recovery, whichever is less, directly from the Providers to whom the Plan has made

payments on Your behalf. In such a circumstance, it may then be Your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse You.

You acknowledge the Plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and their agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge the Plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 *et seq*, to share Your personal health information in exercising these Subrogation and Reimbursement provisions.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing its rights under these Subrogation and Reimbursement provisions.

Discretion

The Plan Administrator has sole discretion to interpret the terms of the Subrogation and Reimbursement provisions of this Plan in its entirety and reserves the right to make changes as it deems necessary.

YOUR PRESCRIPTION DRUG BENEFITS

PPO Plans like UC PPO let you choose your Pharmacy. However, some medications will require prior authorization. If you have questions about your Prescription Benefits, please call the Anthem Health Guide toll free at **(833) 674-9256** or go to the website www.anthem.com/ca for additional information. Anthem Health Guide is available Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) but you can receive prescription related support after hours by calling **(833) 674-9256** and pressing 2.

You should read your Benefit Booklet carefully. Your booklet tells you which prescription services are covered by your health plan and which are excluded. It also lists your Copayment and Out-of-Pocket responsibilities.

How to Use Your Prescription Drug Benefits

When You Go to an In-Network Pharmacy

To identify you as a Member covered for Prescription Drug benefits, you will be issued an ID card. You must present this card to in-network pharmacies when you have a Prescription filled. Provided you have properly identified yourself as a Member, an In-Network Pharmacy will only charge your Copayment.

Generic Drugs will be dispensed by in-network pharmacies when the Prescription specifies a Generic Drug. When a Brand Name Drug is specified, but a Generic Drug equivalent exists, the Generic Drug will be substituted. Brand Name Drugs will be dispensed by in-network pharmacies when the Prescription specifies a brand name and states “dispense as written” or no Generic Drug equivalent exists.

For information on how to locate an In-Network Pharmacy in your area, call the Anthem Health Guide toll free at **(833) 674-9256** or go to the website www.anthem.com/ca. Anthem Health Guide is available Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) but you can receive prescription related support after hours by calling **(833) 674-9256** and pressing 2.

Important Note: If Anthem determines 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, the Plan 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. Anthem will contact you if they 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 that the Plan offers within 31 days, Anthem will select a single In-Network Pharmacy for you. If you disagree with Anthem’s decision, you may file complaint as described in the COMPLAINT NOTICE.

When You Go to an Out-of-Network Pharmacy

If you purchase a Prescription Drug from an Out-of-Network Pharmacy, you will have to pay the full cost of the Drug and submit a claim

Out-of-network pharmacies do not have the necessary prescription drug claim forms. You must take a claim form with you to an Out-of-Network Pharmacy. The pharmacist must complete the Pharmacy's portion of the form and sign it.

Submitting a Claim Form

Please note that presentation of a prescription to a pharmacy or pharmacist does not constitute a claim for benefit coverage. If you present a Prescription to an In-Network Pharmacy, and the In-Network Pharmacy indicates your Prescription cannot be filled, or requires an additional Copayment, this is not

considered an adverse claim decision. If you want the Prescription filled, you will have to pay either the full cost, or the additional Copayment, for the Prescription Drug.

If you believe you are entitled to some Plan benefits in connection with the Prescription Drug, submit a claim for reimbursement to the Pharmacy Benefits Manager at the address shown below:

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

Claim forms and Member Services are available by calling the Anthem Health Guide toll free at **(833) 674-9256** or going to the website www.anthem.com/ca. Anthem Health Guide is available Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) but you can receive prescription related support after hours by calling **(833) 674-9256** and pressing 2. Mail your claim with the appropriate portion completed by the pharmacist to Anthem within 90 days of the date of purchase. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed.

When You Order Your Prescription Through the Home Delivery Program

You can order your Prescription through the home delivery Prescription Drug program. Not all medications are available through the home delivery pharmacy.

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

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

Order forms can be obtained by contacting the Anthem Health Guide toll free at **(833) 674-9256** or by going to the website www.anthem.com/ca to request one. Anthem Health Guide is available Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) but you can receive prescription related support after hours by calling **(833) 674-9256** and pressing 2.

When You Order Your Prescription Through Specialty Pharmacy Program

Certain specified Specialty Drugs must be obtained through the specialty pharmacy program or select UC Pharmacies unless you are given an exception from the specialty pharmacy program (see Prescription Drug Conditions of Service). These specified Specialty Drugs that must be obtained through the specialty pharmacy program are limited up to a 30-day supply. The specialty pharmacy program will deliver your medication to you by mail or common carrier (you cannot pick up your medication at Anthem Blue Cross Life and Health).

The Prescription for the Specialty Drug must state the drug name, dosage, directions for use, quantity, the Physician's name and phone number, the patient's name and address, and be signed by a Physician.

You or your Physician may order your Specialty Drug by calling the Anthem Health Guide toll free at **(833) 674-9256** or by going to the website www.anthem.com/ca. Anthem Health Guide is available Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) but you can receive prescription related support after hours by calling **(833) 674-9256** and pressing 2. When you call the specialty pharmacy program, a dedicated care coordinator will guide you through the process up to and including actual delivery of your Specialty Drug to you. (If you order your specialty drug by telephone, you will need to use a credit card or debit card to pay for it.) You may also submit your specialty drug prescription with the appropriate payment for the amount of the purchase (you can pay by check, money order, credit card or debit card), and a properly completed order form to the specialty pharmacy program. Once you have met your Deductible, if any, you will only have to pay the cost of your Copayment.

The first time you get a Prescription for a Specialty Drug you must also include a completed Intake Referral Form. The Intake Referral Form is to be completed by calling the Anthem Health Guide toll free at **(833) 674-9256** or by going to the website www.anthem.com/ca. Anthem Health Guide is available Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) but you can receive prescription related support after hours by calling **(833) 674-9256** and pressing 2. You need only enclose the Prescription or refill notice, and the appropriate payment for any subsequent Specialty Drug Prescriptions, or call the toll-free number. Copayments can be made by check, money order, credit card or debit card.

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

Specified Specialty Drugs must be obtained through the specialty pharmacy program or select UC Pharmacies. When these specified Specialty Drugs are not obtained through the specialty pharmacy program, and you do not have an exception, you will not receive any benefits for these Drugs under this Plan.

When You are Out of State

If you need to purchase a Prescription Drug out of the state of California, you may locate an In-Network Pharmacy by calling the Anthem Health Guide toll free at **(833) 674-9256** or by going to the website www.anthem.com/ca. Anthem Health Guide is available Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) but you can receive prescription related support after hours by calling **(833) 674-9256** and pressing 2. If you cannot locate an In-Network Pharmacy, you must pay for the Drug and submit a claim to Anthem. See "When You Go to an Out-of-Network Pharmacy" above.

Prescription Drug Covered Expense

Prescription Drug Covered Expense is the maximum charge for each covered service or supply that will be accepted for each different type of Pharmacy. It is not necessarily the amount a Pharmacy bills for the medication.

You may avoid higher out-of-pocket expenses by choosing an In-Network Pharmacy, or by utilizing the home delivery program whenever possible. In addition, you may also reduce your costs by asking your Physician, and your pharmacist, for the more cost-effective generic form of Prescription Drugs.

Prescription Drug Covered Expense will always be the lesser of the billed charge or the Prescription Drug Maximum Allowed Amount. Expense is Incurred on the date you receive the Drug for which the charge is made.

When you choose an In-Network Pharmacy, the Pharmacy Benefits Manager will subtract any expense which is not covered under your Prescription Drug benefits. The remainder is the amount of Prescription Drug Covered Expense for that claim. You will not be responsible for any amount in excess of the Prescription Drug Maximum Allowed Amount for the Covered Services of an In-Network Pharmacy.

When the Pharmacy Benefits Manager receives a claim for Drugs supplied by an Out-of-Network Pharmacy, they first subtract any expense which is not covered under your Prescription Drug benefits, and then any expense exceeding the Prescription Drug Maximum Allowed Amount. The remainder is the amount of Prescription Drug Covered Expense for that claim.

You will always be responsible for expense Incurred which is not covered under this Plan.

Prescription Drug Copayments and Prescription Drug Out-of-Pocket Amounts

Copayments

After the Pharmacy Benefits Manager determines Prescription Drug Covered Expense, they will subtract your Prescription Drug Copayment for each Prescription.

If your Prescription Drug Copayment includes a percentage of Prescription Drug Covered Expense, then the Pharmacy Benefits Manager will apply that percentage to such expense. This will determine the dollar amount of your Prescription Drug Copayment.

Prescription Drug Out-of-Pocket Amount (combined with your Benefit Year Medical Out-of-Pocket Maximum)

If you pay Prescription Drug Copayments equal to your Prescription Drug Out-of-Pocket Amount per Member during a Benefit Year, you will no longer be required to make Copayments for any Prescription Drug Covered Expense you incur during the remainder of that Benefit Year.

Prescription Drug Utilization Review

Your Prescription Drug benefits include utilization review of Prescription Drug usage for your health and safety. Certain Drugs may require prior authorization. If there are patterns of over-utilization or misuse of Drugs, Anthem's medical consultant will notify your personal Physician and your pharmacist. Anthem reserves the right to limit benefits to prevent over-utilization of drugs.

Prescription Drug Formulary

The presence of a Drug on the Plan's Prescription Drug Formulary list does not guarantee that you will be prescribed that Drug by your Physician. These medications, which include both Generic and Brand Name Drugs, are listed in the Prescription Drug Formulary. The formulary is updated quarterly to ensure that the list includes Drugs that are safe and effective. **Note:** The Formulary Drugs may change from time to time.

Some Drugs may require prior authorization. If you have a question regarding whether a particular Drug is on the Formulary Drug list or requires prior authorization please call the Anthem Health Guide toll free at **(833) 674-9256**. Anthem Health Guide is available Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) but you can receive prescription related support after hours by calling **(833) 674-9256** and pressing 2. Information about the Drugs on the Formulary Drug list is also available by going to the website www.anthem.com/ca.

Exception request for a Drug not on the Prescription Drug Formulary (non-formulary exceptions).

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

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

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

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

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

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

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

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

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

You or your Physician can get the list of the Prescription Drug that require prior authorization by calling the Anthem Health Guide toll free at **(833) 674-9256** or by going to the website www.anthem.com/ca. Anthem Health Guide is available Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) but you can receive prescription related support after hours by calling **(833) 674-9256** and pressing 2. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under your Plan. Your Physician may check with Anthem to verify Prescription Drug coverage, to find out which Prescription Drug are covered under this section and if any drug edits apply.

In order for you to get a Drug that requires prior authorization, your Physician must send a written request to Anthem for the drug using the required uniform prior authorization request form. The form can be facsimiled, mailed or submitted electronically to Anthem. If your Physician needs a copy of the request form, he or she may call the Anthem Health Guide toll free at **(833) 674-9256** to request one. Anthem Health Guide is available Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) but you can receive prescription related support after hours by calling **(833) 674-9256** and pressing 2. The form is also available on-line at www.anthem.com/ca.

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

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

While Anthem is reviewing the request, a 72-hour emergency supply of medication may be dispensed to you if your Physician or pharmacist determines that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment shown in SUMMARY OF BENEFITS - Prescription Drug Benefits - Prescription Drug Copayments for the 72-hour supply of your Drug. If the Plan approves the request for the Drug after you have received a 72-hour supply, you will receive the remainder of the 30-day supply of the Drug with no additional Copayment.

If you have any questions regarding whether a Drug in on the Prescription Drug Formulary, or require prior authorization, please call the Anthem Health Guide toll free at **(833) 674-9256** or go to the website www.anthem.com/ca. Anthem Health Guide is available Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) but you can receive prescription related support after hours by calling **(833) 674-9256** and pressing 2.

If Anthem denies a request for prior authorization of a Drug, you or your prescribing Physician may appeal the decision by calling the Anthem Health Guide toll free at **(833) 674-9256** or by going to the website www.anthem.com/ca. Anthem Health Guide is available Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) but you can receive prescription related support after hours by calling **(833) 674-9256** and pressing 2.

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

- Your coverage under this Plan ends;
- The Plan with UC terminates;
- You reach a benefit maximum that applies to Prescription Drugs, if the Plan includes such a maximum;
- Your Prescription Drug benefits under the Plan change so that Prescription Drugs are no longer covered or are covered in a different way.

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

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

Preventive Prescription Drugs and Other Items

Your Prescription Drug benefits include certain preventive drugs, medications, and other items as listed below that may be covered under this Plan as Preventive Care Services. In order to be covered as a Preventive Care Service, these items must be prescribed by a Physician and obtained from an In-Network Pharmacy or through the home delivery program. This includes items that can be obtained over the counter for which a Physician's prescription is not required by law.

When these items are covered as Preventive Care Services, the Benefit Year Deductible, if any, will not apply and no Copayment will apply. In addition, any separate Deductible that applies to Prescription Drugs will not apply.

- All FDA-approved contraceptives for women, including oral contraceptives, diaphragms, patches, and over-the-counter contraceptives. In order to be covered as a preventive care service, in addition to the requirements stated above, contraceptive Prescription Drugs must be Generic oral contraceptives or Brand Name Drugs.
- Vaccinations prescribed by a Physician and obtained from an In-Network Pharmacy.
- Tobacco cessation drugs, medications, and other items for Members age 18 and older as recommended by the United States Preventive Services Task Force including:
  - Prescription Drugs to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products.
  - FDA-approved smoking cessation products including over-the-counter (OTC) nicotine gum, lozenges and patches when obtained with a Physician's prescription and you are at least 18 years old.
- Aspirin to reduce the risk of heart attack or stroke, for men ages 45-79 and women ages 55-79.
- Aspirin after 12 weeks of gestation in pregnant women who are at high risk for preeclampsia.

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

Prescription Drug Conditions of Service

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

1. It must be prescribed by a licensed prescriber and be dispensed within one year of being prescribed, subject to federal and state laws. This requirement will not apply to covered vaccinations provided at an In-Network Pharmacy.
2. It must be approved for general use by the Food and Drug Administration (FDA).
3. It must be for the direct care and treatment of your illness, injury or condition. Dietary supplements, health aids or drugs for cosmetic purposes are not included. However the following items are covered:
    a. Formulas prescribed by a Physician for the treatment of phenylketonuria.
    b. Vaccinations provided at an In-Network Pharmacy as specified under Preventive Prescription Drugs and Other Items, subject to all terms of this Plan that apply to those benefits.
    c. Vitamins, supplements, and health aids as specified under Preventive Prescription Drugs and Other Items, subject to all terms of this Plan that apply to those benefits.
4. It must be dispensed from a licensed retail Pharmacy, through the home delivery program or through the specialty pharmacy program.
5. **If it is an approved Compound Medication, be dispensed by a participating Pharmacy.** Call the Anthem Health Guide toll free at **(833) 674-9256** to find out where to take your prescription for an approved Compound Medication to be filled. Anthem Health Guide is available Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) but you can receive prescription related support after hours by calling **(833) 674-9256** and pressing 2. (You can also find an In-Network Pharmacy at www.anthem.com/ca.) **Some Compound Medications must be approved before you can get them (See Prescription Drug Formulary - Prior Authorization). You will have to pay the full cost of the Compound Medications you get from a Pharmacy that is not an In-Network Pharmacy.**
6. **If it is a specified Specialty Drug, be obtained by using the specialty pharmacy program or select UC Pharmacies.** See the section "How to Use Your Prescription Drug Benefits - When You Order Your Prescription through Specialty Pharmacy Program" for how to get your Drugs by using the specialty pharmacy program. **You will have to pay the full cost of any Specialty Drugs you get from a retail Pharmacy that you should have obtained from the specialty pharmacy program or select UC Pharmacies. If you order a Specialty Drug that must be obtained using the specialty pharmacy program through the home delivery program, it will be forwarded to the specialty pharmacy program for processing and will be processed according to specialty pharmacy program rules.**

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

    a. The first one month's supply of a specified Specialty Drug which is available through a participating retail Pharmacy;
    b. Drugs, which due to medical necessity, must be obtained immediately;

c. A Member who is unable to pay for delivery of their medication (i.e., no credit card); or

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

How to obtain an exception to the specialty pharmacy program. If you believe that you should not be required to get your medication through the specialty pharmacy program, for any of the reasons listed above, except for d., you must complete an Exception to Specialty Pharmacy Program form to request an exception and send it to Anthem. The form can be faxed or mailed to Anthem. If you need a copy of the form, you may call the Anthem Health Guide toll free at **(833) 674-9256** to request one. Anthem Health Guide is available Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) but you can receive prescription related support after hours by calling **(833) 674-9256** and pressing 2. You can also get the form on-line at www.anthem.com/ca. If Anthem has given you an exception, it will be good for a limited period of time based on the reason for the exception. When the exception period ends, if you believe that you should still not be required to get your medication through the specialty pharmacy program, you must again request an exception. If your request for an exception is denied, it will be in writing and will tell you why they did not approve the exception.

Urgent or Emergency need of a Specialty Drug subject to the specialty pharmacy program. If you are out of a Specialty Drug which must be obtained through the specialty pharmacy program, Anthem will authorize an override of the specialty pharmacy program requirement for 72-hours, or until the next business day following a holiday or weekend, to allow you to get an emergency supply of medication if your doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment shown under SUMMARY OF BENEFITS - Prescription Drug Benefits-Prescription Drug Copayments for the 72-hour supply of your Drug.

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

7. It must not be used while you are confined in a Hospital, Skilled Nursing Facility, rest home, sanitarium, convalescent hospital, or similar Facility. Also, it must not be dispensed in or administered by a Hospital, Skilled Nursing Facility, rest home, sanitarium, convalescent hospital, or similar Facility. Other Drugs that may be prescribed by your Physician while you are confined in a rest home, sanitarium, convalescent hospital or similar Facility, may be purchased at a Pharmacy by the Member, or a friend, relative or care giver on your behalf, and are covered under this Prescription Drug benefit.

8. For a retail Pharmacy or specialty pharmacy program, the Prescription typically does not exceed a 30-day supply. However, a Physician can prescribe an additional supply of your medication for you to receive at a retail Pharmacy or specialty pharmacy. If you receive more than 30-day supply of medication, you will have to pay the applicable Copayment for each additional 30-day supply of medication you receive.

   Prescription Drugs federally-classified as Schedule II which are FDA-approved for the treatment of attention deficit disorder must not exceed a 60-day supply. If the Physician prescribes a 60-day supply for drugs classified as Schedule II for the treatment of attention deficit disorders, the Member has to pay double the amount of Copayment for retail pharmacies. If the drugs are obtained through the home delivery program, the Copayment will remain the same as for any other Prescription Drug.

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

9. Certain drugs have specific quantity supply limits based on the analysis of prescription dispensing trends and the Food and Drug Administration dosing recommendations.

10. For the home delivery program, the Prescription must not exceed a 90-day supply.

11. The Drug will be covered under Your Prescription Drug Benefits only if it is not covered under another benefit of your Plan.

12. Drugs for the treatment of impotence and/or sexual dysfunction are limited to six tablets/units for a 30-day period and are available at retail pharmacies only. Documented evidence of contributing medical condition must be submitted to Anthem for review.

Prescription Drug Services and Supplies That Are Covered

1. Outpatient Drugs and medications which the law restricts to sale by Prescription, except as specifically stated in this section. Formulas prescribed by a Physician for the treatment of phenylketonuria. These formulas are subject to the Copayment for Brand Name Drugs.

2. Insulin.

3. Continuous glucose monitoring systems, including monitors designed to assist the visually impaired;

4. Syringes when dispensed for use with insulin and other self-injectable Drugs or medications.

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

6. When a vaccine for acquired immune deficiency syndrome (AIDS) is approved for marketing by the federal Food and Drug Administration and that is recommended by the United States Public Health Service, the plan will perform necessary due diligence before determining coverage for the vaccine.

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

8. Diabetic supplies (i.e. test strips and lancets).

9. Inhaler spacers and peak flow meters for the treatment of pediatric asthma. These items are subject to the Copayment for Brand Name Drugs.

10. Prescription Drugs, vaccinations (including administration), vitamins, supplements, and certain over-the-counter items as specified under “Preventive Prescription Drugs and Other Items”, subject to all terms of this Plan that apply to those benefits.

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

Prescription Drug Services and Supplies That Are NOT Covered

In addition to the exclusions and limitations listed under YOUR MEDICAL BENEFITS - Medical Care That is NOT Covered, Prescription Drug benefits are not provided for or in connection with the following:

1. Hypodermic syringes and/or needles except when dispensed for use with insulin and other self-injectable Drugs or medications. While not covered under this Prescription Drug benefit, these items are covered under the “Home Health Care Benefits,” “Hospice Care Benefits,” “Infusion / Injectable Therapy Benefits,” and “Diabetes Care Benefits” provisions of YOUR MEDICAL BENEFITS - Medical Care That is Covered (see Table of Contents), subject to all terms of this Plan that apply to those benefits.

2. Drugs and medications used to induce spontaneous and non-spontaneous abortions. While not covered under this Prescription Drug benefit, FDA approved medications that may only be dispensed by or under direct supervision of a Physician, such as drugs and medications used to induce non-spontaneous abortions, are covered as specifically stated in the “Prescription Drug for Abortion Benefits” provision of Your Medical Benefits - Medical Care That is Covered (see Table of Contents), subject to all terms of this Plan that apply to the benefit.

3. Drugs and medications dispensed or administered in an outpatient setting; including, but not limited to, outpatient Hospital facilities and physicians' offices. While not covered under this Prescription Drug benefit, these services are covered as specified under the “Hospital Benefits,” “Home Health Care Benefits,” “Hospice Care Benefits,” and “Infusion / Injectable Therapy Benefits” provisions of YOUR MEDICAL BENEFITS - Medical Care That is Covered (see Table of Contents), subject to all terms of this Plan that apply to those benefits.

4. Professional charges in connection with administering, injecting or dispensing of drugs. While not covered under this Prescription Drug benefit, these services are covered as specified under the “Infusion / Injectable Therapy Benefits” provisions of Your Medical Benefits - Medical Care That is Covered (see Table of Contents), subject to all terms of this Plan that apply to those benefits.

5. Drugs and medications which may be obtained without a Physician’s written Prescription, except insulin or niacin for cholesterol reduction.

   Note: Vitamins, supplements, and certain over-the-counter items as specified under “Preventive Prescription Drugs and Other Items” are covered under this Plan only when obtained with a Physician’s Prescription, subject to all terms of this Plan that apply to those benefits.

6. Drugs and medications dispensed by or while you are confined in a Hospital, Skilled Nursing Facility, rest home, sanitarium, convalescent hospital, or similar Facility while not covered under this Prescription Drug benefit, such drugs are covered as specified under the “Hospital Benefits”, “Skilled Nursing Facility Benefits”, and “Hospice Care Benefits”, provisions of YOUR MEDICAL BENEFITS - Medical Care That is Covered (see Table of Contents), subject to all terms of this Plan that apply to those benefits. While you are confined in a rest home, sanitarium, convalescent hospital or similar Facility, drugs and medications supplied and administered by your Physician are covered as specified under the “Professional Services Benefit” provision of YOUR MEDICAL BENEFITS - Medical Care That is Covered (see Table of Contents), subject to all terms of this Plan that apply to the benefit. Other drugs that may be prescribed by your Physician while you are confined in a rest home, sanitarium, convalescent hospital or similar Facility, may be purchased at a Pharmacy by the Member, or a friend, relative or care giver on your behalf, and are covered under this Prescription Drug benefit.

7. Durable medical equipment, devices, appliances and supplies, even if prescribed by a Physician, except Prescription contraceptives as specified under “Preventive Prescription Drugs and Other Items”. While not covered under this Prescription Drug benefit, these items are covered as specified under the “Durable Medical Equipment Benefits”, “Hearing Aid Benefits”, and “Diabetes” provisions of Your Medical Benefits - Medical Care That is Covered (see Table of Contents), subject to all terms of this Plan that apply to those benefits.

8. Services or supplies for which you are not charged.

9. Oxygen. While not covered under this Prescription Drug benefit, oxygen is covered as specified under the “Hospital Benefits”, “Skilled Nursing Facility Benefits”, “Home Health Care Benefits” and “Hospice Care Benefits” provisions of YOUR MEDICAL BENEFITS - Medical Care That is Covered (see Table of Contents), subject to all terms of this Plan that apply to those benefits.

10. Cosmetics and health or beauty aids. However, health aids that are Medically Necessary and meet the requirements for durable medical equipment as specified under the “Durable Medical Equipment Benefits” provision of YOUR MEDICAL BENEFITS - Medical Care That is Covered (see Table of Contents), are covered, subject to all terms of this Plan that apply to that benefit.

11. Drugs labeled "Caution, Limited by Federal Law to Investigational Use" or Non-FDA approved investigational Drugs. Any Drugs or medications prescribed for Experimental indications. If you are denied a drug because Anthem determines that the Drug is Experimental or Investigative, you may ask that the denial be reviewed.

12. Any expense Incurred for a Drug or medication in excess of Prescription Drug Maximum Allowed Amount.

13. Drugs which have not been approved for general use by the Food and Drug Administration. This does not apply to Drugs that are Medically Necessary for a covered condition.

14. Drugs used primarily for cosmetic purposes (e.g., Retin-A for wrinkles). However, this will not apply to the use of this type of Drug for Medically Necessary treatment of a medical condition other than one that is cosmetic.

15. Drugs used primarily for the purpose of treating Infertility (including but not limited to Clomid, Pergonal, and Metrodin), unless Medically Necessary for another covered condition.

16. Anorexiants and Drugs used for weight loss except when used to treat morbid obesity (e.g., diet pills and appetite suppressants). This exclusion does not apply to Drugs used for weight loss which are listed as covered under the PreventiveRx program, if included.

17. Drugs obtained outside of the United States unless they are furnished in connection with Urgent Care or an Emergency.

18. Allergy desensitization products or allergy serum. While not covered under this Prescription Drug benefit, such Drugs are covered as specified under the "Hospital Benefits", "Skilled Nursing Facility Benefits", and "Professional Services Benefits" provisions of YOUR MEDICAL BENEFITS - Medical Care That is Covered (see Table of Contents), subject to all terms of this Plan that apply to those benefits.

19. Infusion Drugs, except Drugs that are self-administered subcutaneously. While not covered under this Prescription Drug benefit, infusion Drugs are covered as specified under the "Professional Services Benefits" and "Infusion / Injectable Therapy Benefits" provisions of YOUR MEDICAL BENEFITS - Medical Care That is Covered (see Table of Contents), subject to all terms of this Plan that apply to those benefits.

20. Herbal supplements, nutritional and dietary supplements. However, formulas prescribed by a Physician for the treatment of phenylketonuria that are obtained from a Pharmacy are covered as specified under "Prescription Services and Supplies That Are Covered". Special food products that are not available from a Pharmacy are covered as specified under the "Phenylketonuria (PKU) Benefits" provision of YOUR MEDICAL PLAN - Medical Care That is Covered (see Table of Contents), subject to all terms of this Plan that apply to the benefit. Also, vitamins, supplements, and certain over-the-counter items as specified under "Preventive Prescription Drugs and Other Items" are covered under this Plan only when obtained with a Physician's Prescription, subject to all terms of this Plan that apply to those benefits.

21. Prescription Drugs with a non-prescription (over-the-counter) chemical and dose equivalent except insulin, even if written as a *prescription*. This does not apply if an over-the-counter equivalent was tried and was ineffective.

22. Onychomycosis (toenail fungus) Drugs except to treat Members who are immuno-compromised or diabetic.

23. Gene therapy that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material. While not covered under the "Prescription Drug Benefits" benefit, benefits may be available under the "Gene Therapy Services" benefit. Please see that section for details.24. Compound Medications unless all the ingredients are FDA-approved in the form in which they are used in the Compound Medication, require a prescription to dispense, and the Compound Medication is not essentially the same as an FDA-approved product from a Drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants. Compound Medications must be obtained from an In-Network Pharmacy. **You will have to pay the full cost of the Compound Medications you get from an Out-of-Network Pharmacy**.

25. Specialty Drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail Pharmacy or through the home delivery program. Unless you qualify for an exception, these Drugs are not covered by this Plan (please see YOUR PRESCRIPTION DRUG BENEFITS - Prescription Drug Conditions of Service). **You will have to pay the full cost of the Specialty Drugs you get from a retail Pharmacy that you should have obtained from the specialty pharmacy program**.

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

26. Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.

27. *Drugs* which are over any quantity or age limits set by the *plan* or the *claims administrator*.

28. *Prescription drugs* prescribed by a provider that does not have the necessary qualifications, registrations and/or certifications.

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

30. Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin or other Drugs provided in the Preventive Care paragraph of the YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED section. This exclusion does not apply to over-the-counter Drugs that we must cover under state law, or federal law when recommended by the U.S. Preventive Services Task Force, and prescribed by a Physician.

31. Services the *claims administrator* concludes are not *medically necessary*. This includes services that do not meet medical policy, clinical coverage, or benefit policy guidelines.

32. Prescription Drugs related to the medical and surgical treatment of excessive sweating (hyperhidrosis).

33. Services from an Out-of-Network Pharmacy that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Pharmacy's failure to submit medical records required to determine the appropriateness of a claim.

COORDINATION OF BENEFITS

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

DEFINITIONS

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

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

The following are not Allowable Expense:

1. Use of a private hospital room is not an Allowable Expense unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage for hospital private rooms.

2. If you are covered by two plans that calculate benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method, any amount in excess of the higher of the reasonable and customary amounts.

3. If a person is covered by two plans that provide benefits or services on the basis of negotiated rates or fees, an amount in excess of the lower of the negotiated rates.

4. If a person is covered by one plan that calculates its benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar

reimbursement method and another plan provides its benefits or services on the basis of negotiated rates or fees, any amount in excess of the negotiated rate.

5. The amount of any benefit reduction by the Principal Plan because you did not comply with the plan's provisions is not an Allowable Expense. Examples of these types of provisions include second surgical opinions, utilization review requirements, and network provider arrangements.

6. If you advise us that all plans covering you are high deductible health plans as defined by Section 223 of the Internal Revenue Code, and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code, any amount that is subject to the primary high deductible health plan's deductible.

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage;

2. Group service plan contract, group practice, group individual practice and other group prepayment coverages;

3. Group coverage under labor-management trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.

4. Medicare. This does not include Medicare when, by law, its benefits are secondary to those of any private insurance program or other non-governmental program.

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

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

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

EFFECT ON BENEFITS

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

1. If This Plan is the Principal Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan.

2. If This Plan is not the Principal Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed Allowable Expense. Benefits of This Plan cannot be determined until the Principal Plan has completed processing.

3. The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if you were covered under This Plan only.

ORDER OF BENEFITS DETERMINATION

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

1. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision. This would include Medicare in all cases, except when the law requires that This Plan pays before Medicare.

2. A plan which covers you as a member pays before a plan which covers you as a dependent. But, if you are retired and eligible for Medicare, Medicare pays (a) after the plan which covers you as a dependent of an active employee, but (b) before the plan which covers you as a retired employee.

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

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

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

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

   a. If the parent with custody of that child for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that child as a dependent pays first.

   b. If the parent with custody of that child for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:

      i. The plan which covers that child as a dependent of the parent with custody.

      ii. The plan which covers that child as a dependent of the stepparent (married to the parent with custody).

      iii. The plan which covers that child as a dependent of the parent without custody.

      iv. The plan which covers that child as a dependent of the stepparent (married to the parent without custody).

   c. Regardless of a and b above, if there is a court decree which establishes a parent's financial responsibility for that child's health care coverage, a plan which covers that child as a dependent of that parent pays first.

4. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But if either plan does not have a provision regarding laid-off or retired employees, provision 6 applies.

5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan do not agree under these circumstances with the Order of Benefit Determination provisions of This Plan, this rule will not apply.

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

OUR RIGHTS UNDER THIS PROVISION

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

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

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

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

BENEFITS FOR MEDICARE ELIGIBLE MEMBERS

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

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

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

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

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

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

UTILIZATION REVIEW PROGRAM

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

REVIEWING WHERE SERVICES ARE PROVIDED

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

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

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

If you have any questions about the utilization review process, the medical policies or clinical guidelines information in this section, you may call Anthem Health Guide number at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) or go to the website at www.anthem.com/ca.

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

1. You must be eligible for Benefits;
2. The service or supply must be a Covered Service under your Plan;
3. The service cannot be subject to an exclusion under your Plan (See "Medical Care That Is NOT Covered" for more information); and
4. You must not have exceeded any applicable limits under your Plan.

Types of Reviews

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

    For admissions following an Emergency, you, your authorized representative or Physician must tell the Plan within 24 hours or as soon as it is possible within a reasonable period of time.

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

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

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

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

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

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

- All inpatient Hospital admissions.
- Specific non-Emergency outpatient services, including diagnostic treatment and other services.
- Surgical procedures, wherever performed.
- Organ and tissue transplants, peripheral stem cell replacement and similar procedures.
- Air ambulance in a non-medical Emergency.
- Speech therapy services. A specified number of additional visits may be authorized after your initial visit. While there is no limit on the number of covered visits for medically necessary speech therapy, visits must be authorized in advance.
- Specific durable medical equipment.
- Infusion therapy / injectable therapy, if the attending Physician has submitted both a prescription and a plan of treatment before services are rendered.
- Home health care. The following criteria must be met:
  - ♦ The services can be safely provided in your home, as certified by your attending Physician;
  - ♦ Your attending Physician manages and directs your medical care at home; and
  - ♦ Your attending Physician has established a definitive treatment plan which must be consistent with your medical needs and lists the services to be provided by the Home Health Agency.
- Admissions to a Skilled Nursing Facility if you require daily skilled nursing or rehabilitation, as certified by your attending Physician.
- Bariatric surgical services, such as gastric bypass and other surgical procedures for weight loss, including bariatric travel expense, if:
  - ♦ The services are to be performed for the treatment of morbid obesity;
  - ♦ The physicians on the surgical team and the Facility in which the surgical procedure is to take place are approved for the surgical procedure requested; and
  - ♦ The bariatric surgical procedure will be performed at a BDCSC Facility.

- Advanced imaging procedures, including but not limited to: Magnetic Resonance Imaging (MRI), Computerized Tomography (CT scan), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography, and Nuclear Cardiac Imaging. You may call Anthem Health Guide toll free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) to find out if an imaging procedure requires pre-service review.

- Behavioral health treatment for autism spectrum disorders, as specified in the section BENEFITS FOR AUTISM SPECTRUM DISORDERS.

- Partial hospitalization, Intensive Outpatient Programs, transcranial magnetic stimulation (TMS).

- Transgender services, including transgender travel expense, as specified under the "Transgender Benefits" provision of YOUR MEDICAL BENEFITS - Medical Care That Is Covered. You must be diagnosed with gender identity disorder or gender dysphoria by a Physician.

For a list of current procedures requiring precertification, please call Anthem Health Guide toll free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific).

Who is Responsible for Precertification?

Typically, UCMC Providers and Anthem Preferred Providers know which services need precertification and will get any precertification when needed. Your Physician and UCMC Providers and other Anthem Preferred Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering provider, Hospital or attending Physician ("requesting provider") will get in touch with the Plan 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**
UCMC / Anthem Preferred Providers	Provider	• The Provider must get precertification when required.
Out-of-Network Providers	Member	• Member must get precertification when required. (Call Anthem Health Guide) • Member should contact Anthem Health Guide before seeking care with an Out-of-Network Provider when outside of the U.S. • Member may be financially responsible for charges or costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary.
Blue Card Provider	Member **(Except for Inpatient Admissions)**	• Member must get precertification when required. (Call Anthem Health Guide) • Member may be financially responsible for charges or costs related to the service and/or setting in whole or in part if the service and or setting is found to not be Medically Necessary. • **Blue Card Providers must obtain precertification for all Inpatient Admissions.**
NOTE: For an Emergency admission, precertification is not required. However, you, your authorized representative or Physician must notify the Plan within 24 hours or as soon as it is possible within a reasonable period of time.		

How Decisions Are Made

Decisions are based on multiple sources, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make medical necessity determinations. This includes decisions about Prescription Drugs as detailed in the section "Prescription Drugs Obtained From Or Administered By a Medical Provider". Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. Anthem reserves the right to review and update these clinical coverage guidelines from time to time.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, please call Anthem Health Guide toll free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific). You can also find our medical policies on our website at www.anthem.com/ca.

If you are not satisfied with Anthem's decision under this section of your Benefits, please refer to the YOUR RIGHT TO APPEALS section to see what rights may be available to you.

Decision Notice and Requirements

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

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

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

Anthem will notify you and your Physician of a decision as required by state and federal law. Notice may be given by one or more of the following methods: verbal, written and/or electronic.

For a copy of the medical necessity review process, please contact Anthem Health Guide toll free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific).

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

- Your coverage under this Plan ends;
- The agreement with the group terminates;
- You reach a Benefit maximum that applies to the service in question;

- Your Benefits under the Plan change so that the service is no longer covered or is covered in a different way.

HEALTH PLAN INDIVIDUAL CASE MANAGEMENT

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

How Health Plan Individual Case Management Works

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

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

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

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

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

Exceptions to the Utilization Review Program

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

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

Anthem 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 Anthem may use one or more clinical utilization management guidelines in the review of claims submitted by this provider, even if those guidelines are not used for all Providers delivering services to this Plan's Members.

You may determine whether a health care Provider participates in certain programs or a provider arrangement by checking Anthem's online provider directory on the website at www.anthem.com/ca or by calling Anthem Health Guide toll-free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific).

UNIVERSITY OF CALIFORNIA ELIGIBILITY, ENROLLMENT, TERMINATION AND PLAN ADMINISTRATION PROVISIONS

The University establishes its own medical plan eligibility, enrollment and termination criteria based on the University of California Group Insurance Regulations and any corresponding Administrative Supplements.

ELIGIBLE STATUS

Employees

Information pertaining to your eligibility, enrollment, cancellation or termination of coverage and conversion options can be found by contacting your campus GME or Human Resources office. Additional resources are also available ucresidentbenefits.com, campus GME or Human Resources website to help you with your health and welfare plan decisions.

Dependents

The following are eligible to enroll as Dependents*:* (a) Either the Employee's Spouse or Domestic Partner*;* and (b) A child.

Definition of Dependent

1. **Spouse** is the Employee's spouse as recognized under state or federal law. This includes same sex spouses when legally married in a state that recognizes same sex marriages. Spouse does not include any person who is: (a) covered as an Employee; or (b) in active service in the armed forces.

2. **Domestic partner** is the Employee's domestic partner under a legally registered and valid domestic partnership. Domestic partner does not include any person who is: (a) covered as an Employee; or (b) in active service in the armed forces.

3. **Child** is the Employee's or Spouse's or Domestic Partner's natural child, stepchild, legally adopted child, or a child for whom the Employee*,* Spouse or Domestic Partner has been appointed legal guardian by a court of law, subject to the following:

    a. The child is under 26 years of age.

    b. The unmarried child is 26 years of age, or older and: (i) was covered under the prior plan, was covered as a dependent of the Employee under another plan or health insurer, or has six or more months of other creditable coverage, (ii) is chiefly dependent on the Employee*,* Spouse or Domestic Partner for support and maintenance*,* and (iii) is incapable of self-sustaining employment due to a physical or mental condition. A Physician must certify in writing that the child is incapable of self-sustaining employment due to a physical or mental condition. We must receive the certification, at no expense to us, within 60-days of the date the Employee receives our request. We may request proof of continuing dependency and that a physical or mental condition still exists, but not more often than once each year after the initial certification. This exception will last until the child is no longer chiefly dependent on the Employee*,* Spouse or Domestic Partner for support and maintenance due to a continuing physical or mental condition. A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

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

Legal evidence to control the health care of the child means a written document, including, but not limited to, a health Facility minor release report, a medical authorization form, or relinquishment form, signed by the child's birth parent, or other appropriate authority, or in the absence of a written document, other evidence of the Employee's, the Spouse's or Domestic Partner's right to control the health care of the child.

d. A child for whom the Employee, Spouse or Domestic Partner is a legal guardian is considered eligible on the date of the court decree (the "eligibility date"). We must receive legal evidence of the decree.

CONTINUATION OF COVERAGE

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

DEFINITIONS

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

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

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

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

1. **For Members and Dependents:**
    a. The Member’s termination of employment, for any reason other than gross misconduct; or
    b. Loss of coverage under an employer’s health plan due to a reduction in the Member’s work hours.
2. **For Dependents:**
    a. The death of the Member;
    b. The Spouse’s divorce or legal separation from the Member;
    c. The end of a Domestic Partner’s partnership with the Member;
    d. The end of a child’s status as a Dependent child, as defined by the plan; or
    e. The Member’s entitlement to Medicare.

ELIGIBILITY FOR COBRA CONTINUATION

A Member or Dependent may choose to continue coverage under the Plan if his or her coverage would otherwise end due to a Qualifying Event.

TERMS OF COBRA CONTINUATION

Notice. UC will notify either the Member or Dependent of the right to continue coverage under COBRA, as provided below:

1. For Qualifying Event 1, UC will notify the Member of the right to continue coverage.
2. For Qualifying Events 2(a) or 2(e) above, a Dependent will be notified of the COBRA continuation right.
3. You must inform UC within 60 days of Qualifying Events 2(b), 2(c), or 2(d) above, if you wish to continue coverage. UC, in turn, will promptly give you official notice of the COBRA continuation right.

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

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

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

Additional Dependents. A Spouse, Domestic Partner or child acquired during the COBRA continuation period is eligible to be enrolled as a Dependent. The standard enrollment provisions of the Plan apply to enrollees during the COBRA continuation period.

Cost of Coverage. UC may require that you pay the entire cost of your COBRA continuation coverage. This cost, called the "required monthly contribution", must be remitted to UC each month during the COBRA continuation period in order to maintain the coverage in force.

Besides applying to the Member, the Member's rate will also apply to:

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

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

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

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

For Dependents properly enrolled during the COBRA continuation, coverage begins according to the enrollment provisions of the Plan.

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

1. The end of 18 months from the Qualifying Event, if the Qualifying Event was termination of employment or reduction in work hours;*
2. The end of 36 months from the Qualifying Event, if the Qualifying Event was the death of the Member, divorce or legal separation, the end of a domestic partnership, or the end of Dependent child status;*

3. The end of 36 months from the date the Member became entitled to Medicare, if the Qualifying Event was the Member's entitlement to Medicare. If entitlement to Medicare does not result in coverage terminating and Qualifying Event 1 occurs within 18 months after Medicare entitlement, coverage for Qualified Beneficiaries other than the Member will end 36 months from the date the Member became entitled to Medicare;

4. The date the Plan terminates;

5. The end of the period for which required monthly contributions are last paid;

6. The date, following the election of COBRA, the Member first becomes covered under any other group health plan; or

7. The date, following the election of COBRA, the Member first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

Other Coverage Options Besides COBRA Continuation Coverage. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

EXTENSION OF CONTINUATION DURING TOTAL DISABILITY

If at the time of termination of employment or reduction in hours, or at any time during the first 60 days of the COBRA continuation, a Qualified Beneficiary is determined to be disabled for Social Security purposes, all covered Members may be entitled to up to 29 months of continuation coverage after the original Qualifying Event.

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

1. Satisfy the legal requirements for being totally and permanently disabled under the Social Security Act; and

2. Be determined and certified to be so disabled by the Social Security Administration.

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

1. The date of the Social Security Administration's determination of the disability;

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

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

4. The date on which the Qualified Beneficiary is informed of the obligation to provide the disability notice.

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

1. If the disabled Member continues coverage during this extension, this charge shall be **150%** of the applicable rate for the length of time the disabled Member remains covered, depending upon the number of covered Dependents. If the disabled Member does not continue coverage during this extension, this charge shall remain at **102%** of the applicable rate.

2. The cost for extended continuation coverage must be remitted to us each month during the period of extended continuation coverage. We must receive timely payment of the required monthly contribution in order to maintain the extended continuation coverage in force.

3. You may be required to pay the entire cost of the extended continuation coverage.

If a second Qualifying Event occurs during this extended continuation, the total COBRA continuation may continue for up to 36 months from the date of the first Qualifying Event. The required monthly contribution shall then be **150%** of the applicable rate for the 19th through 36th months if the disabled Member remains covered. The charge will be **102%** of the applicable rate for any periods of time the disabled Member is not covered following the 18th month.

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

1. The end of the month following a period of 30 days after the Social Security Administration's final determination that you are no longer totally disabled;
2. The end of 29 months from the Qualifying Event*;
3. The date the Plan terminates;
4. The end of the period for which required monthly contributions are last paid;
5. The date, following the election of COBRA, the Member first becomes covered under any other group health plan; or
6. The date, following the election of COBRA, the Member first becomes entitled to Medicare.

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

GENERAL PROVISIONS

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

Independent Contractors. Anthem's relationship with Providers is that of an independent contractor. Physicians, and other health care professionals, Hospitals, skilled nursing facilities and other community agencies are not Anthem's agents nor are they, or any of their employees, an employee or agent of any Hospital, medical group or medical care Provider of any type.

Non-Regulation of Providers. The Benefits of this Plan do not regulate the amounts charged by Providers of medical care, except to the extent that the rates for Covered Services are regulated with UCMC Providers or Anthem Preferred Providers.

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 geographic area we serve (the "Anthem Blue Cross Service Area"), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below

When you receive care outside of the Anthem Blue Cross Service Area, you will receive it from one of two kinds of providers. Most Providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("non-participating providers") do not contract with the Host Blue. We explain below how we pay both kinds of providers.

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

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to us.

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

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

B. Negotiated (non–BlueCard Program) Arrangements

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

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

C. Special Cases: Value-Based Programs

BlueCard® Program

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

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

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

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

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

E. Non-participating Providers Outside Our Service Area

1. Allowed Amounts and Member Liability Calculation

When Covered Services are provided outside of Anthem Blue Cross's Service Area by non-participating providers, 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 a Deductible or Copayment will be based on that allowed amount. Also, you may be responsible for the difference between the amount that the non-participating provider bills and the payment we will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network Emergency Services.

2. Exceptions

In certain situations, we may use other pricing methods, such as billed charges or the pricing we would use if the healthcare services had been obtained within the Anthem Blue Cross Service Area, or a special negotiated price to determine the amount we will pay for services provided by non-participating providers. In these situations, you may be liable for the difference between the amount that the non-participating provider bills and the payment we make for the Covered Services as set forth in this paragraph.

F. Blue Cross Blue Shield Global Core® Program

Benefits will also be provided for Emergency and non-Emergency Covered Services received outside of the United States, Puerto Rico, and U.S. Virgin Islands. If you live or plan to travel outside the United States, call Anthem Health Guide toll-free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) to find out your Blue Cross Blue Shield Global Core Benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with you.

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

If you need inpatient Hospital care, you or someone on your behalf, should contact us for preauthorization. Keep in mind, if you need Emergency medical care, go to the nearest Hospital. There is no need to call before you receive care.

Please refer to the UTILIZATION REVIEW PROGRAM section in this booklet for further information. You can learn how to get pre-authorization when you need to be admitted to the Hospital for Emergency or non-Emergency care.

How Claims are Paid with Blue Cross Blue Shield Global Core

In most cases, when you arrange inpatient Hospital care with Blue Cross Blue Shield Global Core, claims will be filed for you. The only amounts that you may need to pay up front are any Copayment or Deductible amounts that may apply.

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

- Physician services;
- Inpatient Hospital care not arranged through Blue Cross Blue Shield Global Core; and
- Outpatient services.

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

When you need Blue Cross Blue Shield Global Core claim forms you can get international claims forms in the following ways:

- Call the Blue Cross Blue Shield Global Core Service Center at the numbers above; or
- Online at www.bcbsglobalcore.com.

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

Terms of Coverage

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

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

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

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

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

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

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

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

Provider Reimbursement. Physicians and other professional Providers are paid on a fee-for-service basis, according to an agreed schedule. A participating Physician may, after notice from Anthem, be subject to a reduced negotiated rate in the event the participating Physician fails to make routine referrals to UCMC Providers or Anthem Preferred Providers, except as otherwise allowed (such as for Emergency Services). Hospitals and other health care facilities may be paid either a fixed fee or on a discounted fee-for-service basis.

Other forms of payment arrangement are Payment Innovation Programs. These programs may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner. The programs may vary in methodology and subject area of focus and may be modified by UC from time to time, but they will be generally designed to tie a certain portion of a UCMC Provider's or an Anthem Preferred Provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, a UCMC Provider or Anthem Preferred Provider may be required to make payment to the Plan under the program as a consequence of failing to meet these pre-defined standards. The programs are not intended to affect the Member's access to health care. The program payments are not made as payment for specific Covered Services provided to the Member, but instead, are based on the UCMC Provider's or Anthem Preferred Provider's achievement of these pre-defined standards. The Member is not responsible for any Copayment amounts related to payments made by the Plan or to the Plan under the programs and the Member does not share in any payments made by UCMC Providers or Anthem Preferred Providers to the Plan under the programs.

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

Medical Necessity. The Benefits of this Plan are provided only for services which Anthem determines to be Medically Necessary. The services must be ordered by the attending Physician for the direct care and treatment of a covered condition. They must be standard medical practice where received for the condition being treated and must be legal in the United States. The process used to authorize or deny health care services under this Plan is available to you upon request.

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

Benefits Not Transferable. Only the Member is entitled to receive Benefits under this Plan. The right to Benefits cannot be transferred.

Notice of Claim. You must send Anthem properly and fully completed claim forms within 90 days of the date you receive the service or supply for which a claim is made. If it is not reasonably possible to submit

the claim within that time frame, an extension of up to 12 months will be allowed. UC is not liable for the Benefits of the Plan if you do not file claims within the required time period, unless an extension is required by federal law. UC will not be liable for Benefits if Anthem does not receive written proof of loss on time.

Services received and charges for the services must be itemized, and clearly and accurately described including the Tax ID and National Provider Identifier of the provider(s) whom rendered each service. Claim forms must be used; canceled checks or receipts are not acceptable.

To obtain a claim form you or someone on your behalf may call Anthem Health Guide toll-free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) or go to the website at www.anthem.com/ca and download and print one.

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

Payment to Providers. The Benefits of this Plan will be paid directly to UCMC Providers or Anthem Preferred Providers and medical transportation providers. If you or one of your Dependents receives services from Out-of-Network Providers, payment may be made directly to the Member and you will be responsible for payment to the Provider. Any assignment of Benefits, even if assignment includes the provider's right to receive payment, is void unless an Authorized Referral has been approved by Anthem. The Plan will pay other Providers of service directly when Emergency Services and care are provided to you or one of your Dependents. The Plan will continue such direct payment until the Emergency care results in stabilization. If you are a MediCal beneficiary and you assign Benefits in writing to the State Department of Health Services, the Benefits of this Plan will be paid to the State Department of Health Services. These payments will fulfill the Plan's obligation to you for those Covered Services.

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

Out-of-Network Provider and other health care providers will be paid directly when Emergency Medical Condition services and care are provided to you or one of your Dependents. The Plan will continue such direct payment until the Emergency care results in stabilization.

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

Assignment. You authorize the Claims Administrator, in its own discretion and on behalf of the employer, to make payments directly to providers for covered services. In no event, however, shall the Plan's right to make payments directly to a provider be deemed to suggest that any provider is a beneficiary with independent claims and appeal rights under the Plan. The Claims Administrator also reserves the right, in its own discretion, to make payments directly to you as opposed to any provider for covered service. In the event that payment is made directly to you, you have the responsibility to apply this payment to the claim from the 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 an Employee who is recognized under a "Qualified Medical Child Support Order" as having a right to enrollment under the employer's Plan), or that person's custodial parent or designated representative. Any payments made by the Claims Administrator (whether to any provider for covered service or you) will discharge the employer's obligation to pay for covered services. You cannot assign your right to receive payment to anyone, except as required by a "Qualified Medical Child Support Order" as defined by, and if subject to, ERISA or any applicable Federal law. Once a provider performs a covered service, the Claims Administrator will not honor a request to withhold payment of the claims submitted.

The coverage, rights, and benefits under the Plan are not assignable by any member without the written consent of the Plan, except as provided above. This prohibition against assignment includes rights to receive payment, claim benefits under the Plan and/or law, sue or otherwise begin legal action, or request Plan documents or any other information that a participant or beneficiary may request under ERISA. Any assignment made without written consent from the Plan will be void and unenforceable.

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

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

Under certain circumstances, if Anthem pays your healthcare Provider amounts that are your responsibility, such as Deductibles or Copayments, Anthem may collect such amounts directly from you. You agree that Anthem has the right to recover such amounts from you.

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

Anthem has established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses, and whether to settle or compromise recovery amounts. Anthem will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. Anthem may not provide you with notice of overpayments made by the Plan or you if the recovery method makes providing such notice administratively burdensome.

Plan Administrator - COBRA. In no event will Anthem be Plan Administrator for the purposes of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA. The term "Plan Administrator" refers to UC Health or to a person or entity other than Anthem, engaged by to perform or assist in performing administrative tasks in connection with the Plan. In providing notices and otherwise performing under the CONTINUATION OF COVERAGE section of this Benefit Booklet, UC is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as your agent.

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

Prepayment Fees. UC may require that you contribute all or part of the costs of the required monthly contributions. Please consult UC for details.

Financial Arrangements with Providers. Anthem or an affiliate has contracts with certain health care providers and suppliers (hereafter referred to together as "Providers" in this section) for the provision of and payment for health care services rendered to its members and members entitled to health care benefits under individual certificates and group policies or contracts to which Anthem or an affiliate is a party, including all persons covered under the Plan.

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

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

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

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

2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Anthem in consultation with you and the Out-of-Network Provider and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the time you enroll in this Plan.

3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Services shall be provided for the duration of the pregnancy.

4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of Covered Services shall be provided for the duration of the terminal illness.

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

6. Performance of a surgery or other procedure that Anthem have authorized as part of a documented course of treatment and that has been recommended and documented by the Provider to occur within 180 days of the time you enroll in this Plan.

Please contact Anthem Health Guide toll-free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) to request Transition Assistance or to obtain a copy of the written policy. Eligibility is based on your clinical condition and is not determined by diagnostic classifications. Transition Assistance does not provide coverage for services not otherwise covered under the Plan.

You will be notified by telephone, and the Provider by telephone and fax, as to whether or not your request for Transition Assistance is approved. If approved, you will be financially responsible only for applicable Deductibles and Copayments under the Plan. Financial arrangements with Out-of-Network Providers are negotiated on a case-by-case basis. The Out-of-Network Provider will be asked to agree to accept reimbursement and contractual requirements that apply to UCMC Providers or Anthem Preferred Providers, including payment terms. If the Out-of-Network-Provider does not agree to accept said reimbursement and contractual requirements, the Out-of-Network-Provider's services will not be continued. If you do not meet the criteria for Transition Assistance, you are afforded due process including having a Physician review the request.

Continuity of Care after Termination of Provider: Subject to the terms and conditions set forth below, Benefits will be provided at the UCMC Provider or Anthem Preferred Provider level for Covered Services (subject to applicable Copayments, Deductibles and other terms) received from a Provider at the time the provider's contract with Anthem terminates (unless the provider's contract terminates for reasons of medical disciplinary cause or reason, fraud, or other criminal activity). If your *physician* leaves our network for any reason other than termination of cause, or if coverage under this Plan ends because your Group's Contract ends, or because your Group changes plans, and you are in active treatment, you may be able to continue seeing that provider for a limited period of time and still get the In-Network Provider benefits.

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

Benefits for the completion of Covered Services by a terminated Provider will be provided only for the following conditions:

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

2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Anthem in consultation with you and the terminated Provider and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the date the provider's contract terminates.

3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Services shall be provided for the duration of the pregnancy.

4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of Covered Services shall be provided for the duration of the terminal illness.

5. The care of a newborn child between birth and age thirty-six (36) months. Completion of Covered Services shall not exceed twelve (12) months from the date the provider's contract terminates.

6. Performance of a surgery or other procedure that Anthem has authorized as part of a documented course of treatment and that has been recommended and documented by the Provider to occur within 180 days of the date the provider's contract terminates.

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

Please contact Anthem Health Guide toll-free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) to request continuity of care or to obtain a copy of the written policy. Eligibility is based on your clinical condition and is not determined by diagnostic classifications. Continuity of care does not provide coverage for services not otherwise covered under the Plan.

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

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

Voluntary Wellness Incentive Programs. Anthem may offer health or fitness related program options for purchase by UC to help you achieve your best health. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed under this Plan and could be discontinued at any time. If UC has selected one of these options to make available to all Employees, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options UC may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact Anthem Health Guide toll-free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) and Anthem will work with you (and, if you wish, your Physician) to find a wellness program with the same reward that is right for you in light of your health status. If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.

Policies, Procedures, and Pilot Programs. The Claims Administrator is able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules, and interpretations.

Under the terms of the Administrative Service Agreement with your Employer, the Claims Administrator has 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 which may result in the payment of benefits not otherwise specified in this Booklet. The Claim's Administrator reserves the right to discontinue a pilot or test program at any time.

Program Incentives. UC may offer incentives from time to time in order to introduce you to new programs and services available under this Plan. The Claims Administrator may also offer the ability for you to participate in certain voluntary health or condition-focused digital applications or use other technology based interactive tool, or receive educational information in order to help you stay engaged and motivated, manage your health, and assist in your overall health and well-being. The purpose of these programs and incentives include, but are not limited to, making you aware of cost effective Benefit options or services, helping you achieve your best health, and encouraging you to update Member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards and health-related merchandise. Acceptance of these incentives is voluntary as long as the Plan offers the incentives program. Motivational rewards, awards or points for achieving certain milestones may be a feature of the program. UC may discontinue a program or an incentive for a particular new service or program at any time. If you have any questions about whether receipt of an incentive or retailer coupon results in taxable income to you, please consult your tax advisor.

Plan Notice of Privacy Practices for Anthem*

Notice of Privacy Practices

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

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

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

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

For treatment activities: does not provide treatment. This is the role of a health care provider, such as your doctor or a Hospital. Examples of ways Anthem uses your information for payment, treatment and health care operations:

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

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

You may obtain a full copy of the Notice of Privacy Practices at www.anthem.com/ca/health-insurance/about-us/privacy or you may contact Anthem Health Guide toll-free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific).

***Business Associate to the UC Medical Residents and Fellows**

Notice of Privacy Practice for Plan

A copy of the University of California Healthcare Plan Notice of Privacy Practices-Self-Funded Plans (Notice) that applies to your Plan can be found at ucal.us/hipaa or you may obtain a paper copy of the UC Notice by calling the UC Healthcare Plan Privacy Office at 800-888-8267, press 1.

BINDING ARBITRATION

A dispute regarding a claim for Benefits, including Prescription Drug benefits administered as a Covered Service, must proceed first through the claims process described in YOUR RIGHT TO APPEALS section before any further legal action can be taken with respect to that claim. Otherwise any dispute or claim, of whatever nature, including a claim for Benefits that has completed the internal appeals process, that arises out of, in connection with, or in relation to this Plan, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

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

The Member and UC agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

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

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

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

DEFINITIONS

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

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

Ambulatory Surgical Center is a Facility licensed as an Ambulatory Surgery Center as required by law that satisfies our accreditation requirements and is approved by us.

Anthem Preferred Provider is one of the following Providers or other licensed health care professionals who have a Prudent Buyer Plan Participating Provider Agreement in effect with Anthem or is participating in a Blue Cross and/or Blue Shield Plan at the time services are rendered:

- A Hospital
- A Physician
- An Ambulatory Surgical Center
- A Home Health Agency
- A Facility which provides diagnostic imaging services
- A durable medical equipment outlet
- A Skilled Nursing Facility
- A clinical laboratory
- An Infusion Therapy Provider/Injectable Therapy Provider
- An Urgent Care Center
- Centers for Medical Excellence (CME)
- Blue Distinction Centers for Specialty Care (BDCSC)
- A Retail Health Clinic
- A Hospice
- A licensed ambulance company
- A licensed qualified autism service Provider

Anthem Preferred Providers agree to accept the Maximum Allowed Amount as payment for Covered Services. A directory of Anthem Preferred Provider is available upon request.

Authorized Referral occurs when you, because of your medical needs, require the services of a specialist who is an Out-of-Network Provider, or require special services, but only when the referral has been authorized by Anthem before services are rendered and when the following conditions are met:

1. there is no UCMC Provider or Anthem Preferred Provider who practices in the appropriate specialty, or has the necessary facilities;

2. that meets the adequacy and accessibility requirements of state or federal law.

3. the Member is referred to Hospital or Physician that does not have an agreement with Anthem for a covered service by a UCMC Provider or an Anthem Preferred Provider.

Benefits for Medically Necessary and appropriate Authorized Referral services received from an Out-of-Network Provider will be payable as shown in the Medical Benefit Summary Notes.

You or your Physician must call Anthem Health Guide toll-free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) prior to scheduling an admission to, or receiving the services of an Out-of-Network Provider.

Such Authorized Referrals are not available to bariatric surgical services. These services are only covered when performed at a designated bariatric BDCSC.

Balance Billed is when a Provider bills you for the difference between the amount it charges and the amount that the Plan will pay.

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

Benefit is a Benefit provided to eligible Members under the Plan consistent with any terms and conditions stated in the Plan.

Benefit Booklet is this written description of the Benefits provided under the Plan.

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

Blue Distinction Centers for Specialty Care (BDCSC) are health care providers designated by Anthem as a selected Facility for specified medical services. A Provider participating in a BDCSC network has an agreement in effect with Anthem at the time services are rendered or is available through their affiliate companies or our relationship with the Blue Cross and Blue Shield Association. BDCSC agree to accept the Maximum Allowed Amount as payment in full for Covered Services.

A UCMC Provider or an Anthem Preferred Provider in the Prudent Buyer Plan network or the Blue Cross and/or Blue Shield Plan is not necessarily a BDCSC Facility.

Brand Name Prescription Drug (Brand Name Drug) is a Prescription Drug that has been patented and is only produced by one manufacturer.

Centers of Medical Excellence (CME) are health care providers designated by Anthem as a selected Facility for specified medical services. A Provider participating in a CME network has an agreement in effect with Anthem at the time services are rendered or is available through their affiliate companies or their relationship with the Blue Cross and Blue Shield Association. CME agree to accept the Maximum Allowed Amount as payment in full for Covered Services.

A UCMC Provider or an Anthem Preferred Provider in the Prudent Buyer Plan network or the Blue Cross and/or Blue Shield Plan is not necessarily a CME Facility.

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

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

Compound Medication is a mixture of Prescription Drugs and other ingredients, wherein all of the ingredients are FDA-approved in the form in which they are used in the Compound Medication, a prescription is required to dispense, and the Compound Medication is not essentially the same as an FDA-approved product from a drug manufacturer.

Consolidated Appropriations Act of 2021 is a federal law described in the “Consolidated Appropriations Act of 2021 Notice” at the front of this booklet for details.

Copayment is the dollar amount or percentage of the Maximum Allowed Amount unless otherwise specified that a Member is required to pay for specific Covered Services after meeting any applicable Deductible. See page 37 under YOUR MEDICAL BENEFITS section.

Covered Service(s) are those Medically Necessary services and supplies associated with a Benefit under the Plan.

Creditable Coverage is any individual or group plan that provides medical, hospital and surgical coverage, including continuation coverage, coverage under Medicare or Medicaid, TRICARE, the Federal Employees Health Benefits Program, programs of the Indian Health Service or of a tribal organization, a state health benefits risk pool, coverage through the Peace Corps, the State Children's Health Insurance Program, or a public health plan established or maintained by a state, the United States government, or a foreign country. Creditable Coverage does not include accident only, credit, coverage for on-site medical clinics, disability income, coverage only for a specified disease or condition, hospital indemnity or other fixed indemnity insurance, Medicare supplement, long-term care insurance, dental, vision, workers' compensation insurance, automobile insurance, no-fault insurance, or any medical coverage designed to supplement other private or governmental plans. Creditable Coverage is used to set up eligibility rules for children who cannot get a self-sustaining job due to a physical or mental condition. In addition, eligible children were covered under one of the above types of health coverage on his or her own and not as a Dependent child.

If your prior coverage was through an employer, you will receive credit for that coverage if it ended because your employment ended, the availability of medical coverage offered through employment or sponsored by the employer terminated, or the employer's contribution toward medical coverage terminated, and any lapse between the date that coverage ended and the date you become eligible under this Plan is no more than 180 days (not including any waiting period imposed under this Plan by the Employer).

If your prior coverage was not through an employer, you will receive credit for that coverage if any lapse between the date that coverage ended and the date you become eligible under this Plan is no more than 63 days (not including any waiting period imposed under this Plan by the Employer).

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

If Medically Necessary, Benefits will be provided for feeding (by tube or gastrostomy) and suctioning.

Day Treatment Center is an outpatient psychiatric Facility which is licensed according to state and local laws to provide outpatient programs and treatment of Mental Health or substance use disorder under the supervision of physicians.

Deductible is the Benefit Year amount which you must pay for specific Covered Services that are a Benefit of the Plan before you become entitled to receive Benefit payments from the Plan for those services. See page 37 under YOUR MEDICAL BENEFITS section.

Dependent meets the Plan's eligibility requirements for dependents as outlined under the "University of California Eligibility, Enrollment, Termination and Plan Administration Provisions" section and who has enrolled in the Plan.

Designated Pharmacy Provider is an In-Network Pharmacy that has executed a Designated Pharmacy Provider Agreement with the Plan or an In-Network Provider that is designated to provide Prescription Drugs, including Specialty Drugs, to treat certain conditions.

Domestic Partner meets the **P**lan's eligibility requirements for domestic partners as outlined under the "University of California Eligibility, Enrollment, Termination and Plan Administration Provisions" section and who has enrolled in the Plan.

Drug (Prescription Drug) is a substance, that under the Federal Food, Drug & Cosmetic Act, must bear a message on their original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

- Compound (combination) medications, when all of the ingredients are FDA-approved in the form in which they are used in the Compound Drug, require a prescription to dispense and are not essentially the same as an FDA-approved product from a drug manufacturer.

- Insulin, diabetic supplies, and syringes.

Effective date is the date your coverage begins under this Plan.

Emergency (medical condition) is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition placing the health of the individual in serious jeopardy, with serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

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

Employee is an Individual who meets the eligibility requirements established by the Employer and accepted by Anthem.

Employer is the Regents of the University of California.

Experimental is any medical, surgical and/or other procedures, services, products, *drugs* or devices including implants used for research except as specifically stated under the "Clinical Trials" provision from the section Medical Care That is Not Covered.

Facility is a Facility including but not limited to, a *hospital*, freestanding *ambulatory surgery center*, chemical dependency treatment Facility, Residential Treatment Center, Skilled Nursing Facility, or mental health Facility, as defined in this booklet. The Facility must be licensed as required by law, satisfy our accreditation requirements, and be approved by us.

Family Member is the Member and all enrolled Dependents.

Formulary Drug is a Drug listed on the Prescription Drug Formulary.

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

Generic prescription drugs (generic drugs) are Prescription Drugs that are classified as Generic Drugs or that the 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.

Home health agencies are providers, licensed when required by law and approved by us, that:

- Gives skilled nursing and other services on a visiting basis in your home; and
- Supervises the delivery of services under a plan prescribed and approved in writing by the attending Physician.

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

Hospital is a Facility licensed as a Hospital as required by law that satisfies our accreditation requirements and is approved by us. The term Hospital does not include a provider, or that part of a provider, used mainly for:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial Care
- Educational care
- Subacute care

Incurred is a charge that will be considered Incurred on the date the particular services or supply which gives rise to it is provided or obtained.

Infusion Therapy Provider / Injectable Therapy Provider is a Provider licensed according to state and local laws as a pharmacy, and must be either certified as a home health care provider by Medicare, or accredited as a home pharmacy by The Joint Commission (TJC).

In-Network Pharmacy is a Pharmacy which has a Participating Pharmacy Agreement in effect with the Pharmacy Benefits Manager at the time services are rendered. Call your local Pharmacy to determine whether it is a participating pharmacy or call the toll-free Member Services telephone number.

In-Network Provider refers to a Provider that has contracted with Anthem to accept payment, plus any applicable Member Deductible, Copayment, or amounts in excess of specified benefit maximums, as payment in full for Covered Services provided to Members.

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

Intensive Outpatient Program is a short-term behavioral health treatment that provides a combination of individual, group and family therapy.

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

Investigative or **Investigational** 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.

Maximum Allowed Amount is the maximum amount of reimbursement Anthem will allow for covered medical services and supplies under this Plan. See YOUR MEDICAL BENEFITS - Maximum Allowed Amount.

Medically Necessary procedures, supplies equipment or services are those Anthem determines to be:

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

For purposes of treatment of Mental Health and Substance Use Disorder, Medically Necessary means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following:

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

(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration, and

(iii) Not primarily for the economic benefit of the Claims Administrator and the Member or for the convenience of the patient, treating Physician, or other health care Provider.

Member/Individual is the eligible Employee, Spouse, or Dependent covered by the Plan.

Mental health and substance use disorder include conditions that are listed in the most current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders.

Multi-Source Brand Name Drugs are drugs with at least one generic substitute.

National Provider Identifier or NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA.

Out-of-Network Pharmacy is a Pharmacy which does not have a contract in effect with the Pharmacy Benefits Manager at the time services are rendered. In most cases, you will be responsible for a larger portion of your pharmaceutical bill when you go to an Out-of-Network Pharmacy.

Out-of-Network Provider is one of the following Providers which does NOT have a Prudent Buyer Plan Participating Provider Agreement in effect with Anthem or is NOT participating in a Blue Cross and/or Blue Shield Plan at the time services are rendered:

- A Hospital
- A Physician
- An Ambulatory Surgical Center
- A Home Health Agency
- A Facility which provides diagnostic imaging services
- A durable medical equipment outlet
- A Skilled Nursing Facility
- A clinical laboratory
- An Infusion Therapy Provider/Injectable Therapy Provider
- An Urgent Care Center
- A Retail Health Clinic
- A Hospice
- A licensed ambulance company
- A licensed qualified autism service Provider

These Providers are not UCMC Providers nor Anthem Preferred Providers. Remember that the Maximum Allowed Amount may only represent a portion of the amount which an Out-of-Network Provider charges for services. See YOUR MEDICAL BENEFITS - Maximum Allowed Amount.

Out-of-Pocket Maximum is the highest Deductible and Copayment amount an Individual or family is required to for Covered Services each year as indicated in the SUMMARY OF BENEFITS. Charges for services that are not covered, charges in excess of the Maximum Allowed Amount do not accrue to the Benefit Year Out-of-Pocket Maximum.

Partial Hospitalization Program is a structured, multidisciplinary behavioral health treatment that offers nursing care and active individual, group and family treatment in a program that operates no less than 6 hours per day, 5 days per week.

Pharmacy means a licensed retail pharmacy.

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

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

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

Physician means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or

2. One of the following Providers, but only when the Provider is licensed to practice where the care is provided, is rendering a service within the scope of that license and such license is required to render that service, and is providing a service for which Benefits are specified in this booklet:

   - A dentist (D.D.S. or D.M.D.)
   - An optometrist (O.D.)
   - A dispensing optician
   - A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
   - A licensed clinical psychologist
   - A licensed educational psychologist or other Provider permitted by California law to provide behavioral health treatment services for the treatment of autism spectrum disorders only
   - A chiropractor (D.C.)
   - An acupuncturist (A.C.)
   - A licensed clinical social worker (L.C.S.W.)
   - A marriage and family therapist (M.F.T.)
   - A licensed professional clinical counselor (L.P.C.C.)*
   - A physical therapist (P.T. or R.P.T.)*
   - A speech pathologist*
   - An audiologist*
   - An occupational therapist (O.T.R.)*
   - A respiratory care practitioner (R.C.P.)*
   - A nurse midwife**
   - A nurse practitioner
   - A Physician assistant
   - A Psychiatric Mental Health Nurse (R.N.)*
   - A registered dietitian (R.D.)* or another nutritional professional* with a master's or higher degree in a field covering clinical nutrition sciences, from a college or university accredited by a regional accreditation agency, who is deemed qualified to provide these services by the referring M.D. or D.O. A registered dietitian or other nutritional professional as described here are covered for the provision of diabetic medical nutrition therapy and nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa only.
   - A qualified autism service Provider, qualified autism service professional, and a qualified autism service paraprofessional, as described under the BENEFITS FOR AUTISM SPECTRUM DISORDERS section.

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

If there is no nurse midwife who is a UCMC Provider or an Anthem Preferred Provider in your area, you may call Anthem Health Guide toll-free at **(833) 674-9256, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) for a referral to an OB/GYN.

Plan is the UC Medical Residents and Fellows Plan (Medical and Behavioral Health Benefit Plan for eligible Employees of the Employer and their covered Dependents).

Plan Administrator (UC) is the University of California Office of the President- UC Health Division.

Plan Sponsor is The Regents of the University of California, a public corporation and agency of the State of California, and the constitutional trustee of the public trust known as the University of California.

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

Prescription Drug Covered Expense is the expense you incur for a covered Prescription Drug, but not more than the Prescription Drug Maximum Allowed Amount. Expense is Incurred on the date you receive the service or supply.

Prescription Drug Formulary (Formulary) is a list which Anthem has developed of outpatient prescription drugs which may be cost-effective, therapeutic choices. Any In-Network Pharmacy can assist you in purchasing Drug listed on the formulary. You may also get information about covered Formulary Drugs by calling the Anthem Health Guide toll free at **(833) 674-9256** or by going to the website www.anthem.com/ca. Anthem Health Guide is available Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) but you can receive prescription related support after hours by calling **(833) 674-9256** and pressing 2.

Prescription Drug Maximum Allowed Amount is the maximum amount Anthem will allow for any Drug. The amount is determined by Anthem using prescription drug cost information provided to them by the Pharmacy Benefits Manager. The amount is subject to change. You may determine the Prescription Drug Maximum Allowed Amount of a particular drug by calling the Anthem Health Guide toll free at **(833) 674-9256** or by going to the website www.anthem.com/ca. Anthem Health Guide is available Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) but you can receive prescription related support after hours by calling **(833) 674-9256** and pressing 2.

Prescription Drug Tiers are used to classify Drugs for the purpose of setting their Copayment. Anthem will decide which drugs should be in each tier based on clinical decisions made by the Pharmacy and Therapeutics Process. Anthem retains the right at its discretion to determine coverage for dosage formulation in terms of covered dosage administration methods (for example, by mouth, injection, topical or inhaled) and may cover one form of administration and may exclude or place other forms of administration in another tier (if it is Medically Necessary for you to get a Drug in an administrative form that is excluded you will need to get written prior authorization (see "Prescription Drug Formulary - Prior Authorization" above to get that administrative form of the Drug). This is an explanation of what drugs each tier includes:

Tier 1 Drugs are those that have the lowest Copayment. This tier contains low cost preferred Drugs that may be generic, Single-Source Brand Name Drugs, Biosimilars, Interchangeable Biologic Products or Multi-Source Brand Name Drugs.

Tier 2 Drugs are those that have higher Copayments than Tier 1 Drugs, but, lower than Tier 3 Drugs. This tier may contain preferred Drugs that may be generic, Single-Source Brand Name Drugs, Biosimilars, Interchangeable Biologic Products or Multi-Source Brand Name Drugs.

Tier 3 Drugs are those that have the higher Copayments than Tier 2 Drugs, but, lower than Tier 4 Drugs. This tier may contain higher cost preferred Drugs and non-preferred Drugs that may be generic, Single-Source Brand Name Drugs, Biosimilars, Interchangeable Biologic Products or Multi-Source Brand Name Drugs.

Tier 4 Drugs are those that have the higher Copayments than Tier 3 Drugs. This tier may contain higher cost preferred Drugs and non-preferred Drugs that may be generic, Single-Source Brand Name Drugs, Biosimilars, Interchangeable Biologic Products or Multi-Source Brand Name Drugs.

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

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF);

2. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

3. Preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

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

Please call Anthem Health Guide toll-free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) for additional information about services that are covered by this Plan as Preventive Care Services. You may also refer to the following websites that are maintained by the U.S. Department of Health & Human Services.

http://www.healthcare.gov/what-are-my-preventive-care-benefits

http://www.ahrq.gov

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

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

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

Provider(s) A professional or Facility licensed when required by law that gives health care services within the scope of that license, satisfies our accreditation requirements and, for In-Network Providers and is approved by us. Details on our accreditation requirements can be found at [https://www.anthem.com/provider/credentialing/. This includes any Provider that state law says we must cover when they give you services that state law says we must cover. Providers that deliver Covered Services are described throughout this Benefit Booklet. If you have a question about a Provider not described in this Plan, please call Anthem Health Guide toll-free at **(8**33**)** 674-9256, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific).

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

Psychiatric Health Facility is an acute 24-hour Facility as defined in California Health and Safety Code 1250.2. It must be:

1. Licensed by the California Department of Health Services;
2. Qualified to provide short-term inpatient treatment according to the California Insurance Code;
3. Accredited by The Joint Commission (TJC); and
4. Staffed by an organized medical or professional staff which includes a Physician as medical director.

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

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

Residential treatment center is an inpatient Facility that treats Mental Health or substance use disorder conditions. The Facility must be licensed as a treatment center pursuant to state and local laws. The Facility must be fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

The term Residential Treatment Center/Facility does not include a provider, or that part of a provider, used mainly for:

- Nursing care

- Rest care
- Convalescent care
- Care of the aged
- Custodial Care
- Educational care

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

Single-Source Brand Name Drugs are drugs with no generic substitute.

Skilled nursing facility is a Facility licensed as a Skilled Nursing Facility in the state in which it is located that satisfies our accreditation requirements and is approved by us.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, or a place for rest, educational, or similar services.

Special Care Units are special areas of a Hospital which have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

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

Spouse meets the Plan's eligibility requirements for spouses as outlined under the "University of California Eligibility, Enrollment, Termination and Plan Administration Provisions" section and who has enrolled in the Plan.

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

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

UCMC Provider includes facility and professional services throughout California. Covered Services received from a UCMC Provider may be subject to lower Copayments than services received from other Providers and there is no Deductible when you use these Providers. To locate a UCMC Provider, please call Anthem Health Guide toll-free at **(833)** 674-9256, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific).

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

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

To find an Urgent Care Center, please call Anthem Health Guide number at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific) or you can also search online using the "Find a Doctor" function on the website at www.anthem.com/ca. Please call the Urgent Care Center directly for hours of operation and to verify that the center can help with the specific care that is needed.

We (us, our) refers to Anthem.

Year or **Benefit Year** is a 12 month period starting July 1 at 12:01 a.m. Pacific Standard Time.

You (your) refers to the Member and Dependents who are enrolled for Benefits under this Plan.

YOUR RIGHT TO APPEALS

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

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

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

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

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

Notice of Adverse Benefit Determination

If your claim is denied, Anthem’s notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific plan provision(s) on which Anthem’s determination is based;
- a description of any additional material or information needed to perfect your claim;
- an explanation of why the additional material or information is needed;
- a description of the plan’s review procedures and the time limits that apply to them if you appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision; and
- information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision; and
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you.

For claims involving urgent/concurrent care:

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

Appeals

You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and

other information supporting your claim. Anthem's review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

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

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

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

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

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

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

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

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

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

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

How Your Appeal will be Decided

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

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

Notification of the Outcome of the Appeal

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

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

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

Appeal Denial

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

Voluntary Second Level Appeals

If you are dissatisfied with the plan's mandatory first level appeal decision, a voluntary second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.

External Review

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

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

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

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

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

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

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

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

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent External Review.

Requirement to file an Appeal before taking further legal action

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

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

FOR YOUR INFORMATION

Anthem Blue Cross Web Site

Information specific to your Benefits and claims history are available by calling Anthem Health Guide toll-free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific). Anthem Blue Cross Life and Health is an affiliate of Anthem Blue Cross. You may use Anthem Blue Cross's web site to access benefit information, claims payment status, benefit maximum status, In-Network Providers or to order an ID card. Simply log on to www.anthem.com/ca, select "Member", and click the "Register" button on your first visit to establish a User ID and Password to access the personalized and secure MemberAccess Web site. Once registered, simply click the "Login" button and enter your User ID and Password to access the MemberAccess Web site.

Identity Protection Services

Anthem has made identity protection services available to Members. To learn more about these services, please visit https://anthemcares.allclearid.com/**.**

Language Assistance Program

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

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

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

Oral interpretation services are also available in these languages.

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

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

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

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

STATEMENT OF RIGHTS UNDER THE NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

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

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

In addition, a plan or issuer may not, under federal law, require that a Physician obtain authorization for prescribing a length of Stay of up to 48 hours (or 96 hours). However, to use certain Providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, please call Anthem Health Guide toll-free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific).

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

This Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides Benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). If you have any questions about this coverage, please call Anthem Health Guide toll-free at **(833) 674-9256**, Monday through Friday, 5:00 a.m. to 8:00 p.m. (Pacific).

Language Assistance Services for Self-Funded PPO Plans

English: Language assistance services, free of charge, are available to you. Call 1-877-437-0486 TTY Users Call 711.

Arabic: 711 ب اتصل تي 0486-437-877-1 بالرقم اتصل. مجانا لك متاحة اللغوية المساعدة خدمات.

Armenian: Լեզվի օգնության ծառայությունները մատչելի են ձեզ համար անվճար: Զանգահարեք 1-877-437-0486 TTY Users զանգահարեք 711:

Farsi: 0486-437-877-1 تلفن شماره با. است رایگان شما برای زبان به کمک خدمات TTY 711 بگیرید تماس.

Hindi: महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

Hmong: Cov kev pabcuam hauv kev txhais lus muaj rau koj dawb xwb. Hu rau 1-877-437-0486 TTY Cov Neeg Siv Hu Xov tooj 711.

Japanese: 言語支援サービスは無料でご利用いただけます。電話1-877-437-0486 TTYユーザーは711に電話をかける。

Khmer: សេវាកម្មជំនួយភាសាអាចរកបានសម្រាប់អ្នកដោយមិនគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-877-437-0486 អ្នកប្រើ TTY ហៅលេខ 711 ។

Korean: 언어 지원 서비스는 무료로 이용하실 수 있습니다. 전화 1-877-437-0486 TTY 사용자는 711에 전화하십시오.

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

Russian: Языковые услуги предоставляются вам бесплатно. Вызов 1-877-437-0486 Пользователи TTY Вызов 711.

Spanish: Los servicios de asistencia lingüística están disponibles gratuitamente. Llame al 1-877-437-0486 Usuarios de TTY Llame al 711.

Tagalog: Ang mga serbisyo ng tulong sa wika ay libre sa iyo. Tumawag sa 1-877-437-0486 Mga gumagamit ng TTY Tumawag sa 711.

Thai: มีบริการช่วยเหลือด้านภาษาโดยไม่เสียค่าใช้จ่าย โทร 1-877-437-0486 ผู้ใช้ TTY โทร. 711

Chinese: 免费提供语言援助服务。致电1-877-437-0486 TTY用户致电711。

Vietnamese: Các dịch vụ hỗ trợ ngôn ngữ có sẵn cho bạn miễn phí. Gọi số 1-877-437-0486 Người sử dụng TTY Gọi số 711.

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements

Discrimination is Against the Law. UC's Self-Funded Plans comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. The UC Self-Funded Plans do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

UC's Self-Funded Plans:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact 1-877-437-0486 (TTY 711).

If you believe that UC's Self-Funded Plans have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: UC's Lead Discrimination Affirmative Action Title IX Officer, 1111 Franklin St., 5th Floor, Oakland, CA 94607, Phone Number: (510) 987-0606, Fax Number: (510) 217-9114, Email: John.Sims@ucop.edu. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, UC's Lead Discrimination, Affirmative Action Title IX Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Claims Administered by:

ANTHEM BLUE CROSS

on behalf of

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

By authority of the Regents, UC Health, located in Oakland, administers all benefit plans in accordance with applicable plan documents and regulations, and custodial agreements, for Residents and Fellows, group insurance contracts, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by the Regents. Source documents are available for inspection upon request (I510-587-6410). What is written here does not constitute a guarantee of plan coverage or benefits—particular rules and eligibility requirements must be met before benefits can be received. The University of California intends to continue the benefits described here indefinitely; however, the benefits of all employees and plan beneficiaries are subject to change or termination at the time of contract renewal or at any other time by the University or other governing authorities. The University also reserves the right to determine new premiums, employer contributions and monthly costs at any time. Health and welfare benefits are not accrued or vested benefit entitlements. UC's contribution toward the monthly cost of the coverage is determined by UC and may change or stop altogether, and may be affected by the state of California's annual budget appropriation. If you belong to an exclusively represented bargaining unit, some of your benefits may differ from the ones described here. For more information, employees should contact their GME or Campus Human Resources office.

In conformance with applicable law and University policy, the University is an affirmative action/equal opportunity employer. Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to Systemwide AA/EEO Policy Coordinator, University of California, Office of the President, 1111 Franklin Street, 5th Floor, Oakland, CA 94607, and for faculty to the Office of Academic Personnel and Programs, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.