Benefit Booklet

(Referred to as “Booklet” in the following pages)

SISC

Self-Insured Schools of California

Schools Helping Schools

PPO

October 1, 2026

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.

Surprise Billing Claims

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

- Emergency Services provided by Out-of-Network Providers.
- Covered Services provided by an Out-of-Network Provider at an In-Network Facility.
- Out-of-Network Air Ambulance Services.

No Surprises Act Requirements

Emergency Services

As required by the CAA, Emergency Services are covered under your Plan:

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

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

Note that if you receive Emergency Services from an Out-of-Network Provider, your out-of-pocket costs will be limited to amounts that would apply if the Covered Services had been furnished by an In-Network Provider. However, Out-of-Network 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 an In-Network 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 cost shares, and the Out-of-Network Provider will also be able to charge you any difference between the Maximum Allowed 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.

Out-of-Network Services Provided at an In-Network Facility

When you receive Covered Services from an Out-of-Network Provider at an In-Network Facility, your out-of-pocket costs will be limited to amounts that would apply if the Covered Service had been furnished by an In-Network Provider. However, if the Out-of-Network Provider gives you proper notice of its charges, and you give written consent to such charges, claims will be paid at the Out-of-Network benefit level. 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 Allowed Amount and the Out-of-Network Provider's billed charges. This Notice and Consent process described below does not apply to Ancillary Services furnished by an Out-of-Network Provider at an In-Network Facility. Your out-of-pocket costs for claims for Covered Ancillary Services furnished by an Out-of-Network Provider at an In-Network Facility will be limited to amounts that would apply if the Covered Service had been furnished by an In-Network Provider. Ancillary Services are one of the following services: (A) Emergency Services; (B) anesthesiology; (C) laboratory and pathology services; (D) radiology; (E) neonatology; (F) diagnostic services; (G) assistant surgeons; (H) Hospitalists; (I) Intensivists; and (J) any services set out by the U.S. Department of Health & Human Services.

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

1. By obtaining your written consent not later than 72 hours prior to the delivery of services.
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.

Out-of-Network Air Ambulance Services

When you receive Covered Services from an Out-of-Network Air Ambulance Provider, your out-of-pocket costs will be limited to amounts that would apply if the Covered Service had been furnished by an In-Network Air Ambulance Provider.

How Cost Shares Are Calculated

Your cost shares for Surprise Billing Claims will be calculated based on the Recognized Amount. Any out-of-pocket cost shares you pay to an Out-of-Network Provider for either Emergency Services or for Covered Services provided by an Out-of-Network Provider at an In-Network Facility or for Covered Services provided by an Out-of-Network Air Ambulance Service Provider will be applied to your In-Network Out-of-Pocket Limit.

Appeals

If you receive Emergency Services from an Out-of-Network Provider or Covered Services from an Out-of-Network Provider at an In-Network Facility or Out-of-Network Air Ambulance Services and believe those services are covered by the No Surprise Billing 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 cost shares will be calculated based upon the Maximum Allowed Amount.

Transparency Requirements

The Claims Administrator provides the following information on its website:

- 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 covered items, services, and drugs, as required by the Centers for Medicare & Medicaid Services (CMS).
- A listing / directory of all In-Network Providers.

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

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

Federal Notices

Choice of Primary Care Physician

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

Access to Obstetrical and Gynecological (ObGyn) Care

You do not need Precertification from the Claims Administrator or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Precertification for certain services or following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your Identification Card or refer to our website, www.anthem.com/ca/sisc.

Statement of Rights Under the Newborns' and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, 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 cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay in excess of 48 hours (or 96 hours).

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 and 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, Copayment, Coinsurance, and out-of-pocket expenses on Mental Health and Substance Use Disorder benefits that are more restrictive than Deductibles, Copayment, Coinsurance, and out-of-pocket expenses applicable to substantially all other medical and surgical benefits in the same classification. Medical Necessity criteria and other plan documents showing comparative criteria, as well as the processes, strategies, evidentiary standards, and substantially all factors used to apply an NQTL are available upon request.

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

If you or your spouse are required, due to a QMCSO, to provide coverage for your child(ren), you may ask your Employer or SISC III to provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Statement of Rights Under the Women's Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. (See the "Schedule of Benefits" for details.) If you would like more information on WHCRA benefits, call the number on the back of your Identification Card.

Special Enrollment Notice

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility.
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program).

The Subscriber or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, contact your school district.

Community Assistance, Recovery, and Empowerment (CARE) Act

Benefits are provided for all health care services or Prescription Drugs a Member receives when required or recommended for the Member pursuant to a CARE agreement or CARE plan approved by a court in accordance with the court's authority under Sections 5977.1, 5977.2, 5977.3, and 5982 of the Welfare and Institutions Code. Anthem will cover the cost of developing an evaluation pursuant to Section 5977.1 of the Welfare and Institutions Code and the provision of all healthcare services for a Member when required or recommended for the Member pursuant to a CARE agreement or a CARE plan approved by a court in accordance with the court's authority, regardless of whether the service is provided by an In-Network or Out-of-Network Provider.
Precertification is not required for Covered Services in this provision, except for Prescription Drugs which will still require prior authorization. Covered Services under this provision are subject to post claims review, however, to determine appropriate payment of a claim. Payment for Covered Services in this provision may be denied only if we reasonably determine that you were not insured at the time of service, that the services were never performed, or that the services were not provided by a health care Provider appropriately licensed to provide the services.
Services provided to a Member pursuant to a CARE agreement or CARE plan, excluding Prescription Drugs, are not subject to a Copayment, Coinsurance or Deductible. Members cannot be billed for any services pursuant to a CARE agreement or CARE plan, regardless if the services are received from In-Network or Out-of-Network Providers.

Timely Access to Care

The Claims Administrator has contracted with health care service Providers to provide Covered Services in a manner appropriate for your condition, consistent with good professional practice. The Claims Administrator ensures that its contracted Provider networks have the capacity and availability to offer appointments within the timeframes specified below. Where there is no In-Network Provider available for a Medically Necessary Covered Service, an Authorized Referral for an Out-of-Network Provider may be provided at the In-Network cost share amounts (Deductible, Copayment, and/or Coinsurance). If you receive prior authorization for an Out-of-Network Provider due to network adequacy issues, you may still be responsible for the difference between the Provider's Out-of-Network charge and the Maximum Allowed Amount. Please contact Member Services at the telephone number on the back of your Identification Card for Authorized Referrals information or to request authorization.

For Medical care:

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

For Mental Health and Substance Use Disorder care:

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

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

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

For Medical care:

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

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, the Claims Administrator will provide a Complaint Form which you may use to explain the matter.

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

Claims Administered by:

ANTHEM BLUE CROSS

on behalf of

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

Introduction

This Benefit Booklet gives you a description of your benefits while you are enrolled under the health care plan (the "Plan"). The benefits of this plan are provided for medically necessary services and supplies for the subscriber and enrolled dependents for a covered condition, subject to all of the terms and conditions of this plan, the participation agreement between the participating employers and SISC III, and the eligibility rules of SISC III. You should read this Benefit Booklet carefully to get to know the Plan's main provisions and keep it handy for reference. A thorough understanding of your coverage will allow you to use your benefits wisely.

SISC III has agreed to be subject to the terms and conditions of the Administrator'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 Plan benefits described in this Benefit Booklet are for eligible Members only. The health care services are subject to the Limitations and Exclusions, Copayments, Deductible, and Coinsurance rules given in this Benefit Booklet. Any group plan which you received before will be replaced by this Benefit Booklet.

Many words used in the Benefit Booklet have special meanings (e.g., SISC, SISC III, Covered Services and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. See these definitions for the best understanding of what is being stated. Throughout this Booklet you may also see references to "we," "us," "our," "you," and "your." The words "we," "us," and "our" refer to the Claims Administrator or The Plan or any of our subsidiaries, affiliates, subcontractors, or designees. The words "you" and "your" mean the Member, Subscriber and each covered Dependent.

If you have any questions about your Plan, please be sure to call Member Services at the number on the back of your Identification Card. Also be sure to check the Claims Administrator's website, www.anthem.com/ca/sisc for details on how to locate a Provider, get answers to questions, and access valuable health and wellness tips.

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

Anthem is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, permitting Anthem to use the Blue Cross Service Mark in the State of California. Although Anthem is the Claims Administrator and is licensed in California you will have access to providers participating in the Blue Cross and Blue Shield Association BlueCard® PPO network across the country. Anthem has entered into a contract with SISC on its own behalf and not as the agent of the Association.

Note: Prescription Drugs are not covered under this Plan. Prescription Drugs received from a Retail or Home Delivery (Mail Order) Pharmacy are not covered under this Plan. Benefits for drugs received from a Retail or Home Delivery (Mail Order) Pharmacy are covered under another vendor or plan provided by your employer. Please see your employer for details on benefits for prescription drugs.

How to Get Language Assistance

The Claims Administrator is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of our Member Services call centers. Simply call the Member Services phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Member Services. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

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Schedule of Benefits

In this section you will find an outline of the benefits included in your Plan and a summary of any Deductibles, Coinsurance, and Copayments that you must pay. Also listed are any Benefit Period Maximums or limits that apply. Please read the “What’s Covered” for more details on the Plan’s Covered Services. Read the “What’s Not Covered” section for details on Excluded Services.

All Covered Services are subject to the conditions, Exclusions, limitations, and terms of this Booklet including any endorsements, amendments, or riders.

Note: To get the highest benefits at the lowest out-of-pocket cost, you must get Covered Services from an In-Network Provider. Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. Except for Surprise Billing Claims, when you use Out-of-Network Providers you may have to pay the difference between the Out-of-Network Provider’s billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please read the “Claims Payment” section for more details.

Coinsurance and Benefit Period Maximums are calculated based upon the Maximum Allowed Amount, not the Provider’s billed charges.

Essential Health Benefits provided within this Booklet are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a benefit period and/or dollar maximum.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories.

- **Ambulatory patient services.**
- **Emergency services.**
- **Hospitalization.**
- **Maternity and newborn care.**
- **Mental Health and Substance Use Disorder services, including behavioral health treatment.**
- **Rehabilitative and habilitative services and devices.**
- **Laboratory services.**
- **Preventive and wellness services.**
- **Chronic disease management and pediatric services, including oral and vision care.**

Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

Benefit Period	Calendar Year
Dependent Age Limit	Available to the end of the calendar month in which the child turns 26. Please see the “Eligibility and Enrollment – Adding Members” section for further details.

Coinsurance	**In-Network**	**Out-of-Network**
Plan Pays	100%	100%

Coinsurance	In-Network	Out-of-Network
Member Pays	0%	0%

Reminder: Your Coinsurance will be based on the Maximum Allowed Amount. Except for Surprise Billing Claims, if you use an Out-of-Network Provider, you may have to pay Coinsurance plus the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount.

Maximum Allowed Amount and Your Copayment or Coinsurance: The Maximum Allowed Amount for Out-of-Network Providers is significantly lower than what Providers customarily charge. You must pay all of this excess amount in addition to your Copayment or Coinsurance.

Note: The Coinsurance listed above may not apply to all benefits, and some benefits may have a different Coinsurance. Please see the rest of this Schedule for details.

Out-of-Pocket Limit	In-Network	Out-of-Network
Per Member	$1,000	Unlimited
Per Family – All other Members combined	$3,000	Unlimited

Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.

No one person will pay more than their individual In-Network Out-of-Pocket Limit.

The In-Network Out-of-Pocket Limit includes all Coinsurance and Copayments you pay during a Benefit Period unless otherwise indicated below. Once the In-Network Out-of-Pocket Limit is satisfied, you will not have to pay any additional Coinsurance or Copayments for the rest of the Benefit Period,

There is no Out-of-Network Out-of-Pocket Limit, and the In-Network Out-of-Pocket Limit does not apply to Out-of-Network services.

The Out-of-Pocket Limit does not include amounts you pay for the following.
These costs are always your responsibility:

- Amounts paid for Out-of-Network services, including applicable Copayments, Coinsurance, facility charges, and amounts exceeding the Out-of-Network provider allowance;
- Charges exceeding the Maximum Allowed Amount.
- Amounts you pay for non-Covered Services or supplies, including services that are not medically necessary.
- Penalties for not getting required Precertification.

Important Notice about Your Cost Shares

In certain cases, if the Plan pays a Provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, SISC III may collect such amounts directly from you. You agree that we, on behalf of the Employer, have the right to collect such amounts from you.

The tables below outline the Plan's Covered Services and the cost share(s) you must pay. In many spots you will see the statement, "Benefits are based on the setting in which Covered Services are received." In these cases, you should determine where you will receive the service (i.e., in a Doctor's office, at an outpatient hospital facility, etc.) and look up that location to find out which cost share will apply. For example, you might get physical therapy in a Doctor's office, an outpatient hospital facility, or during an inpatient hospital stay. For services in the office, look up "Office and Home Visits." For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services during an inpatient stay, look up "Inpatient Services." For services involving Mental Health, Substance Use Disorder, or behavioral health treatment for Autism Spectrum Disorders, look up "Mental Health and Substance Use Disorder Services."

This Plan has two types of Providers.

- **In-Network Providers** who contract with us and charge a lower Copayment / Coinsurance on many services.
- **Out-of-Network Providers subject to Maximum Dollar Amounts for services or supplies** are Not In-Network Providers and are Not contracted with us. No Coinsurance applies, except member is responsible for any amount exceeding the maximum allowed amount in this Plan.

Please see "How Your Plan Works" for more information on In-Network and Out-of-Network Providers.

Medical Benefit Maximum

The plan may pay for the following services and supplies, up to the maximum number of days or visits shown. When using an out-of-network provider, the plan will pay the lesser of the benefit maximum or the maximum allowed amount. If the maximum allowed amount is less than the listed benefit maximum, the plan will not exceed the maximum allowed amount. Likewise, if the listed benefit maximum is less than the maximum allowed amount, the plan will not exceed the listed benefit maximum. Providers may also bill you for any charges over the Plan's Maximum Allowed Amount or benefit maximum.

Benefits	In-Network	Out-of-Network
Acupuncture	See "Therapy Services."	
Allergy Services	Benefits are based on the setting in which Covered Services are received.	
Ambulance Services (Ground, Air and Water)	$100 Copayment per trip	$100 Copayment per trip

Note:

- All scheduled ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through Precertification. Please see "Getting Approval for Benefits" for details.
- For ground or water ambulance services, Out-of-Network Providers may bill you for any charges over the Plan's Maximum Allowed Amount.
- For air ambulance services, Out-of-Network Providers may not bill you for any charges over the Plan's Maximum Allowed Amount.
- When using a ground or air ambulance for non-Emergency transportation, the Plan reserves the right to select the ground or air ambulance Provider. If you do not use the ground or air ambulance Provider the Plan selects, no benefits will be available.
- Benefits for non-Emergency air ambulance services will be limited to $50,000 per trip if an Out-of-Network Provider is used. The Plan will pay the lesser of the benefit maximum or the Maximum Allowed Amount.

Benefits	In-Network	Out-of-Network
Autism Spectrum Disorders	Mental Health and Substance Use Disorder Services are covered as required by federal law. Please see the rest of this Schedule for the cost shares that apply in each setting.	
Bariatric Surgery **Bariatric surgery is covered only when performed at a designated Blue Distinction (BD) and Blue Distinction+ (BD+).**		
• Inpatient Services (designated Hospital)	No Coinsurance	Not covered
• Outpatient Facility Services (designated Hospital or Ambulatory Surgery Center)	No Coinsurance	Not covered
Bariatric Surgery Travel Expense Bariatric travel expense coverage is available when the closest Blue Distinction (BD) or Blue Distinction+ (BD+) Facility is 50 miles or more from the Member's residence.	No Copayment, Deductible or Coinsurance	Not covered
• Bariatric Surgery Travel Expense Benefit Maximum	For the Member and 1 companion: Up to $3,000 per procedure. Maximum of 3 trips per procedure: 1 pre-operative trip, 1 surgery trip, and 1 post-operative trip, if needed.	
• Hotel Accommodations Benefit Maximum	For the Member and 1 companion: 1 night maximum per pre-operative or post-operative trip, if needed. 7 nights maximum per surgery trip. $150 per night maximum. $250 per night room rate in higher cost areas according to GSA.gov lodging website.	
- Flight	Economy / Coach (preferred seats for surgery trip when aisle seat is not available)	
- Check in bag fees	1 bag each for each flight	
- Ground Transportation (rental)	Economy / Intermediate / Standard Travel benefit includes rental car rate, taxes and insurance for the planned dates. Any additional products or services are not covered.	
- Ground Transportation (personal car)	Mileage reimbursement is based on current limits set forth in the Internal Revenue Code, not to exceed the maximum amount specified above.	
- Meals	Not covered	

Benefits	In-Network	Out-of-Network
Behavioral Health Services	Mental Health and Substance Use Disorder Services are covered as required by state and federal law. Please see the rest of this Schedule for the cost shares that apply in each setting.	
Cellular and Gene Therapy Service Precertification required	See the "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services" section later in this Schedule of Benefits.	
Clinical Trials	Benefits are based on the setting in which Covered Services are received.	
Dental Services (All Members / All Ages)	Benefits are based on the setting in which Covered Services are received.	
Diabetes Equipment, Education, and Supplies Screenings for gestational diabetes are covered under "Preventive Care."	Benefits for diabetic education are based on the setting in which Covered Services are received.	
Diagnostic Services	Benefits are based on the setting in which Covered Services are received. Please see those settings to determine your cost share.	
All Diagnostic Services are based on the setting in which Covered Services are received. Please see those settings to determine your Cost Share.		
Doula Services		
• Prenatal / Postnatal Visit	$20 Copayment per visit	No Copayment, Deductible or Coinsurance
• Prenatal / Postnatal Visit Benefit Maximum (combined)	Benefit maximum of 9 visits per Benefit Period In- and Out-of-Network combined.	
• Doula Support Services Provided During or After Miscarriage	$20 Copayment per visit	No Copayment, Deductible or Coinsurance
• Labor/Delivery Support Provided by a Doula	See "Inpatient Services."	

Benefits	In-Network	Out-of-Network
Durable Medical Equipment (DME), Medical Devices and Supplies		
• Durable Medical Equipment (DME) and Medical Devices	No Copayment, Deductible or Coinsurance	Not covered
• Prosthetics	No Copayment, Deductible or Coinsurance	Not covered
• Prosthetics Limbs	No Copayment, Deductible or Coinsurance	Not covered
• Orthotics	No Copayment, Deductible or Coinsurance	Not covered
• Orthotics Benefit Maximum	Orthotics are limited to 2 pair per calendar year. Post-surgery, an additional 2 pair Orthotics are covered.	Not covered
The cost shares listed above apply when your Provider submits separate bills for the equipment or supplies.		
The Plan's reimbursement for durable medical equipment, orthotics, prosthetics, devices and supplies will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary to meet your needs. If you choose to purchase an item with features that exceed what is Medically Necessary, benefits will be limited to the Maximum Allowed Amount for the standard item, and you will be required to pay any costs that exceed the Maximum Allowed Amount. Please check with your Provider or contact us if you have questions about the Maximum Allowed Amount.		
• Surgical Implants	No Copayment, Deductible or Coinsurance	Not covered
• Hearing Aids	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
• Hearing Aids Benefit Maximum	$700 combined for both ears every 24 months** In- and Out-of-Network combined.	
**The Plan will pay the lesser of the benefit maximum or the Maximum Allowed Amount. Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount or benefit maximum.		
• Wigs Needed After Cancer Treatment	No Copayment, Deductible or Coinsurance	Not covered
• Wigs Needed After Cancer Treatment Benefit Maximum	Benefit maximum of 1 wig per Benefit Period.	Not Applicable

Benefits	In-Network	Out-of-Network
Emergency Room Services		
Emergency Room		
• Emergency Room Facility Charge	$100* Copayment per visit	$100* Copayment per visit
• Urgent Care Facility Charge	$100* Copayment per visit	$100* Copayment per visit
*Your Copayment will not apply if you are admitted to the Hospital as inpatient immediately following Emergency Room treatment.		
• Emergency Room Doctor Charge (ER Physician, Radiologist, Anesthesiologist, Surgeon, etc.)	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
• Emergency Room Doctor Charge (Mental Health and Substance Use Disorder)	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
• Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
For Emergency room services from an Out-of-Network Provider, you will pay the Out-of-Network Provider no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider.		
As described in the “Consolidated Appropriations Act of 2021 Notice” at the front of this Booklet, for Emergency Services, Out-of-Network Providers may only bill you for any applicable Copayments, Deductible and Coinsurance and may not bill you for any charges over the Plan’s Maximum Allowed Amount until the treating Out-of-Network Provider has determined you are stable and followed the notice and consent process. Please refer to the Notice at the beginning of this Booklet for more details.		

Benefits	In-Network	Out-of-Network
Gender Affirming Services Precertification required	No Coinsurance	No Coinsurance
• **Gender Affirming Services Travel Expense** For an approved Gender Affirming surgery, the following travel expenses incurred by the Member and/or 1 companion are covered. - Ground transportation for the Member and/or 1 companion to and from the Hospital when it is 75 miles or more from the Member's place of residence. - Coach airfare to and from the Hospital when it is 300 miles or more from the Member's place of residence. - Lodging, limited to 1 room, double occupancy. - Other reasonable expenses. Meals, tobacco, alcohol and drug expenses are excluded from coverage.	No Copayment, Deductible or Coinsurance	
• Gender Affirming Services Travel Expense Benefit Maximum	For the Member and 1 companion, up to $10,000 per procedure.	
The Gender Affirming Medical Benefits are based on the Standards of Care published by the World Professional Association for Transgender Health (WPATH). All Gender Affirming services are subject to Precertification review to determine medical necessity. Please see "Getting Approval for Benefits" for details.		
Habilitative Services Outpatient Facility Services	Benefits are based on the setting in which Covered Services are received. See "Office Visits" and "Outpatient Facility Services" for details on Benefit Maximums.	
Hip, Knee Replacement or Spine Surgery Services **Blue Distinction+ Requirement** The Blue Distinction+ (BD+) hospital requirement applies to inpatient Hip Replacement, Knee Replacement or Spine Surgery. The BD+ requirement does not apply to outpatient Hip Replacement, Knee Replacement or Spine Surgery. Covered inpatient procedures include Total/Revision Knee Replacement, Total/Revision Hip Replacement, Discectomy, Decompression (without fusion), Primary Fusion, and Revision Fusion.		
Inpatient Facility Services*	No Coinsurance	Not covered

Benefits	In-Network	Out-of-Network

*Inpatient services and supplies provided for Hip Replacement, Knee Replacement and Spine Surgery must be performed by a designated Blue Distinction+ (BD+) hospital. No coverage if inpatient services and supplies are provided by a hospital that is not designated as Blue Distinction+ (BD+). To find a Blue Distinction+ (BD+) hospital facility, please contact Member Services and/or visit www.anthem.com/ca/sisc.

Inpatient Hip Replacement, Knee Replacement or Spine Surgery services are subject to Precertification review to determine medical necessity. Please see "Getting Approval for Benefits" for details.

Blue Distinction+ Exceptions

The Blue Distinction+ requirement does not apply to the following:

- Emergencies
- Members under the age of 18
- Urgent surgery to treat a recent fracture
- Additional complications such as cancer
- You have primary coverage with Medicare or another carrier
- You live outside of the state of California

Outpatient Facility Services	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance

The Blue Distinction+ (BD+) hospital requirement does not apply to outpatient Hip Replacement, Knee Replacement or Spine Surgery. Benefits follow the plan's ordinary outpatient surgery setting benefits shown in this Schedule.

Travel Expenses	No Copayment, Deductible or Coinsurance	Not covered

Coverage is available when the closest Blue Distinction+ (BD+) Facility is 50 miles or more from the Member's residence. Hip replacement, knee replacement or spine surgery travel expense will only be covered through HealthBase. For reimbursable expenses by HealthBase, the Member must first call Member Services, who will submit the Referral to HealthBase. HealthBase will contact the Member to begin travel arrangements.

• Travel Expense Benefit Maximum	For the Member and 1 companion: Up to $6,000 per procedure. Maximum of 3 trips per procedure: 1 pre-operative trip, 1 surgery trip, and 1 post-operative trip, if needed.
• Hotel Accommodations Benefit Maximum	For the Member and 1 companion: 1 night maximum per pre-operative or post-operative trip, if needed. 7 nights maximum per surgery trip. $150 per night maximum. $250 per night room rate in higher cost areas according to GSA.gov lodging website.
- Flight	Economy / Coach (preferred seats for surgery trip when aisle seat is not available)
- Check in bag fees	1 bag each for each flight

Benefits	In-Network	Out-of-Network
- Ground Transportation (rental)	Economy / Intermediate / Standard Travel benefit includes rental car rate, taxes and insurance for the planned dates. Any additional products or services are not covered.	
- Ground Transportation (personal car)	Mileage reimbursement is based on current limits set forth in the Internal Revenue Code, not to exceed the maximum amount specified above.	
- Meals	Not covered	
Home Health Care		
• Home Health Care Visits from a Home Health Care Agency (including intermittent skilled nursing services)	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance $150 per day benefit maximum not to exceed the Maximum Allowed Amount**
• Home Health Care Benefit Maximums	100 visits per Benefit Period, Home Health Care and Private Duty Nursing combined, In- and Out-of-Network combined. Home health aide: 4 hours maximum per visit. Home Infusion Therapy and Home Dialysis do not count toward the Home Health Care visit maximum.	
• Private Duty Nursing (only when billed by a Home Health Care Agency)	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance $150 per day benefit maximum not to exceed the Maximum Allowed Amount**
• Private Duty Nursing Benefit Maximums	Included in the shared 100-visit Home Health Care and Private Duty Nursing maximum per Benefit Period, In- and Out-of-Network combined.	
**The Plan will pay the lesser of the benefit maximum or the Maximum Allowed Amount. Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount or benefit maximum.		
• Dialysis	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance $350 per visit benefit maximum not to exceed the Maximum Allowed Amount**

Benefits	In-Network	Out-of-Network
**The Plan will pay the lesser of the benefit maximum or the Maximum Allowed Amount. Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount or benefit maximum.		
• Home Infusion Therapy/Chemotherapy	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance $600 per day benefit maximum not to exceed the Maximum Allowed Amount**
**The Plan will pay the lesser of the benefit maximum or the Maximum Allowed Amount. Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount or benefit maximum.		
• Other Home Health Care Services / Supplies	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
Hospice Care		
• Home Hospice Care	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
• Bereavement	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
• Inpatient Hospice	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
• Outpatient Hospice	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
• Respite Care	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount. 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.		
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services Precertification required	**Note on Kidney Transplants:** If you choose to receive a kidney transplant from an In-Network Transplant Provider, benefits will be paid under the "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services" section later in this Schedule. If you choose to receive a kidney transplant from any other Provider, benefits will be paid as any other surgery.	

Benefits	In-Network	Out-of-Network
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services		

Please call the Plan's Transplant Department as soon as you think you may need a Covered Procedure to talk about your benefit options. To get the In-Network Level of benefits under your Plan, you must get certain Covered Procedures from an Approved In-Network Provider. Even if a Hospital is an In-Network Provider for other services, it may not be an Approved In-Network Provider for certain Covered Procedures. Please see the "What's Covered" section for further details.

The requirements described below do not apply to the following.

- Cornea and kidney transplants, which are covered as any other surgery.
- Any Covered Services related to a Covered Transplant Procedure that you get before or after the Transplant Benefit Period. Please note that the initial evaluation, any added tests to determine your eligibility as a candidate for a transplant by your Provider, and the collection and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

Benefits for Covered Services that are not part of the Human Organ and Tissue Transplant benefit will be based on the setting in which Covered Services are received. Please see the "What's Covered" section for additional details.

	Approved In-Network Provider	All Other Providers
Covered Procedure Benefit Period	The number of days or the applicable case rate / global time period will vary depending on the type of Covered Procedure and the Approved In-Network Provider agreement. Before and after the Covered Procedure Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending on where the service is performed.	Not applicable – There is no unique Benefit Period for services from All Other Providers.
Inpatient Facility Services • Precertification required	No Copayment, Deductible or Coinsurance	Not covered
Inpatient Professional and Ancillary (non-Hospital) Services	No Copayment, Deductible or Coinsurance	Not covered
Outpatient Facility Services	No Copayment, Deductible or Coinsurance	Not covered

Benefits	In-Network	Out-of-Network
Outpatient Facility Professional and Ancillary (non-Hospital) Services	No Copayment, Deductible or Coinsurance	Not covered
Travel Expenses	No Copayment, Deductible or Coinsurance	Not covered
• Transportation and Lodging Limit	For the Member and 1 companion (2 companions if the Member is a minor), covered as approved by us, up to $10,000 per transplant. In-Network only. Benefits are not available Out-of-Network.	
Unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants for a Covered Human Organ or Tissue Transplant Procedure	No Copayment, Deductible or Coinsurance	Not covered
• Donor Search Limit	Covered, as approved by us, up to $30,000 per transplant. In-Network only. Benefits are not available Out-of-Network.	
Live Donor Health Services		
• Inpatient Facility Services	No Copayment, Deductible or Coinsurance	Not covered
• Outpatient Facility Services	No Copayment, Deductible or Coinsurance	Not covered
• Donor Health Service Limit	Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to 6 weeks from the date of procurement.	
Inpatient Services		
Facility Room & Board Charge:		
• Hospital / Acute Care Facility	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance $600* per day benefit maximum not to exceed the Maximum Allowed Amount**

*The maximum does not apply to Emergency Medical Conditions.

**The Plan will pay the lesser of the benefit maximum or the Maximum Allowed Amount. Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount or benefit maximum.

Benefits	In-Network	Out-of-Network
• Skilled Nursing Facility	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance $600 per day benefit maximum not to exceed the Maximum Allowed Amount**
• Rehabilitation	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance $600 per day benefit maximum not to exceed the Maximum Allowed Amount**
**The Plan will pay the lesser of the benefit maximum or the Maximum Allowed Amount. Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount or benefit maximum.		
• Skilled Nursing Facility / Rehabilitative Services Benefit Maximum	150 days per Benefit Period In- and Out-of-Network combined	
• Doctor Services when billed separately from the Facility for:		
- General Medical Care / Evaluation and Management (E&M) / Physician fees	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
- Surgery	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
- Maternity	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
Maternity and Reproductive Health Services		
• Maternity Visits (Global fee for the ObGyn's prenatal, postnatal and delivery services)	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
If you change Doctors during your pregnancy, the prenatal and postnatal fees will be billed separately.		
• Prenatal and Postpartum Office Visits	No Copayment, Deductible or Coinsurance for the first 3 visits then $20 Copayment per visit*	No Copayment, Deductible or Coinsurance
*These visits count toward the shared first 3 In-Network visits per Benefit Period described in the Note on First 3 Visit Copayments.		

Benefits	In-Network	Out-of-Network
If you obtain prenatal or postnatal care from a provider that is not your main Ob or ObGyn, (e.g. specialty care, labs, fetal non-stress tests, ultrasounds, etc.) or for services covered outside of your main ObGyn's Global Fee, benefits are based on the setting in which Covered Services are received. Please see those settings to determine your cost share. If you obtain services other than Prenatal or Postpartum Office Visits (e.g., postnatal office visits), please see that setting for your cost share.		
• Inpatient Services (Delivery)	See "Inpatient Services."	
Newborn / Maternity Stays: If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission.		
Mental Health and Substance Use Disorder Services (includes behavioral health treatment for Autism Spectrum Disorders)		
Inpatient Services		
• Inpatient psychiatric hospitalization	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance $600* per day benefit maximum not to exceed the Maximum Allowed Amount**
*The maximum does not apply to Emergency Services. **The Plan will pay the lesser of the benefit maximum or the Maximum Allowed Amount. Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount or benefit maximum.		
• Residential Treatment Center Services	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance $600* per day benefit maximum not to exceed the Maximum Allowed Amount**
*The maximum does not apply to Emergency Services. **The Plan will pay the lesser of the benefit maximum or the Maximum Allowed Amount. Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount or benefit maximum.		
• Inpatient Provider Services (e.g., Doctor and other professional Providers)	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
Outpatient Services		
• Outpatient Services	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance

Benefits	In-Network	Out-of-Network
• Partial Hospitalization Program (PHP) (Facility)	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
• Partial Hospitalization Program (PHP) (professional)	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
• Intensive Outpatient Program (IOP) (Facility)	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
• Intensive Outpatient Program (IOP) (professional)	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
• Behavioral health treatment for Autism Spectrum Disorders delivered in the home	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
• Outpatient Office Visits (Including In-Person and/or Virtual Visits and Intensive In-Home Behavioral Health Programs) - Individual / group Mental Health evaluation and treatment - Individual / group chemical dependency counseling - Medical treatment for withdrawal symptoms	$20 Copayment per visit	No Copayment, Deductible or Coinsurance

Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount.

Please see "Mental Health and Substance Use Disorder Services" under the "What's Covered" section for a listing of Covered Services.

Mental Health and Substance Use Disorder Services / chemical dependency will be covered as required by state and federal law. Please see "Mental Health Parity and Addiction Equity Act" in the "Additional Federal Notices" section for details.

Office and Home* Visits

*Home visits are not the same as Home Health Care. For Home Health Care benefits please see the "Home Health Care" section.

• Primary Care Physician / Provider (PCP) (Including In-Person and/or Virtual Visits)	No Copayment, Deductible or Coinsurance for the first 3 visits then $20 Copayment per visit*	No Copayment, Deductible or Coinsurance
• Additional Telehealth/Telemedicine Services from a Primary Care Provider (PCP) (as required by law)	No Copayment, Deductible or Coinsurance for the first 3 visits then $20 Copayment per visit*	No Copayment, Deductible or Coinsurance

Benefits	In-Network	Out-of-Network
*Note on First 3 Visit Copayments: The first 3 visits per Benefit Period are not subject to a copay and are a shared pool across applicable In-Network Primary Care Physician / Provider office visits and PCP telehealth/telemedicine visits, Prenatal and Postpartum Office Visits. This applies only to the charge for the applicable visit itself. It does not apply to any other charges made during that visit, such as testing procedures, surgery, etc. Starting with the fourth combined visit, the applicable Copayment applies. Preventive Care, Retail Health Clinic visits, and Urgent Care are covered separately. The Plan defines a primary care physician as a physician specializing in family practice, general practice, internal medicine, pediatrics, obstetrics, gynecology, OB/GYN and nurse practitioner.		
• Specialty Care Physician / Provider (SCP) (Including In-Person and/or Virtual Visits)	$20 Copayment per visit	No Copayment, Deductible or Coinsurance
• Additional Telehealth/Telemedicine Services from a Specialty Care Provider (SCP) (as required by law)	$20 Copayment per visit	No Copayment, Deductible or Coinsurance
• Retail Health Clinic Visit	$20 Copayment per visit	No Copayment, Deductible or Coinsurance
• Virtual Visits by LiveHealth Online (LHO) (Including Primary Care and Mental Health & Substance Use Disorder Services)	No Copayment, Deductible or Coinsurance	Not Applicable
• Other Virtual Visits (including Primary Care and Mental Health & Substance Use Disorder Services)	$20 Copayment per visit	No Copayment, Deductible or Coinsurance
Additional Services in an Office Setting In addition to the applicable Office Visit Copayment listed above, if you receive any services listed below that have a Coinsurance cost share, the cost share for those services will also apply.		
• Counseling – Includes Family Planning and Nutritional Counseling (Other Than Eating Disorders)	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
• Nutritional Counseling for Eating Disorders	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
• Allergy Testing	No Copayment, Deductible or Coinsurance	Not covered
• Shots / Injections (including allergy shots and allergy serum)	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
• Diagnostic Labs	No Copayment, Deductible or Coinsurance	Not covered
• Diagnostic X-ray	No Copayment, Deductible or Coinsurance	Not covered
• Other Diagnostic Tests (including Hearing Exams and EKG)	No Copayment, Deductible or Coinsurance	Not covered

Benefits	In-Network	Out-of-Network
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance $800 per procedure benefit maximum not to exceed the Maximum Allowed Amount**
**The Plan will pay the lesser of the benefit maximum or the Maximum Allowed Amount. Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount or benefit maximum.		
• Office Surgery	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
• Therapy Services:		
- Physical Therapy/ Occupational Therapy/ Chiropractic/Osteopathic / Manipulative Therapy	No Copayment, Deductible or Coinsurance	Not covered
Precertification is required after any combination of 5 physical medicine visits per Benefit Period for Physical Therapy, Occupational Therapy, and Chiropractic / Osteopathic / Manipulative Therapy. There is no limit on the number of covered visits for Medically Necessary Physical Therapy, Occupational Therapy, and Chiropractic / Osteopathic / Manipulative Therapy. Visits are counted per Benefit Period, per Member, and are accumulated regardless of provider type. If Precertification is not obtained, services may be reviewed upon receipt of the claim. Precertification review is not required if physical medicine services are provided in an outpatient hospital setting, when Medicare is the primary insurance, or outside the state of California. See "Therapy Services" for further details.		
- Speech Therapy	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
- Dialysis	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance $350 per visit benefit maximum not to exceed the Maximum Allowed Amount**
**The Plan will pay the lesser of the benefit maximum or the Maximum Allowed Amount. Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount or benefit maximum.		
- Radiation Therapy	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
- Chemotherapy	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance

Benefits	In-Network	Out-of-Network
- Respiratory Therapy	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
- Cardiac Rehabilitation	No Copayment, Deductible or Coinsurance	Not covered
- Pulmonary Therapy	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
• Acupuncture	No Copayment, Deductible or Coinsurance	50% Coinsurance
• Acupuncture Benefit Maximum	Benefit maximum of 12 visits per Benefit Period In- and Out-of-Network combined.	
• Non-Specialty Prescription Drugs Administered in the Office	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
• Specialty Prescription Drugs Administered in the Office	No Copayment, Deductible or Coinsurance	Not covered
Orthotics	See “Durable Medical Equipment (DME), Medical Devices and Supplies.”	
Other Eligible Providers	No Coinsurance plus all charges in excess of the Maximum Allowed Amount	
Nurse anesthetists and blood banks do not enter into participating agreements with us, and these Providers must be licensed according to state and local laws to provide covered medical services.		
Outpatient Facility Services		
• Arthroscopy Surgery (Outpatient Hospital Setting)	No Copayment, Deductible or Coinsurance $4,500 per procedure benefit maximum	No Copayment, Deductible or Coinsurance
• Cataract Surgery (Outpatient Hospital Setting)	No Copayment, Deductible or Coinsurance $2,000 per procedure benefit maximum	No Copayment, Deductible or Coinsurance

Benefits	In-Network	Out-of-Network
• Colonoscopy (Outpatient Hospital Setting)	No Copayment, Deductible or Coinsurance $1,500 per procedure benefit maximum	No Copayment, Deductible or Coinsurance
• Colonoscopy (Ambulatory Surgical Facility)	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
• Upper GI Endoscopy (Outpatient Hospital Setting)	No Copayment, Deductible or Coinsurance $1,000 per procedure benefit maximum	No Copayment, Deductible or Coinsurance
• Upper GI Endoscopy with Biopsy (Outpatient Hospital Setting)	No Copayment, Deductible or Coinsurance $1,250 per procedure benefit maximum	No Copayment, Deductible or Coinsurance
Note: The benefit maximum for Arthroscopy Surgery, Cataract Surgery, Colonoscopy, Upper GI Endoscopy and Upper GI Endoscopy with Biopsy does not apply to the following: • The surgery is performed in an in-network Ambulatory Surgical Facility. • The Member lives more than 50 miles from an In-Network Ambulatory Surgical Facility. • If no appointment is available for the Member at an In-Network Ambulatory Surgical Facility within a reasonable period of time. • The provider can provide clinical documentation supporting the need for an outpatient setting. The member should consult their physician and contact member services prior to the procedure for instructions on how to receive an approved exception.		
• Facility Surgery Charge (Outpatient Surgery Facility Charges for all other surgeries)	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
• Urgent Care Facility Charge	$100* Copayment per visit	$100* Copayment per visit
• Other Facility Surgery Charges (including diagnostic x-ray and lab services, medical supplies)	No Copayment, Deductible or Coinsurance	Not covered
• Ambulatory Surgical Facility - Facility Surgery	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance $350 per admission benefit maximum not to exceed the Maximum Allowed Amount**

Benefits	In-Network	Out-of-Network
**The Plan will pay the lesser of the benefit maximum or the Maximum Allowed Amount. Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount or benefit maximum.		
• Doctor Surgery Charges	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
• Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant, Nutritional Counseling and Diabetes Education)	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
• Other Facility Charges (for procedure rooms or other ancillary services)	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
Additional Services in an Outpatient Facility Setting		
If you receive only 1 or more of the services listed below, you will be responsible only for the cost shares for those services. You will not in addition have to pay the Facility charge.		
• Shots / Injections (including allergy shots and allergy serum)	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
• Diagnostic Labs	No Copayment, Deductible or Coinsurance	Not covered
• Diagnostic X-ray	No Copayment, Deductible or Coinsurance	Not covered
• Other Diagnostic Tests (including Hearing Exams and EKG)	No Copayment, Deductible or Coinsurance	Not covered
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance $800 per procedure benefit maximum not to exceed the Maximum Allowed Amount**
**The Plan will pay the lesser of the benefit maximum or the Maximum Allowed Amount. Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount or benefit maximum.		
Therapy Services:		
• Physical Therapy/ Occupational Therapy/ Chiropractic/Osteopathic / Manipulative Therapy	No Copayment, Deductible or Coinsurance	Not covered

Benefits	In-Network	Out-of-Network
Precertification is required after any combination of 5 physical medicine visits per Benefit Period for Physical Therapy, Occupational Therapy, and Chiropractic / Osteopathic / Manipulative Therapy. There is no limit on the number of covered visits for Medically Necessary Physical Therapy, Occupational Therapy, and Chiropractic / Osteopathic / Manipulative Therapy. Visits are counted per Benefit Period, per Member, and are accumulated regardless of provider type. If Precertification is not obtained, services may be reviewed upon receipt of the claim. Precertification review is not required if physical medicine services are provided in an outpatient hospital setting, when Medicare is the primary insurance, or outside the state of California. See “Therapy Services” for further details.		
• Speech Therapy	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
• Dialysis	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance $350 per visit benefit maximum not to exceed the Maximum Allowed Amount**
**The Plan will pay the lesser of the benefit maximum or the Maximum Allowed Amount. Out-of-Network Providers may also bill you for any charges over the Plan’s Maximum Allowed Amount or benefit maximum.		
• Radiation Therapy	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
• Chemotherapy	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
• Respiratory Therapy	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
• Cardiac Rehabilitation	No Copayment, Deductible or Coinsurance	Not covered
• Pulmonary Therapy	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance

Benefits	In-Network	Out-of-Network
Preventive Care	No Copayment, Deductible or Coinsurance	Not covered
Preventive Care for Chronic Conditions (per IRS guidelines) Please see the "What's Covered" section for additional detail on IRS guidelines.	No Copayment, Deductible or Coinsurance	Not covered
Prosthetics	See "Durable Medical Equipment (DME), Medical Devices and Supplies."	
Rehabilitative Services Outpatient Facility Services	Benefits are based on the setting in which Covered Services are received. See "Office Visits" and "Outpatient Facility Services" for details on Benefit Maximums.	
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Transplant	See the "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services" section later in this Schedule of Benefits.	
Urgent Care Services		
• Urgent Care Visit Charge	$20 Copayment per visit	No Copayment, Deductible or Coinsurance
• Allergy Testing	No Copayment, Deductible or Coinsurance	Not covered
• Shots / Injections (including allergy shots and allergy serum)	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
• Diagnostic Labs	No Copayment, Deductible or Coinsurance	Not covered
• Diagnostic X-ray	No Copayment, Deductible or Coinsurance	Not covered

Benefits	In-Network	Out-of-Network
• Other Diagnostic Tests (including Hearing Exams and EKG)	No Copayment, Deductible or Coinsurance	Not covered
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance $800 per procedure benefit maximum not to exceed the Maximum Allowed Amount**
**The Plan will pay the lesser of the benefit maximum or the Maximum Allowed Amount. Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount or benefit maximum.		
• Office Surgery (including anesthesia)	No Copayment, Deductible or Coinsurance	No Copayment, Deductible or Coinsurance
If you get Urgent Care at a Hospital or other outpatient Facility, please refer to "Outpatient Facility Services" for details on what you will pay.		
Virtual Visits (Telehealth/Telemedicine Visits)	See the "Office Visits" section. For Mental Health and Substance Use Disorder Services, also refer to the "Mental Health and Substance Use Disorder Services" section.	
If Preventive Care is provided during a Virtual Visit, it will be covered under the "Preventive Care" benefit, as required by law. Please refer to that section for details.		
Vision Services (All Members / All Ages) (for medical and surgical treatment of injuries and/or diseases of the eye) Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.	Benefits are based on the setting in which Covered Services are received.	

How Your Plan Works

Introduction

Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. For services from Out-of-Network providers (including emergency services), you may have to pay the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount, as well as any applicable Coinsurance, Copayment or Deductible.

Certain non-essential health benefits are subject to either a lifetime and/or dollar maximum. Please see the "Schedule of Benefits" for details on the Cost Shares and benefit limits that apply to this Plan.

Covered Services are subject to change. For a list of current Covered Services, please call the Member Services telephone number listed on your Identification Card.

Regardless of Medical Necessity, benefits will not be provided for care that is not a Covered Service. The Claims Administrator has final authority to determine the Medical Necessity of the service.

Choice of Hospital, Skilled Nursing Facility, Attending Physician and Other Providers of Care

Nothing contained in this Booklet restricts or interferes with your right to select the Hospital, Skilled Nursing Facility, attending Physician or other Providers of your choice. However, your choice may affect the benefits payable according to this Plan.

Your Plan is a PPO plan

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, you will pay less in out-of-pocket costs, such as Copayments, Deductibles, and Coinsurance. If you use an Out-of-Network Provider, you will have to pay more out-of-pocket costs.

Note: If you receive services from an In-Network Facility at which, or as a result of which, you receive non-Emergency Covered Services provided by an Out-of-Network Provider, you will pay the Out-of-Network Provider no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider, but you may have to pay the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount, as well as any applicable Coinsurance, Copayment or Deductible. (Please see "Member Cost Share" in the "Claims Payment" section for more information.)

Cost sharing for services with Copayments is the lesser of the Copayment amount or the Maximum Allowed Amount.

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

In-Network Services

When you use an In-Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the In-Network level. To maximize your benefits, be sure to confirm that the Provider you wish to see is an In-Network Provider with your Plan. Do not assume that a Provider is participating in the network of Providers participating on your Plan. Claims paid for Out-of-Network Provider services may mean a higher financial responsibility for you. However, if you receive services from an In-Network Facility at which, or as a result of which, you receive non-Emergency Covered Services provided by Out-of-Network Providers, you will pay no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider, but you may have to pay the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount, as well as any applicable Coinsurance, Copayment or Deductible. Please see "Member Cost Share" in the "Claims Payment" section for more information.

If you receive Covered Services from an Out-of-Network Provider after the Plan failed to provide you with accurate information in our Provider Directory, or after the Plan failed to respond to your telephone or web-based inquiry within the time required by federal law, your cost share for Covered Services will be based on the In-Network level.

Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. We, on behalf of the Employer, have final authority to decide the Medical Necessity of the service.

In-Network Providers include Primary Care Physicians (PCP), Specialists (Specialty Care Physicians / Providers – SCPs), other professional Providers, Hospitals, and other Facilities who contract with the Claims Administrator to care for you. Referrals are never needed to visit an In-Network Specialist, including behavioral health Providers.

It is important to understand that you may be referred by In-Network Providers to other Providers who may be contracted with the Claims Administrator but are not part of your Plan's network of In-Network Providers.

It is your responsibility to confirm that the Provider you are seeing or have been referred to see is an In-Network Provider with your Plan. While your Plan has provided a network of In-Network Providers, it is important to understand that the Claims Administrator has many contracting Providers who are not participating in the network of Providers for your Plan. Any claims incurred with a participating Provider, who is not participating in your network panel of Providers, will be paid as Out-of-Network Provider services, even if you have been referred by another participating Provider. However, if you receive services from an In-Network Facility at which, or as a result of which, you receive non-Emergency Covered Services provided by an Out-of-Network Provider, you will pay the Out-of-Network Provider no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider, but you may have to pay the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount, as well as any applicable Coinsurance, Copayment or Deductible. Please see "Member Cost Share" in the "Claims Payment" section for more information.

To see a Doctor, call their office:

- Tell them you are a Member.
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

For services from In-Network Providers:

- You will not need to file claims. In-Network Providers will file claims for Covered Services for you. (You will still need to pay any Coinsurance, Copayments, and/or Deductibles that apply.) You may be billed by your In-Network Provider(s) for any non-Covered Services you get or when you have not followed the terms of this Booklet.
- Precertification will be done by the In-Network Provider. (See the "Getting Approval for Benefits" section for further details.)

Please read the "Claims Payment" section for additional information on Authorized Referrals.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor's office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call the 911 Emergency response system or the 988 suicide and crisis lifeline or go to the nearest Emergency Room. If you are experiencing a Mental Health crisis, you may also call 988 for assistance.

Out-of-Network Services

When you do not use an In-Network Provider or get care as part of an Authorized Referral, Covered Services are covered at the Out-of-Network level, unless otherwise indicated in this Booklet.

For services rendered by an Out-of-Network Provider:

- The Out-of-Network Provider can charge you the difference between their bill and the Plan's Maximum Allowed Amount plus any Deductible and/or Coinsurance/Copayments, including for Emergency Care, unless your claim involves a Surprise Billing Claim.

- You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments), unless your claim involves a Surprise Billing Claim.
- You will have to pay for services that are not Medically Necessary.
- You will have to pay for non-Covered Services.
- You may have to file claims.
- You must make sure any necessary Precertification is done. (Please see the "Getting Approval for Benefits" section for further details.)

After Coinsurance is applied, certain Out-of-Network benefits, such as inpatient and outpatient Facilities, are payable based on a maximum payment. If your Out-of-Network Deductible has not been satisfied and you submit a claim for services which have a maximum payment (e.g., per day, visit or admission), the Plan will apply only up to the applicable maximum payment, not the Maximum Allowed Amount, toward your Out-of-Network Deductible. For all other Out-of-Network benefits that are **not** payable based on a maximum payment, the Plan will apply only up to the Maximum Allowed Amount toward your Out-of-Network Deductible.

Surprise Billing Claims

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

Connect with Us Using Our Mobile App

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

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/sisc.

How to Find a Provider in the Network

There are several ways you can find out if a Provider or Facility is in the Claims Administrator's network. You can also find out where they are located and details about their license or training:

- See your Plan's directory of In-Network Providers at www.anthem.com/ca/sisc, which lists the Physicians, Providers, and Facilities that participate in this Plan's network. **Note: It is very important that you select your specific Plan to receive an accurate list of In-Network Providers for your Plan.**
- Search for a Provider in our mobile app.
- Contact Member Services to request a list of Physicians and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Physician or Provider.

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

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

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 would be provided according to the benefits, limitations and Exclusions of this Booklet. If you wish to receive a second medical opinion, remember that greater benefits are provided when you choose an In-Network Provider. You may also ask your Physician to refer you to an In-Network Provider to receive a second opinion.

Continuity of Care

Transition Assistance for New Members

Transition Assistance is a process that allows for continuity of care 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 due to a disease, illness or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by the Claims Administrator in consultation with the Member 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 the Member enrolls with the 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. For purposes of this provision an individual who presents written documentation of being diagnosed with a Maternal Mental Health Condition from the individual's treating health care provider, completion of covered services for the Maternal Mental Health Condition shall not exceed twelve (12) months from the diagnosis or from the end of pregnancy, whichever occurs later. A Maternal Mental Health Condition is a Mental Health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.
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 Member enrolls with the Plan.
6. Performance of a surgery or other procedure that the Claims Administrator has authorized as part of a documented course of treatment and that has been recommended and documented by the Provider to occur within 180 days of the time the Member enrolls.

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

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, the Member will be financially responsible only for applicable Deductibles, Coinsurance, Copayments under this Plan and amounts exceeding the Out-of-Network provider allowance. If the Member does not meet the criteria for Transition Assistance, the Member is afforded due process including having a Physician review the request.

Continuation of Care after Termination of Provider

Subject to the terms and conditions set forth below, the Plan will pay benefits to a Member at the In-Network Provider level for Covered Services (subject to applicable Copayments, Coinsurance, Deductibles and other terms) rendered by a Provider whose participation in the Claims Administrator's Provider network has terminated. If your In-Network Provider leaves our network for any reason other than termination of cause, retirement or death, or if coverage under this Plan ends because the Plan's Administrative Services Agreement 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 benefits. These provisions also apply to Blue Distinction surgeries and hospitals.

1. The Member must be under the care of the In-Network Provider at the time of the termination of the Provider's participation. The terminated Provider must agree in writing to provide services to the Member in accordance with the terms and conditions of his/her agreement with the Claims Administrator prior to termination. The Provider must also agree in writing to accept the terms and reimbursement rates under his/her agreement with the Claims Administrator prior to the termination. If the Provider does not agree with these contractual terms and conditions, the Claims Administrator is not required to continue the Provider's services beyond the contract termination date.
2. The Plan will furnish such benefits for the continuation of services by a terminated Provider only for any of the following conditions:
    a. 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.
    b. A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by the Claims Administrator in consultation with the Member and the terminated Provider and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the Provider's contract termination date.
    c. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Services shall be provided for the duration of the pregnancy. For purposes of this provision an individual who presents written documentation of being diagnosed with a Maternal Mental Health Condition from the individual's treating health care provider, completion of covered services for the Maternal Mental Health Condition shall not exceed twelve (12) months from the diagnosis or from the end of pregnancy, whichever occurs later. A Maternal Mental Health Condition is a Mental Health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.
    d. 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.
    e. 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 Provider's contract termination date.
    f. Performance of a surgery or other procedure that the Claims Administrator has authorized as part of a documented course of treatment and that has been recommended and documented by the Provider to occur within 180 days of the Provider's contract termination date.
3. Such benefits will not apply to Providers who have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity.
4. Please contact Member Services at the telephone number on the back of your Identification Card to request continuation of care or to obtain a copy of the written policy. Eligibility is based on the Member's clinical condition; it is not determined by diagnostic classifications. Continuation of care does not provide coverage for services not otherwise covered under the Agreement.

You will be notified by telephone, and the Provider by telephone and fax, as to whether or not your request for continuation of care is approved. If approved, the Member will be financially responsible only for applicable Deductibles, Coinsurance and/or Copayments under this Plan. Financial arrangements with terminated Providers are negotiated on a case-by-case basis. The Claims Administrator will request that the terminated Provider agree to negotiate reimbursement and/or contractual requirements that apply to In-Network Providers, including payment terms. If the terminated Provider does not agree to negotiate said reimbursement and/or contractual requirements, the Claims Administrator is not required to continue that Provider's services. If you disagree with our determination regarding continuation of care, please refer to the "Your Right To Appeals" section for additional details.

Your Cost Shares

Your Plan may involve Copayments, Deductibles, and/or Coinsurance, which are charges that you are required to pay when receiving Covered Services. Your Plan may also have an Out-of-Pocket Limit, which limits the amount of cost-sharing you must pay. Please refer to the “Schedule of Benefits” for details on the cost shares that apply to this Plan. Also refer to the “Definitions” section for a better understanding of each type of cost share.

The BlueCard Program

Like all Blue Cross and Blue Shield plans throughout the country, the Claims Administrator participates in a program called “BlueCard,” which provides services to you when you are outside the Service Area. For more details on this program, please see “Inter-Plan Arrangements” in the “Claims Payment” section.

Identification Card

The Claims Administrator will provide an Identification Card to each Member enrolled in the Plan. When you get care, you must show your Identification Card. Only covered Members have the right to receive services under this Plan. If anyone gets services or benefits to which they are not entitled to under the terms of this Benefit Booklet, he/she must pay for the actual cost of the services.

Getting Approval for Benefits

Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigational as those terms are defined in this 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 the 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.

In-Network Providers will initiate the review on your behalf. An Out-of-Network Provider may or may not initiate the review for you. In both cases, it is your responsibility to initiate the process and ask your Physician to request prior authorization. You may also call us directly.

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

Coverage for or payment of the service or treatment reviewed is not guaranteed even if it's decided your services are Medically Necessary. For benefits to be covered, on the date you get service:

1. You must be eligible for benefits.
2. Fees must be paid for the time period that services are given.
3. The service or supply must be a Covered Service under your Plan.
4. The service cannot be subject to an Exclusion under your Plan.
5. You must not have exceeded any applicable limits under your Plan.

Types of Reviews

- **Pre-service Review** – A review of a service, treatment or admission for a benefit coverage determination which is done before the service or treatment begins or admission date.
  - **Precertification –** A required Pre-service Review, for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for you to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental / Investigational as those terms are defined in this Booklet.

    For admission following Emergency Care, you, your authorized representative or Doctor must notify the Claims Administrator of the admission as soon as possible.

For labor/childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time. Precertification is not required 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 Doctor with knowledge of your medical condition, without such care or treatment, your life or health or your ability to regain maximum function could be seriously threatened or you could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.

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

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

- All inpatient Hospital admissions.
- Inpatient Facility treatment for Mental Health and Substance Use Disorder Services and residential treatment (including detoxification and rehabilitation).
- Skilled Nursing Facility stays.
- Human Organ and Tissue Transplants (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services and similar procedures.
- All Infusion Therapy (in any setting) inclusive of Specialty Drugs and related services (for each Course of Therapy) in any setting, including, but not limited to: Physician's office, infusion center, outpatient Hospital or clinic, or your home or other residential setting.
- Specific outpatient services, including diagnostic treatment and other services.
- Specific surgical procedures (including bariatric and TMJ), wherever performed, as specified by us.
- Specific diagnostic procedures, including advanced imaging procedures, wherever performed.
- Specific medical supplies and equipment.
- Air ambulance services for non-Emergency Hospital to Hospital transfers.
- Certain non-Emergency ground ambulance services.
- Behavioral health treatment for autism spectrum disorders.
- Physical Therapy, Occupational Therapy and Chiropractic / Osteopathic / Manipulative Therapy after the number of visits listed in the Schedule of Benefit. While there is no limit on the number of covered visits for Medically Necessary services, additional visits in excess of the stated number of visits require Precertification.
- Precertification review is not required if physical medicine services are provided in an outpatient hospital setting when Medicare is the primary insurance, or outside the state of California.
- Gender affirming services, including gender affirming travel expense, as specified under the "Gender Affirming Services" provision of "What's Covered." A Physician must diagnose you with Gender Dysphoria.
- Partial hospitalization, intensive outpatient programs, transcranial magnetic stimulation (TMS).
- Genetic testing.

- All interventional spine pain, elective hip, knee, and shoulder arthroscopic/open sports medicine, and outpatient spine surgery procedures.
- Second opinion.
- Certain Prescription Drugs under the section “Prescription Drugs Administered by a Medical Provider.”
- All hip, knee replacement or spine surgery procedures.
- Other specific procedures, wherever performed, as specified by the Claims Administrator.

For a list of current procedures requiring Precertification, please call the toll-free number for Member Services printed on your Identification Card.

Who is Responsible for Precertification?

Typically, In-Network Providers know which services need Precertification and will get any Precertification when needed, even though it is not required. Your Primary Care Physician and other In-Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor (“requesting Provider”) will get in touch with the Claims Administrator to ask for a Precertification review. However, you may request a Precertification or you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsibility to get Precertification	Comments
In-Network	Provider	• The Provider must get Precertification when required
Out-of-Network / Non-Participating	Member	• Member must get Precertification when required. (Call Member Services.) • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and or setting is found to not be Medically Necessary.
BlueCard Provider	Member **(except for Inpatient Admissions)**	• Member must get Precertification when required. (Call Member Services.) • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary. • **BlueCard Providers must obtain Precertification for all Inpatient Admissions.**
Note: For an Emergency Care admission, Precertification is not required. However, you, your authorized representative, or Doctor must tell us of the admission as soon as possible.		

How Decisions are Made

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

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

If you are not satisfied with the Claims Administrator'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 and Notification Requirements

The Claims Administrator will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on federal regulations. You may call the telephone number on your Identification Card for additional information.

Type of Review	**Timeframe Requirement for Decision and Notification**
Urgent Pre-service Review	72 hours from the receipt of request
Non-Urgent Pre-service Review	15 calendar 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	72 hours from the receipt of the request.
Urgent Continued Stay / Concurrent Review when request is received more than 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 or no previous authorization exists	72 hours from the receipt of the request
Non-Urgent Continued Stay / Concurrent Review for ongoing outpatient treatment	15 calendar 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 their decision, the Claims Administrator will tell the requesting Provider of the specific information needed to finish the review. If the Claims Administrator does not get the specific information needed by the required timeframe, a decision will be made based upon the information received.

The Claims Administrator will give notice to you and your Provider of its decision as required by state and federal regulations. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

Important Information

The Claims Administrator may, from time to time, waive, enhance, change or end certain medical management processes (including utilization management, case management, and disease management) and/or offer an alternate benefit if such change furthers the provision of cost-effective, value based and/or quality services.

The Claims Administrator may also select certain qualifying Providers to take part in a program or a Provider arrangement that exempts them from certain procedural or medical management processes that would otherwise apply. The Claims Administrator may also exempt your claim from medical review if certain conditions apply.

Just because the Claims Administrator exempts a process, Provider or Claim from the standards which otherwise would apply, it does not mean that the Claims Administrator will do so in the future or will do so in the future for any other Provider, claim or Member. The Claims Administrator may stop or change any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs or a Provider arrangement by contacting the Member Services number of the back of your ID card.

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

Health Plan Individual Case Management

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

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 in, the Claims Administrator will help you meet your identified health care needs. This is reached through contact and team work with you and/or your chosen authorized representative, treating Physician(s), and other Providers.

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

In certain cases of severe or chronic illness or injury, the Plan may provide benefits for alternate care that is not listed as a Covered Service. The Plan may also extend Covered Services beyond the Benefit Period Maximums of this Plan. The Claims Administrator will make its decision case-by-case, if the alternate or extended benefit is in the best interest of you and the Plan, and you or your authorized representative agree to the alternate or extended benefit in writing. A decision to provide extended benefits or approve alternate care in one case does not obligate the Plan to provide the same benefits again to you or to any other Member. The Plan reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, the Claims Administrator will notify you or your authorized representative in writing.

What's Covered

This section describes the Covered Services available under your Plan. Your Covered Services are subject to all the terms and conditions listed in this Benefit Booklet, including, but not limited to, Benefit Maximums, Deductibles, Copayments, Coinsurance, exclusions and Medical Necessity requirements. Please refer to the "Schedule of Benefits" for details on the amounts you are required to pay for Covered Services and for details on any Benefit Maximums. Also be sure to refer to the "How Your Plan Works" section for additional information on your Plan's rules. Read the "What's Not Covered" section for important details on excluded services. In addition, read "Getting Approval for Benefits" to determine when services require Precertification.

Your benefits are described below. Benefits are listed alphabetically to make them easy to find. Please note that several sections may apply to your claims. For example, if you have inpatient surgery, benefits for your Hospital stay will be described under "Inpatient Services" and benefits for your Physician's services will be described under "Office Visits and Physician Services." As a result, you should review all benefit descriptions that might apply to your claims.

You should also be aware that many of the Covered Services can be received in several settings, including a Physician's office or your home, an Urgent Care Facility, an Outpatient Facility, or an Inpatient Facility. Benefits will often vary depending on where and from whom you choose to receive Covered Services, and this can result in a change in the amount you will need to pay. Please see the "Schedule of Benefits" for more details.

Acupuncture

Please see "Therapy Services" later in this section.

Allergy Services

Your Plan includes benefits for Medically Necessary allergy testing and treatment, including allergy serum and allergy shots.

Ambulance Services

Medically Necessary ambulance services are a Covered Service as described in this section when you are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. Ambulance services include medical and Mental Health Medically Necessary non-Emergency ambulance transportation, including psychiatric transportation for safety issues. Ambulance Services do not include transportation by car, taxi, bus, gurney van, wheelchair van and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Provider.

Ambulance services are a Covered Service when one or more of the following criteria are met:

- For ground ambulance, you are taken:
  - From your home, scene of accident or medical Emergency to a Hospital.
  - Between Hospitals, including when the Claims Administrator requires you to move from an Out-of-Network Hospital to an In-Network Hospital.
  - Between a Hospital or Skilled Nursing Facility or other approved Facility.
- For air or water ambulance, you are taken:
  - From the scene of an accident or medical Emergency to a Hospital.
  - Between Hospitals, including when the Claims Administrator requires you to move from an Out-of-Network Hospital to an In-Network Hospital.
  - Between a Hospital and an approved Facility.
- Non-Emergency ambulance services are subject to Medical Necessity reviews by us. Please see the "Schedule of Benefits" for details on benefit limits for Out-of-Network Non-Emergency services.
- Emergency ground ambulance services do not require Precertification and are allowed regardless of whether the Provider is an In-Network or Out-of-Network Provider.

When using a ground or air ambulance for non-Emergency transportation, we, on behalf of the Employer reserve the right to select the air ambulance Provider. Out-of-Network ambulance services are covered in a non-Emergency when Precertification is obtained. If you do not use the ambulance Provider we select, benefits may not be available.

For Emergency and non-Emergency air ambulance services, Out-of-Network Providers cannot bill you for more than your applicable In-Network Deductible, Coinsurance, and/or Copayment. For ground or water ambulance services, Out-of-Network Providers may bill you for any charges over the Plan's Maximum Allowed Amount.

You must be taken to the nearest Facility that can give care for your condition. In certain circumstances the Claims Administrator may approve benefits for transportation to a Facility that is not the nearest Facility.

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

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 or Doctor are not a Covered Service.

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

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

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

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

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

Note: Air Ambulance Benefits

Benefits are only available for air ambulance 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 Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if you are in an area 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 your home.

Hospital to Hospital Transport

If you are moving 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 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. To be covered, you must be taken to the closest Hospital that can treat you. **Coverage is not available for air ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.**

Autism Spectrum Disorders Services

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

Behavioral health treatment services covered under this Plan are subject to the same Deductibles, Coinsurance, and Copayments that apply to services provided for other covered medical conditions. Services provided by Qualified Autism Service Providers, Qualified Autism Service Professionals, and Qualified Autism Service Paraprofessionals (see the “Definitions” below) will be covered under Plan benefits that apply for outpatient office visits or other outpatient items and services. Services provided in a Facility, such as the outpatient department of a Hospital, will be covered under Plan benefits that apply to such Facilities. See also the section “Mental Health and Substance Use Disorder Services” for more detail.

Behavioral Health Treatment

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

- The treatment must be prescribed by a licensed 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 by the Qualified Autism Service Provider, or (c) Qualified Autism Service Paraprofessional supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional.
- The treatment plan must have measurable goals over a specific timeline and be developed and approved by the Qualified Autism Service Provider for the specific patient being treated. The treatment plan must be reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate, and must be consistent with applicable state law that imposes requirements on the provision of applied behavioral analysis services and intensive behavioral intervention services to certain persons pursuant to which the Qualified Autism Service Provider does all of the following:
  - Describes the patient's behavioral health impairments to be treated.
  - Designs an intervention plan that includes the service type, number of hours, and parental participation needed (if any) to achieve the intervention plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported.
  - Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating autism spectrum disorders, and
  - Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.
- The treatment plan must not be used for purposes of providing or for the reimbursement of respite care, day care, or educational services, and must not be used to reimburse a parent for participating in the treatment program. The treatment plan must be made available to us upon request.

Our network of Providers is limited to licensed Qualified Autism Service Providers who contract with the Claims Administrator and who may supervise and employ Qualified Autism Service Professionals or Paraprofessionals who provide and administer behavioral health treatment.

For purposes of this section, the following definitions apply:

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

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

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

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

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

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

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

Qualified Autism Service Provider is either of the following:

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

You must obtain Precertification for all behavioral health treatment services for the treatment of autism spectrum disorders in order for these services to be covered (see the “Getting Approval for Benefits” section for details).

Behavioral Health Services

Please see “Autism Spectrum Disorders Services” and “Mental Health and Substance Use Disorder Services” later in this section.

Cardiac Rehabilitation

Please see “Therapy Services” later in this section.

Cellular and Gene Therapy Services

Your Plan includes benefits for certain cellular and gene therapy services, when Anthem approves the benefits in advance through Precertification. Please see the section “Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services” for additional details.

Chemotherapy

Please see “Therapy Services” later in this section.

Chiropractic Services

Please see “Therapy Services” later in this section.

Clinical Trials

Benefits include coverage for services, such as routine patient care costs, given to you as a qualified enrollee in an approved clinical trial if the services are Covered Services under this Plan. A “qualified enrollee” means that you meet both of the following conditions.

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

b) Either of the following applies.

   i. The referring health care professional is an In-Network Provider and has concluded that your participation in the clinical trial would be appropriate because you meet the conditions of subparagraph (a).

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

An “approved clinical trial” means a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or another life-threatening disease or condition. The term “life-threatening disease or condition” means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Benefits are limited to the following trials:

- Federally funded trials approved or funded by one of the following:
  - The National Institutes of Health.
  - The Centers for Disease Control and Prevention.
  - The Agency for Health Care Research and Quality.
  - The Centers for Medicare & Medicaid Services.
  - Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
  - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

- Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
  i. The Department of Veterans Affairs.
  ii. The Department of Defense.
  iii. The Department of Energy.

- Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration.
- Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use an In-Network Provider to maximize your benefits.

- If one or more In-Network Providers is conducting an approved clinical trial, your Plan may require you to use an In-Network Provider to utilize or maximize your benefits if the In-Network Provider accepts you as a clinical trial participant. It may also require that an approved clinical trial be located in California, unless the clinical trial is not offered or available through an In-Network Provider in California.
- Routine patient care costs include items and services provided to you in connection with an approved clinical trial that would otherwise be covered by this Plan.

All requests for clinical trials services, including services that are not part of approved clinical trials, will be reviewed according to the Claims Administrator's Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services and reserves the right to exclude any of the following services:

- The Investigational item, device, or service.
- Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services

Preparing the Mouth for Medical Treatments

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

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia

Treatment of Accidental Injury

Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. An injury that results from chewing or biting is not considered an Accidental Injury under this Plan, unless the chewing or biting results from a medical or mental condition.

Admissions for dental services up to three (3) days of inpatient Hospital services when a Hospital stay is Medically Necessary due to an unrelated medical condition.

Emergency services to your natural teeth as a result of an Accidental Injury that occurs following your Effective Date are eligible for coverage. Treatment excludes orthodontia. Damage to your teeth due to chewing or biting is not an Accidental Injury, unless the chewing or biting results from a medical or mental condition.

General anesthesia and associated Facility charges for dental procedures in a Hospital or surgery center is covered if Member is:

- Under the age of 20.
- Developmentally disabled regardless of age.
- The Member's health is compromised and general anesthesia is Medically Necessary, regardless of age.

Note: If you decide to receive dental services that are not covered under this Booklet, an In-Network Provider who is a dentist may charge you his or her usual and customary rate for those services. Prior to providing you with dental services that are not a Covered Service, the dentist should provide a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about the dental services that are covered under this Booklet, please call us at the telephone number listed on your Identification Card. To fully understand your coverage under this plan, please carefully review this Booklet.

Diabetes Equipment, Education, and Supplies

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

- The following Diabetes Equipment and Supplies:
  - Glucose monitors, including monitors designed to assist the visually impaired.
  - Blood glucose testing strips.
  - Insulin pumps and related necessary supplies.
  - Pen delivery systems for Insulin administration.
  - Podiatric devices, such as therapeutic shoes and shoe inserts, to prevent and treat diabetes-related complications are limited to a maximum listed in your Schedule of Benefits. These devices are covered under your Plan's benefits for Orthotics.
  - Visual aids (but not eyeglasses) to help the visually impaired to properly dose Insulin.

  These equipment and supplies are covered under your Plan's benefits for medical equipment (please see "Durable Medical Equipment (DME), Medical Devices and Supplies" later in this section).
- The Diabetes Outpatient Self-Management Training Program, which:
  - 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.
  - 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.
  - is supervised by a Doctor.

  Diabetes education services are covered under the Plan benefits for professional services by Doctors.
- Insulin and other prescriptive medications, insulin syringes, lancets, urine testing strips, blood glucose testing strips and disposable pen delivery systems for insulin administration are covered under your drug card Plan unless you are enrolled in Medicare Part B as primary. If Medicare Part B covers any of the aforementioned under part B, this medical Plan will cover as secondary.
- Screenings for gestational diabetes are covered under "Preventive Care" in this section.

Diagnostic Services

Your Plan includes benefits for tests or procedures to find or check a condition when specific symptoms exist. Tests must be ordered by a Provider and include diagnostic services ordered before a surgery or Hospital admission. Benefits include the following services:

Diagnostic Laboratory and Pathology Services

- Laboratory and pathology tests, such as blood tests.
- Genetic tests, when allowed by the Plan.

Diagnostic Imaging Services and Electronic Diagnostic Tests

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

Advanced Imaging Services

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

- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Spectroscopy (MRS)
- Nuclear Cardiology
- PET scans
- PET/CT Fusion scans
- QCT Bone Densitometry
- Diagnostic CT Colonography

The list of advanced imaging services is subject to change as medical technologies change.

Dialysis

Please see “Therapy Services” later in this section.

Doula Services

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

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

Durable Medical Equipment (DME), Medical Devices and Supplies

Durable Medical Equipment and Medical Devices

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

- Is meant for repeated use and is not disposable.
- Is used for a medical purpose and is of no further use when medical need ends.
- Is meant for use outside a medical Facility.
- Is only for the use of the patient.
- Is made to serve a medical use.
- Is ordered by a Provider.

Covered Services include but are not limited to:

- Standard curved handle or quad cane and replacement supplies.
- Standard or forearm crutches and replacement supplies.
- Dry pressure pad for a mattress.
- IV pole.
- Enteral pump and supplies.
- Bone stimulator.
- Cervical traction (over door).
- Phototherapy blankets for treatment of jaundice in newborns.

Benefits include purchase-only equipment and devices (e.g., crutches and customized equipment), purchase or rent-to-purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by us. The Plan may limit the amount of coverage for ongoing rental of equipment. The Plan may not cover more in rental costs than the cost of simply purchasing the equipment.

Benefits include repair and replacement costs as well as supplies and equipment needed for the use of the equipment or device, for example, a battery for a powered wheelchair.

Oxygen and equipment for its administration are also Covered Services.

Hearing Aids Services

The following hearing aids services are covered when provided by or purchased as a result of a written recommendation from an otolaryngologist or a state-certified audiologist. Please see the “Schedule of Benefits” for details on your cost shares and benefit maximums.

- Audiological evaluations to measure the extent of hearing loss and determine the most appropriate make and model of hearing aid.
- Hearing aids (monaural or binaural) including ear mold(s), the hearing aid instrument, batteries, cords and other ancillary equipment.
- Visits for fitting, counseling, adjustments and repairs for a one year period after receiving the covered hearing aid.

Benefits will not be provided for charges for a hearing aid which exceeds specifications prescribed for the correction of hearing loss, or for more than the benefit maximums in the “Schedule of Benefits.”

Orthotics

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.

Benefits will not be provided for charges for orthotics for more than the benefit maximums in the “Schedule of Benefits.”

Prosthetics

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

Benefits include the purchase, fitting, adjustments, repairs and replacements. Covered Services may include, but are not limited to:

- Artificial limbs and accessories.
- One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes.
- Breast prosthesis (whether internal or external) and surgical bras after a mastectomy, as required by the Women’s Health and Cancer Rights Act, and up to three brassieres required to hold a prosthesis every 12 months as required for Medically Necessary mastectomy.
- Colostomy supplies.
- Restoration prosthesis (composite facial prosthesis).
- Prosthetic devices (except electronic voice producing machines) to restore a method of speaking after laryngectomy.
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury or congenital defect.
- Benefits are also available for cochlear implants.
- Hearing aids. This includes bone-anchored hearing aids as well as FDA-approved over-the-counter hearing aids when Members have been certified as deaf or hearing impaired by a Physician or licensed audiologist.
- One wig per Benefit Period when needed after cancer treatment.

Medical and Surgical Supplies

Your Plan includes coverage for medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented).

Covered supplies include syringes, needles, surgical dressings, compression burn garments, lymphedema wraps and garments, splints, and enteral formula required for tube feeding in accordance with Medicare guidelines, and other similar items that serve only a medical purpose.

Covered Services do not include items often stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Ostomy and Urological Supplies

Covered Services for ostomy (surgical construction of an artificial opening) and urological supplies include but are not limited to:

- Adhesives – liquid, brush, tube, disc or pad
- Adhesive removers
- Belts – ostomy
- Belts – hernia
- Catheters

- Catheter Insertion Trays
- Cleaners
- Drainage Bags / Bottles – bedside and leg
- Dressing Supplies
- Irrigation Supplies
- Lubricants
- Miscellaneous Supplies – urinary connectors; gas filters; ostomy deodorants; drain tube attachment devices; soma caps tape; colostomy plugs; ostomy inserts; irrigation syringes, bulbs and pistons; tubing; catheter clamps, leg straps and anchoring devices; penile or urethral clamps and compression devices
- Pouches – urinary, drainable, ostomy
- Rings – ostomy rings
- Skin barriers
- Tape – all sizes, waterproof and non-waterproof

Blood and Blood Products

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

Diabetes Equipment and Supplies

See “Diabetes Equipment, Education, and Supplies” earlier in this section.

Asthma Treatment Equipment and Supplies

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

Infusion Therapy Supplies

Your Plan includes coverage for all necessary durable, reusable supplies and durable medical equipment including: pump, pole, and electric monitor. Replacement blood and blood products required for blood transfusions associated with this therapy are also covered.

Donor Human Milk

Benefits are available for Medically Necessary pasteurized donor human milk obtained from a tissue bank licensed by the State Department of Public Health.

Emergency Care Services

If you are experiencing an Emergency please call the 911 Emergency response system or visit the nearest Hospital for treatment. If you are experiencing a Mental Health crisis, you may also call 988 for assistance.

Emergency Services

Benefits are available in a Hospital Emergency Room for services and supplies to treat the onset of symptoms for an Emergency, which is defined below.

Benefits are also available for services provided by a Community Paramedicine Program, Triage to Alternate Destination Program, or Mobile Integrated Health Program, and if you receive Covered Services from an Out-of-Network Provider, you will pay no more than the same Cost Sharing that you would pay for the same Covered Services received from an In-Network Provider.

Emergency (Emergency Medical Condition)

"Emergency," or "Emergency Medical Condition" means a medical or behavioral health condition of recent onset and sufficient severity, including but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in: (a) placing the patient's health or the health of another person in serious jeopardy or, for a pregnant women, placing the women's health or the health of her unborn child in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Such conditions include but are not limited to chest pain, stroke, poisoning, serious breathing problems, unconsciousness, severe burns or cuts, uncontrolled bleeding, or seizures and such other acute conditions as may be determined to be Emergencies by the Claims Administrator.

Emergency Care

"Emergency Care" means a medical or behavioral health exam done in the Emergency Department of a Hospital and includes services routinely available in the Emergency Department to evaluate an Emergency Condition. It includes any further medical or behavioral health exams and treatment required to stabilize the patient. Emergency Care may also include necessary services, including observation services, provided as part of the Emergency visit regardless of the department in which the services are provided.

Medically Necessary services will be covered whether you get care from an In-Network or Out-of-Network Provider. Emergency Care you get from an Out-of-Network Provider will be covered as an In-Network service and will not require Precertification. The Out-of-Network Provider can only charge you any applicable Deductible, Coinsurance, and/or Copayment and cannot bill you for the difference between the Maximum Allowed Amount and their billed charges until your condition is stable and the Out-of-Network Provider has complied with the notice and consent process as described in the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet. Your cost shares will be based on the Recognized Amount and will be applied to your In-Network Deductible and In-Network Out-of-Pocket Limit.

The Maximum Allowed Amount for Emergency Care from an Out-of-Network Provider will be determined using the median Plan In-Network contract rate the Plan pays In-Network Providers for the geographic area where the service is provided for the same or similar services.

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor calls the Claims Administrator as soon as you are stabilized. The Claims Administrator will review your care to decide if a Hospital stay is needed and how many days you should stay. See "Getting Approval for Benefits" for more details.

Treatment you get after your condition has stabilized is not Emergency Care. Please refer to the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet for more details on how this will impact your benefits.

Note: If you receive services from an In-Network Facility at which, or as a result of which, you receive non-Emergency Covered Services provided by an Out-of-Network Provider, you will pay the Out-of-Network Provider no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider, but you may have to pay the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount, as well as any applicable Coinsurance, Copayment or Deductible. (Please see "Member Cost Share" in the "Claims Payment" section for more information.)

We provide coverage for emergency room medical care and follow-up healthcare treatment for a Member who is treated following a rape or sexual assault without Cost Sharing for the first nine months after the Member initiates treatment. Follow-up health care treatment includes medical or surgical services for the diagnosis, prevention or treatment of medical conditions arising from an instance of rape or sexual assault. We will only cover follow-up healthcare treatment by an Out-of-Network Provider in the case of Emergency Medical Condition and/or if no In-Network Provider is available to ensure timely access.

Fertility Preservation Services

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

Gender Affirming Services

Benefits are provided for services and supplies in connection with Gender Transition when you are diagnosed with Gender Dysphoria. This coverage is provided according to the terms and conditions of this Booklet that apply to all other medical conditions, including Medical Necessity requirements, utilization management, and exclusions for Cosmetic Services.

Coverage includes, but is not limited to, Medically Necessary services identified in the most recent edition of the Standards of Care developed by the World Professional Association for Transgender Health (WPATH) related to Gender Transition such as gender affirming surgery, psychotherapy, and vocal training. Coverage is provided for specific services according to benefits under this Booklet that apply to that type of service generally, if the Plan includes coverage for the service in question. For example, gender affirming surgery would be covered on the same basis as any other covered, Medically Necessary surgery.

Some services are subject to prior authorization in order for coverage to be provided. Please refer to “Getting Approval for Benefits” for information on how to obtain the proper reviews.

Gender Affirming Surgery Travel Expense. Certain travel expenses incurred by the Member, up to a maximum $10,000 payment per procedure, will be covered. All travel expenses are limited to the maximum set forth in the Internal Revenue Code, not to exceed the maximum specified above, at the time services are rendered and must be approved by the Claims Administrator in advance.

Travel expenses include the following for the Member and one companion:

- Ground transportation to and from the approved Facility when the Facility is 75 miles or more from the Member’s home. Air transportation by coach is available when the distance is 300 miles or more.
- Lodging.

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

Travel expenses that are not covered include, but are not limited to: meals, alcohol, tobacco, or any other non-food item; child care; mileage within the city where the approved Facility is located, rental cars, buses, taxis or shuttle services, except as specifically approved by us; frequent flyer miles, coupons, vouchers or travel tickets; prepayments or deposits; services for a condition that is not directly related to, or a direct result of, the gender affirming procedure; telephone calls; laundry; postage; or entertainment.

Habilitative Services

Benefits include habilitative health care services and devices that help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn’t walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Please see “Therapy Services” later in this section for further details.

Hip, Knee Replacement or Spine Surgery Services

Inpatient services and supplies provided for Hip, Knee Replacement or Spine Surgery when performed by a designated Blue Distinction+ (BD+) hospital facility. Benefits for the following services are as follows:

- Total Knee Replacement
- Revision Knee Replacement
- Total Hip Replacement
- Revision Hip Replacement
- Discectomy
- Decompression (without fusion)
- Primary or Revision Fusion

Covered services are subject to any applicable deductibles and co-payments set forth in the “Schedule of Benefits.”

For outpatient Hip Replacement, Knee Replacement or Spine Surgery, the Blue Distinction+ (BD+) requirement does not apply. Benefits follow the plan’s ordinary outpatient surgery setting benefits shown in the “Schedule of Benefits”.

To find a Blue Distinction+ (BD+) hospital facility, please contact Member Services at the number on the back of your Identification Card

Hip, Knee Replacement or Spine Surgery services are subject to Precertification review to determine medical necessity. Please see “Getting Approval for Benefits” for details.

Blue Distinction.

- The Blue Distinction+ requirement does not apply to the following.
  - Members under the age of 18
  - Emergencies
  - Urgent surgery to treat a recent fracture
  - Additional complications such as cancer
  - You have primary coverage with Medicare or another carrier
  - You live outside of the state of California

Hip, Knee Replacement or Spine Surgery Travel Expense

Benefits are available for travel expense when the Member’s home is fifty (50) miles or more from a designated Blue Distinction+ (BD+) facility.

- Transportation for the Member and one companion to and from the Blue Distinction+ (BD+) facility (limited to $6,000 maximum per procedure for the pre-operative trip, surgery trip and post-operative trip, if needed).
- Hotel accommodations for the Member and one companion not to exceed $150 per day maximum or $250 per night room rate in higher cost areas according to GSA gov lodging website for one (1) night stay per pre-operative trip / post-operative trip, if needed, and (7) nights per surgery trip.
- Flight for the Member and one companion to and from the Blue Distinction+ (BD+) facility will only be Economy / Coach seating (preferred seats for surgery trip when aisle seat is not available).
- Check in bag fees will be 1 bag for Member, 1 bag for companion for each flight.
- Ground Transportation (rental) will only be Economy / Intermediate / Standard.
- Ground Transportation (personal car) - Mileage reimbursement is based on current limits set forth in the Internal Revenue Code, not to exceed the maximum amount specified above.

Hip, knee replacement or spine surgery travel expense reimbursement is supported through our vendor, HealthBase.

For reimbursable expenses by HealthBase, the Member must first call Member Services who will submit the Referral to HealthBase. HealthBase will contact the Member to begin travel arrangements. Hip, knee replacement or spine surgery travel expense will only be covered through HealthBase.

Travel Benefit Details

- Flight.
  - Travel benefit offers an economy class flight. In case of any seat upgrades, you will be responsible for any upgrade cost.
  - If you check-in a bag and the airline charges a fee, only one check-in bag charge per eligible traveler is reimbursable. Please save your receipts.

- Rental car.
  - Type of rental car: Economy / Intermediate / Standard.
  - At the time picking up the rental car, your driver's license will need to be shown.
  - When you return the rental car, it should have "full" fuel. If you do not return it with a full tank, the rental car company will charge you a fee, and that fee is not included in the travel benefit; therefore you will be responsible for that fee. Please save your fuel receipts for reimbursement.
  - Toll, GPS, parking charges, etc. are not included in the travel benefit program. You are responsible for such charges.
  - Travel benefit includes rental car rate, taxes and insurance for the planned dates. Any additional products that you purchase will be your responsibility and you are to pay the rental car company directly.
  - Taxi charges are not included in the travel benefit.
- Personal car.
  - If you are eligible to use your car for driving to the Blue Distinction+ (BD+) facility, instead of flight or car rental, the mileage reimbursement will be based on current limits set forth in the Internal Revenue Code, not to exceed the maximum amount specified above. You are responsible for all insurances, fuel charges, car maintenance, toll charges, GPS, parking charges, etc.
- Hotel.
  - Only room rent and taxes are included in the travel benefit.
  - Any charges for meals, laundry, minibar, internet, phone, movies, parking, etc. are not included in the travel benefit program. You are responsible for such charges.
  - At the time of check-in, the hotel staff will require your credit card for incidental charges and/or security deposit.
- Reimbursement.
  - After your trip, HealthBase will send you the expense reimbursement form. You can submit the form to HealthBase with your receipts by fax or postal mail. HealthBase will process the expense reimbursement form and send you a check to your home address for the approved expenses.

Home Health Care Services

Benefits are available for Covered Services performed by a Home Health Care Agency or other Home Health Care Provider in your home.

Covered Services include but are not limited to:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the home health care Provider. 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 care Provider or other Provider as approved by the Claims Administrator.
- Therapy Services
- Medical supplies
- Durable medical equipment
- Private duty nursing services

Home health care under this section does not include behavioral health treatment for autism spectrum disorders. Services for behavioral health treatment for autism spectrum disorders are covered under “Mental Health and Substance Use Disorder Services.”

Benefits are also available for Intensive In-Home Behavioral Health Services. These do not require confinement to the home. These services are described in the “Mental Health and Substance Use Disorder Services” section below.

Home Infusion Therapy

Please see “Therapy Services” later in this section.

Hospice Care

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

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms but is not meant to cure a terminal illness. Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Nursing care services on a continuous basis or short-term Inpatient Hospital care when needed in periods of crisis.
- Short-term respite care for the Member only when necessary to relieve the family members or other persons caring for the Member.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Medical social services under the direction of a Physician.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes or hyperalimentation.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- 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.
- Volunteer services provided by trained Hospice volunteers under the direction of a Hospice staff member.
- Medical direction, with the medical director being also responsible for meeting the general medical needs of the Member to the extent that these needs are not met by an attending Physician.

Your Doctor must agree to care by the Hospice and must be consulted in the development of the treatment plan. The Hospice must keep a written care plan on file and give it to the Claims Administrator upon request.

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

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services

Your Plan includes coverage for Medically Necessary human organ and tissue transplants as well as certain cellular and gene therapies. **To be eligible for coverage, we must approve the benefits in advance through Precertification and services must be performed by an approved In-Network Provider to be covered at the In-Network level**.

Certain transplants (e.g., cornea and kidney) are covered like any other surgery, under the regular inpatient and outpatient benefits described elsewhere in this Booklet.

In this section you will see some key terms, which are defined below:

Covered Procedure

A Covered Procedure includes:

- Any Medically Necessary human solid organ, tissue, and stem cell / bone marrow transplants and infusions.
- Any Medically Necessary cellular or other gene therapies.
- Any Medically Necessary acquisition procedures, mobilization, collection and storage. It also includes Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.

Approved In-Network Provider

A Provider who has entered into an agreement with us to provide Covered Procedures to you. The agreement may only cover certain Covered Procedures or all Covered Procedures. Approved In-Network Providers may include the following:

- **Blue Distinction Center (BDC) Facility**: Blue Distinction facilities have met or exceeded national quality standards for transplant care delivery.
- **Centers of Medical Excellence (CME) Facility:** Centers of Medical Excellence facilities have met or exceeded quality standards for transplant care delivery.

All Other Providers

Any Provider that is NOT an Approved In-Network Provider. This includes In-Network Providers who participate in the Plan's networks, but who are not an Approved In-Network Provider for a Covered Procedure, as well as Out-of-Network Providers.

Prior Approval and Precertification

To maximize your benefits, you should call the Claims Administrator's Transplant Department as soon as you think you may need a Covered Procedure to talk about your benefit options. You must do this before you receive services. They will help you maximize your benefits by giving you coverage information, including details on what is covered as well as information on any clinical coverage guidelines, medical policies, Approve In-Network Provider rules, or Exclusions that apply.

Call the Member Services phone number on the back of your Identification Card and ask for the transplant coordinator.

You or your Provider must call our Transplant Department for Precertification prior to the Covered Procedure whether this is performed in an Inpatient or Outpatient setting. Your Physician must certify, and the Claims Administrator must agree, that the Covered Procedure is Medically Necessary. Your Physician should send a written request for Precertification to the Claims Administrator as soon as possible to start this process. Not getting Precertification will result in a denial of benefits.

Note that there are cases where your Provider asks for approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final decision as to what Covered 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 and/or collection and storage is NOT an approval for the later Covered Procedure. A separate Medical Necessity decision will be needed for the Covered Procedure.

Donor Benefits

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 plan.
- When the person getting the organ is a covered Member under this Plan, but the person donating the organ is not, benefits under this Plan are limited to benefits not available to the donor from any other source. This includes but is not limited to other insurance, grants, foundations, and government programs.
- If a covered Member under this Plan is donating the organ to someone who is not a covered Member, benefits are not available under this Plan.

Transportation and Lodging

The Plan will cover the cost of reasonable and necessary travel costs when you get prior approval and need to travel more than 75 miles from your permanent home to reach the Facility where the Covered Procedure will be performed. Help with travel costs includes transportation to and from the Facility, and lodging for the patient and one companion. If the Member receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions. You must send itemized receipts for transportation and lodging costs in a satisfactory form to the Claims Administrator when claims are filed. Call the Claims Administrator for complete information or refer to IRS Publication 502.

For lodging and ground transportation benefits, the Plan will cover costs up to the current limits set forth in the Internal Revenue Code.

Non-Covered services for transportation and lodging include, but are not limited to:

- Childcare.
- Mileage within the city where the Covered Procedure is performed.
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by the Claims Administrator.
- Frequent Flyer miles.
- Coupons, Vouchers, or Travel tickets.
- Prepayments or deposits.
- Services for a condition that is not directly related, or a direct result, of the Covered Procedure.
- Phone calls.
- Laundry.
- Postage.
- Entertainment.
- Travel costs for donor companion/caregiver.
- Return visits for the donor for treatment of an illness found during the evaluation.
- Meals.

Infertility Services

Please see “Maternity and Reproductive Health Services” later in this section.

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a hospital setting and coordinated discharge planning including the planning of such continuing care as may be necessary, both medically and as a means of preventing possible early re-hospitalization.

Benefits for room, board, and nursing services include.

- A room with two or more beds.
- A private room. The most the Plan will cover for a private room is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by the Claims Administrator. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
- Routine nursery care for newborns during the mother's normal Hospital stay.
- Meals, special diets.
- General nursing services.

Benefits for ancillary services include.

- Operating, childbirth, and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by the Hospital or other Provider.
- Medical and surgical dressings and supplies, casts, and splints.
- Diagnostic services.
- Therapy services.

Skilled Nursing Facility

Covered Services include.

- Physician and nursing services.
- Room and board.
- Drugs prescribed by a Physician as part of your care in the Skilled Nursing Facility.
- Durable medical equipment if Skilled Nursing Facilities ordinarily furnish the equipment.
- Imaging and laboratory services that Skilled Nursing Facilities ordinarily provide.
- Medical social services.
- Blood, blood products, and their administration.
- Medical supplies.
- Physical, Occupational, and Speech Therapy.
- Respiratory therapy.

Inpatient Professional Services

Covered Services include.

- Medical care visits.
- Intensive medical care when your condition requires it.

- Treatment for a health problem by a Doctor who is not your surgeon while you are in the Hospital for surgery. Benefits include treatment by two or more Doctors during one Hospital stay when the nature or severity of your health problem calls for the skill of separate Doctors.
- A personal bedside examination by a Physician when asked by your Physician. Benefits are not available for staff consultations required by Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals via phone.
- Surgery and general anesthesia.
- Newborn exam. A Physician other than the one who delivered the child must do the examination.
- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

Maternity and Reproductive Health Services

Maternity Services

Covered Services include those services needed during a normal or complicated pregnancy and for services needed for a miscarriage. Covered maternity services include.

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed or certified nurse midwife.
- Routine nursery care for the newborn during the mother's normal Hospital stay to include circumcision of a covered male Dependent.
- Prenatal, postnatal, and postpartum services, including maternal mental health screening and postpartum screening as required by law.
- Medically Necessary fetal screenings, which are genetic or chromosomal status of the fetus, as allowed.
- Participation in the California Prenatal Screening Program, a statewide prenatal testing program administered by California's State Department of Public Health. The Calendar Year Deductible will not apply, and no Copayment/Coinsurance will be required for services you received as part of this program: and

If you are pregnant on your Effective Date and in the first trimester of the pregnancy, you must change to an In-Network Provider to have Covered Services covered at the In-Network level. If you are pregnant on your Effective Date and in your second or third trimester of pregnancy (13 weeks or later) as of the Effective Date, benefits for obstetrical care may be available at the In-Network level even if an Out-of-Network Provider is used. You will need to fill out a Continuation of Care Request Form and submit it to the Claims Administrator for review and approval. If approved, Covered Services will include the obstetrical care given by that Provider through the end of the pregnancy and the immediate post-partum period. For additional information on the continuation of care process and how to begin, see the "Transition Assistance for New Members" provision in the section titled "Continuity of Care."

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

Injectable Drugs and Implants for Birth Control

Benefits include injectable contraceptive drugs and implants. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.

Sterilization Services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive Care" benefit.

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.

Infertility Services

Note: Although this Plan offers limited coverage of certain infertility services, it does not cover all forms of infertility treatment. Benefits do not include assisted reproductive technologies (ART) or the diagnostic tests and Drugs to support it. Examples of ART include artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT).

Covered Services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, semen analysis and services to treat the underlying medical conditions that cause Infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency). Fertility treatments such as artificial insemination and in-vitro fertilization are not a Covered Service.

Family Planning Services

Your Plan includes coverage for sterilization procedures and counseling. Please see the “Preventive Care Services” for additional information.

Covered Services for all Members include.

- Benefits include contraceptive devices such as diaphragms, intrauterine devices (IUDs), and implants.

  Certain contraceptives are covered under the “Preventive Care” benefit. Please see that section for further details
- Voluntary tubal ligation and other similar sterilization procedures.
- Vasectomies and related services. Benefits include services to reverse a non-elective sterilization that resulted from an illness or injury. Reversal of elective sterilization is not covered.
- Clinical services related to the provision or use of contraception, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referrals, and counseling.
- Follow-up services related to FDA-approved contraceptive Drugs, devices, products, and procedures, including, but not limited to, management of side effects, counseling for continued adherence, and device removal.

Mental Health and Substance Use Disorder Services

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, and is not limited to short-term or acute treatment.

You must obtain Precertification for certain Mental Health and Substance Use Disorder services and for the treatment of autism spectrum disorders. (See “Autism Spectrum Disorders Services” in this section and the “Getting Approval for Benefits” section for details.)

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that the Plan must cover per state law. Inpatient benefits include the following:
  - Inpatient psychiatric hospitalization, including room and board, drugs, and services of physicians and other providers who are licensed health care professionals acting within the scope of their license,
  - Psychiatric observation for an acute psychiatric crisis,
  - Detoxification — medical management of withdrawal symptoms, including room and board, physician services, drugs, dependency recovery services, education and counseling.

- Residential treatment which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:
  - Treatment in a crisis residential program:
  - Observation and assessment by a psychiatrist weekly or more often,
  - Rehabilitation and therapy.
- Transitional residential recovery services for Substance Use Disorder (chemical dependency).
- Reconstructive surgery for Gender Dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which the Member identifies, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested.

- **Outpatient Office Visits** including the following:
  - Individual and group Mental Health evaluation and treatment.
  - Individual, family and group substance use and Mental Health counseling.
  - Intensive In-Home Behavioral Health Services.
  - Outpatient services to monitor drug therapy and medication management.
  - Narcotic (opioid) treatment programs and methadone maintenance treatment.
  - Outpatient Prescription Drugs prescribed for Mental Health and Substance Use Disorder pharmacotherapy, including office-based opioid treatment, are not covered when obtained at a Retail or Home Delivery (Mail Order) Pharmacy. Benefits for those Prescription Drugs are covered under another vendor or plan provided by your employer.
  - Intensive community-based treatment, including assertive community treatment and intensive case management.
  - Behavioral health treatment for autism spectrum disorders delivered in an office setting.
  - Urgent Care services rendered inside and outside Anthem's Service Area.
- **Virtual Visits** as described under the "Virtual Visits (Telemedicine / Telehealth Visits)" section.
- **Other Outpatient Services** including the following:
  - Partial Hospitalization Programs and Intensive Outpatient Programs.
  - Outpatient psychological and neuropsychological testing.
  - Outpatient day treatment programs.
  - Multidisciplinary treatment in an intensive outpatient psychiatric treatment program.
  - Electroconvulsive therapy,
  - Behavioral health treatment for autism spectrum disorders delivered at home.
  - Ambulatory care services, including but not limited to physical therapy, occupational therapy, speech therapy and infusion therapy.
  - Ambulatory withdrawal management with or without extended on-site monitoring.
  - Diagnostic laboratory services, diagnostic and therapeutic radiologic services, and other diagnostic and therapeutic services.
  - Drug testing.
  - Preventive health care services.
  - Transcranial magnetic stimulation.

- **Other Services** including the following:
  - Home health care service including but not limited to physical therapy, occupational therapy, and speech therapy.
  - Intensive home-based treatment.
  - Coordinated specialty care for the treatment of first episode psychosis.
  - School site services for a Mental Health and Substance Use Disorder that are delivered to an enrollee at a school site pursuant to state law.
  - For Gender Dysphoria, all health care benefits identified in the most recent edition of the Standards of Care developed by the World Professional Association for Transgender Health.
  - Hospice care.
  - Polysomnography.
  - Prophylaxis, diagnosis, and treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS), including treatment with antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, immunomodulating medicines, plasma exchange, and intravenous immunoglobulin therapy. Coverage will not be subject to a Deductible, Copayment or Coinsurance that is less favorable than that applied to other coverage under your Plan.
- **Behavioral health treatment for autism spectrum disorders**. Inpatient services, office visits, and other outpatient items and services are covered under this section. See “Autism Spectrum Disorders Services” later in this section for a description of additional services that are covered.

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

If you receive services for the Medically Necessary treatment of a Mental Health and Substance Use Disorder from an Out-of-Network Provider, we will reimburse all claims from the Provider(s) for the Medically Necessary treatment of a Mental Health and Substance Use Disorder services delivered to you by the Provider(s). You will pay no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider, but you may have to pay the difference between the Out-of-Network Provider’s charge and the Maximum Allowed Amount, as well as any applicable Coinsurance, Copayment or Deductible.

Coverage is also provided for Emergency services for treatment of Mental Health and Substance Use Disorders, including ambulance and ambulance transportation services (including those provided through the 911 Emergency response system and the 988 suicide and crisis lifeline) and Emergency Services received outside Anthem’s Service Area. Cost sharing for Emergency Services received from Out-of-Network Providers will be the same as In-Network Providers. Precertification is not required for the Medically Necessary treatment of a Mental Health and Substance Use Disorder provided by a 988 center, mobile crisis team, or other Provider of behavioral health crisis services. However, Precertification may be required once you are stabilized.

Examples of Providers from whom you can receive Covered Services include the following:

- Psychiatrist.
- Psychologist.
- Licensed clinical social worker (L.C.S.W.).
- Mental health clinical nurse specialist.
- Licensed marriage and family therapist (L.M.F.T.).
- Licensed professional counselor (L.P.C.).

- Qualified Autism Service Providers, Qualified Autism Service Professionals, and Qualified Autism Service Paraprofessionals. See the definitions of these in the “Autism Spectrum Disorders Services” section below.
- 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.
- Associate clinical social worker functioning pursuant to the CA Business and Professions Code.
- Associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to the CA Business and Professions Code.
- Associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to the CA Business and Professions Code.

Observation Care

Your Plan includes Covered Services for Observation Care. Observation is a care status in an acute care hospital setting that is appropriate when your condition is rapidly changing and it is not clear if inpatient care is needed, but your physician is not confident that you can be treated at home. In observation care, your diagnosis and treatment are not expected to exceed 24 hours to 48 hours without discharge or admission. Observation care can, for example, be delivered in a hospital emergency room, an area designated as “observation,” a bed within a unit, or an entire unit designated as an observation area.

Occupational Therapy

Please see “Therapy Services” later in this section.

Office and Home Visits

Covered Services include:

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

Consultations between your Primary Care Physician and a Specialist, when approved by the Claims Administrator.

Home Visits for medical care to examine, diagnose, and treat an illness or injury. Please note that a Doctor and Primary Care Provider visits in the home are different than the “Home Health Care Services” benefit described earlier in this Benefit Booklet.

Retail Health Clinic Care for limited basic medical care services to Members on a “walk-in” basis. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by Physician’s Assistants or nurse practitioners. Services are limited to routine care and the treatment of common illnesses for adults and children.

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

Behavioral Health and Wellness Screening for children and adolescents 8 to 18 years of age including for both depression and anxiety.

Urgent Care as described in the “Emergency and Urgent Care Services” information earlier in this section.

Virtual Visits as described under the “Virtual Visits (Telemedicine / Telehealth Visits)” section.

Prescription Drugs Administered in the Office

Orthotics

Please see “Durable Medical Equipment (DME), Medical Devices and Supplies” earlier in this section.

Outpatient Facility Services

Your Plan includes Covered Services in an:

- Outpatient Hospital.
- Freestanding Ambulatory Surgery Center.
- Mental Health and Substance Use Disorder Facility, or
- Other Facilities approved by the Claims Administrator.

Benefits include coverage of Facility and related (ancillary) charges, when proper, such as:

- Surgical rooms and equipment.
- Prescribed Drugs including Specialty Drugs.
- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility.
- Medical and surgical dressings and supplies, casts, and splints.
- Diagnostic services.
- Therapy services.

Phenylketonuria (PKU)

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

The cost of the necessary formulas and special food products is covered only as it exceeds the cost of a normal diet. “Formula” means an enteral product or products for use at home. The formula must be prescribed by a Physician or nurse practitioner, or ordered by a registered dietician upon Referral by a health care Provider authorized to prescribe dietary treatments, and is Medically Necessary for the treatment of PKU. 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.
- Consistent with the recommendations and best practices of qualified health professionals with expertise in the treatment and care of PKU.
- Used in place of normal food products, such as grocery store foods, used by the general population.

Note: It does not include 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

Please see “Therapy Services” later in this section.

Preventive Care

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 many preventive care services, including integral items and services to the provision of those preventive care services, are covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider. In addition, office visits associated with a preventive care service will be provided at no cost if the preventive care service is not billed separately or is not tracked as an individual encounter separately from the office visit and the primary purpose of the office visit is the delivery of the preventive care service.

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

Covered Services fall under the following broad groups:

- Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples include screenings for:
  - Breast cancer, including breast MRI (with or without contrast), tomosynthesis, ultrasound and biopsy/pathology services in connection with the preventive screening.
  - Cervical cancer.
  - Colorectal cancer, including preventive colonoscopy, anesthesia, polyp removal and pathology tests in connection with the preventive screening. This also includes a preventive screening following a positive non-invasive stool-based screening test or following a positive direct visualization test (i.e., flexible sigmoidoscopy, CT colonography).
  - High blood pressure.
  - Type 2 Diabetes Mellitus.
  - Cholesterol.
  - Child and adult obesity.
- Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration.
- Preventive care and screening as listed in the guidelines supported by the Health Resources and Services Administration, including:
  - All FDA-approved contraceptive Drugs, devices, and other products that can only be administered in a physician’s office, including over-the-counter items, as prescribed by a Physician. This includes contraceptive Drugs as well as other contraceptive medications such as injectable contraceptives and 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 the Physician, the prescribed FDA-approved form of contraception will be covered as Preventive Care under this section.
- Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.
- Gestational diabetes screening.
- Preventive prenatal care.

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

Examples of preventive care Covered Services are provided below.

Well Baby and Well Child Preventive Care

- Office Visits.
- Routine physical exam including medically appropriate laboratory tests, procedures and radiology services in connection with the exam.
- Screenings including blood lead levels for children at risk for lead poisoning; vision (eye chart only); and hearing screening in connection with the routine physical exam.
- Immunizations including those recommended by the American Academy of Pediatrics and the Advisory Committee on Immunization Practices.
- Health education on pediatric wellness to prevent common sickness including, but not limited to, asthma.
- Hepatitis B and varicella zoster (chicken pox) injectable vaccines and other age appropriate injectable vaccinations as recommended by the American Academy of Pediatrics and the office visit associated with administering the injectable vaccination when ordered by your Physician.
- Human papillomavirus (HPV) test for cervical cancer and HPV vaccine.

Adult Preventive Care

- Routine physical exams.
- Medically appropriate laboratory tests and procedures and radiology procedures in connection with the routine physical exam.
- Cholesterol, osteoporosis (periodic bone density screening for menopausal or post-menopausal women), vision (eye chart only), and hearing screenings in connection with the routine physical exam.
- Immunizations including those recommended by the U.S. Public Health Service and the Advisory Committee on Immunization Practices for Members age 19 and above.
- Health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided.
- Screening and counseling for Human Immunodeficiency Virus (HIV).
- Preventive counseling and risk factor reduction intervention services in connection with tobacco use and tobacco use-related diseases.
- FDA-approved cancer screenings including pap examinations; breast exams; mammography testing; appropriate screening for breast cancer; ovarian, colorectal and cervical cancer screening tests, including the human papillomavirus (HPV) test for cervical cancer, HPV vaccine; prostate cancer screenings, including digital rectal exam and prostate specific antigen (PSA) test; and the office visit related to these services.

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”).

This includes care for the following chronic conditions:

Preventive Care	For Members Diagnosed With
Blood pressure monitor	Hypertension
Retinopathy screening	Diabetes
Peak flow meters	Asthma
Glucometers	Diabetes
Hemoglobin A1c testing	Diabetes
International Normalized Ratio (INR) testing	Liver disease and/or bleeding disorders
Low-density Lipoprotein (LDL) testing	Heart disease
Statins	Heart disease and/or diabetes

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

Prosthetics

Please see “Durable Medical Equipment (DME), Medical Devices and Supplies” earlier in this section.

Pulmonary Therapy

Please see “Therapy Services” later in this section.

Radiation Therapy

Please see “Therapy Services” later in this section.

Rehabilitation Services

Benefits include services in a Hospital, free-standing Facility, Skilled Nursing Facility, or in an outpatient day rehabilitation program.

Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, and services of a social worker or psychologist.

To be Covered Services, rehabilitation services must involve goals you can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and you stop progressing toward those goals.

Please see “Therapy Services“ in this section for further details.

Respiratory Therapy

Please see “Therapy Services” later in this section.

Skilled Nursing Facility

When you require Inpatient skilled nursing and related services for convalescent and rehabilitative care, Covered Services are available if the Facility is licensed or certified under state law as a Skilled Nursing Facility. Custodial Care is not a Covered Service. Please see “Inpatient Services” earlier in this section.

Smoking Cessation

Please see the “Preventive Care” section in this Booklet.

Speech Therapy

Please see “Therapy Services” later in this section.

Surgery

Your Plan covers surgical services on an Inpatient or outpatient basis, including office surgeries. Covered Services include:

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

Bariatric Surgery

The Claims Administrator has established a network of designated Blue Distinction Centers for Specialty Care (BDCSC) facilities and Ambulatory Surgery Centers to provide services for bariatric surgical procedures.

Note: An In-Network Provider is not necessarily a designated BDCSC facility or Ambulatory Surgery Center. Information on designated BDCSC facilities and Ambulatory Surgery Centers can be obtained by calling the Member Services phone number on the back of your Identification Card.

Services and supplies will be provided in connection with Medically Necessary surgery for weight loss, only for morbid obesity and only when performed at a designated BDCSC facility or Ambulatory Surgery Center.

Note: Charges for bariatric procedures and related services are covered only when the bariatric procedure and related services are performed at a designated BDCSC facility or Ambulatory Surgery Center. Precertification is required.

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

- Hotel accommodations for the Member and one companion not to exceed $150 per day maximum or $250 per night room rate in higher cost areas according to GSA gov lodging website for one (1) night stay per pre-operative trip / post-operative trip, if needed, and (7) nights per surgery trip.
- Flight for the Member and one companion to and from the Blue Distinction (BD) or Blue Distinction+ (BD+) facility will only be Economy / Coach seating (preferred seats for surgery trip when aisle seat is not available).
- Check in bag fees will be 1 bag for Member, 1 bag for companion for each flight.
- Ground Transportation (rental) will only be Economy / Intermediate / Standard.
- Ground Transportation (personal car) - Mileage reimbursement is based on current limits set forth in the Internal Revenue Code, not to exceed the maximum amount specified above.

Travel Benefit Details

- Flight.
  - Travel benefit offers an economy class flight. In case of any seat upgrades, you will be responsible for any upgrade cost.
  - If you check-in a bag and the airline charges a fee, only one check-in bag charge per eligible traveler is reimbursable. Please save your receipts.
- Rental car.
  - Type of rental car: Economy / Intermediate / Standard.
  - At the time picking up the rental car, your driver's license will need to be shown.
  - When you return the rental car, it should have "full" fuel. If you do not return it with a full tank, the rental car company will charge you a fee, and that fee is not included in the travel benefit; therefore you will be responsible for that fee. Please save your fuel receipts for reimbursement.
  - Toll, GPS, parking charges, etc. are not included in the travel benefit program. You are responsible for such charges.
  - Travel benefit includes rental car rate, taxes and insurance for the planned dates. Any additional products that you purchase will be your responsibility and you are to pay the rental car company directly.
  - Taxi charges are not included in the travel benefit.
- Personal car.
  - If you are eligible to use your car for driving to the Blue Distinction (BD) or Blue Distinction+ (BD+) facility, instead of flight or car rental, the mileage reimbursement will be based on current limits set forth in the Internal Revenue Code, not to exceed the maximum amount specified above. You are responsible for all insurances, fuel charges, car maintenance, toll charges, GPS, parking charges, etc.
- Hotel.
  - Only room rent and taxes are included in the travel benefit.
  - Any charges for meals, laundry, minibar, internet, phone, movies, parking, etc. are not included in the travel benefit program. You are responsible for such charges.
  - At the time of check-in, the hotel staff will require your credit card for incidental charges and/or security deposit.
- Transportation for the Member and/or one companion to and from the designated BDCSC facility.
- Lodging, limited to one room, double occupancy.
- Other reasonable expenses. Meals, tobacco, alcohol and drug expenses are excluded from coverage.

Member Services will confirm if the bariatric travel benefit is provided in connection with access to the selected designated BDCSC facility. Details regarding reimbursement can be obtained by calling the Member Services phone number on the back of your Identification Card. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

Non-Covered Services for transportation and lodging include, but are not limited to:

- Child care.
- Mileage within the city where the Covered Procedure is performed.
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by us.
- Frequent Flyer miles.
- Coupons, Vouchers, or Travel tickets.
- Prepayments or deposits.
- Services for a condition that is not directly related, or a direct result, of the Covered Procedure.

- Phone calls.
- Laundry.
- Postage.
- Entertainment.
- Meals.

Oral Surgery

Note: Although this Plan provides coverage for certain oral surgeries, many oral surgeries (e.g. removal of wisdom teeth) are not covered.

Benefits are also limited to certain oral surgeries including:

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

Reconstructive Surgery

Benefits include reconstructive surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, injury, or an earlier treatment to create a more normal appearance. Benefits include surgery performed to restore symmetry following mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

Note: This section does not apply to orthognathic surgery. See the “Oral Surgery” section above for that benefit.

Mastectomy Notice

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

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

This coverage will be provided in consultation with the patient and the patient’s attending Physician and will be subject to the same annual Deductible, Coinsurance, Copayment provisions otherwise applicable under the Plan.

Temporomandibular Joint Disorder (TMJ) and Craniomandibular Joint Services

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

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

Therapy Services

Physical Medicine Therapy Services Review Process

The review process for Physical Medicine which includes Physical Therapy, Occupational Therapy, Chiropractic / Osteopathic and Manipulative Therapy is managed by **American Specialty Health** Networks, Inc. (ASH Networks) through a Health Care Service Agreement with Anthem Blue Cross Life and Health Insurance Company (Anthem). The program is designed to ensure that the services you receive are medically necessary and appropriate, and that your benefits are used to your best advantage.

Professional Physical Medicine services provided by in-network providers require Precertification review by ASH after the number of visits listed on the "Schedule of Benefits." The visits are accumulated by any combination of physical medicine visits regardless of provider type. While there is no limit on the number of covered visits for Medically Necessary services, additional visits in excess of the stated number of visits require Precertification. If Precertification is not obtained, services may be reviewed upon receipt of the claim.

Precertification review is not required if physical medicine services are provided in an outpatient hospital setting, when Medicare is the primary insurance, or outside the state of California.

It is your responsibility to initiate the process and ask your Physician to request prior authorization. You may also call us directly. Please see "Getting Approval for Benefits" for more details. If Precertification is denied you have the right to file a Grievance as outlined in the "Your Right to Appeals" section of this Booklet.

Physical Medicine Therapy Services

Your Plan includes coverage for the therapy services described below. To be a Covered Service, the therapy must improve your level of function within a reasonable period of time. Covered Services include:

- **Physical therapy** – The treatment by physical means to ease pain, restore function, and to avoid disability after an illness, injury, or loss of an arm or leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices.
- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities daily living such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- **Chiropractic / Manipulation therapy** – Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments.

Other Therapy Services

Benefits are also available for.

- **Acupuncture** – Treatment of neuromusculoskeletal pain by an acupuncturist who acts within the scope of their license. Treatment consists of inserting needles along specific nerve pathways to ease pain.
- **Cardiac Rehabilitation –** Medical evaluation, training, supervised exercise and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance services.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Cognitive rehabilitation therapy** – Medically Necessary cognitive rehabilitation, including therapy following a post-traumatic brain injury or cerebral vascular accident.
- **Dialysis –** Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis.

- **Infusion Therapy** – Nursing, durable medical equipment and Prescription Drug that are delivered and administered to you through an I.V. in your home. Also includes: Total Parenteral Nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See the section “Prescription Drugs Administered by a Medical Provider” for more details.
- **Post-cochlear implant aural therapy** – Services to help a person understand the new sounds they hear after getting a cochlear implant.
- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore your health after an illness or injury.
- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies used in therapy, and treatment planning.
- **Respiratory Therapy** – Includes the use of dry or moist gases into the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Prescription Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech language and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.

Transplant Services

Please see “Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services” earlier in this section.

Urgent Care Services

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

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

Virtual Visits (Telehealth / Telemedicine Visits)

Covered Services include virtual Telehealth /Telemedicine visits. This includes visits with Providers who also provide services in person, as well as virtual care-only Providers.

- “Telehealth / Telemedicine” 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, 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 Provider 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.

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 Providers offer virtual visits.

Benefits do not include the use of texting 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 Providers outside our network, benefit Precertification, or Provider to Provider discussions except as approved under “Office and Home Visits.”

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

Vision Services (All Members / All Ages)

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

Certain vision screenings required by Federal law are covered under the “Preventive Care” benefit.

Benefits do not include glasses and contact lenses except as listed in the “Prosthetics” benefit.

Prescription Drugs Administered by a Medical Provider

Your Plan covers Prescription Drugs, including Specialty Drugs that must be administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility when they are Covered Services. This may include Drugs for infusion therapy, chemotherapy, hormone replacement therapy to the extent required by law, blood products, certain injectables, and any Drug that must be administered by a Provider. This section applies when a Provider orders the Drug and a medical Provider administers it to you in a medical setting.

This benefit only applies to Prescription Drugs when administered to you as part of a Physician visit**. Prescription drugs you get at a drugstore, retail pharmacy or mail order pharmacy are not covered under this plan (carved out).** Benefits for Prescription Drugs that you take yourself are covered by another plan provided by your **school district**.

Precertification

Precertification may be required for certain Prescription Drugs to help make sure proper use and guidelines are followed. The Claims Administrator will give the results of the decision to both you and your Provider.

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

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

If Precertification is denied you have the right to file a Grievance as outlined in the "Your Right to Appeals" section of this Booklet.

Note that antiretroviral Drugs that are Medically Necessary for the prevention of AIDS/HIV, including preexposure prophylaxis (PrEP) or postexposure prophylaxis (PEP), are not subject to Precertification or step therapy. Also, if the United States Food and Drug Administration has approved one or more therapeutic equivalents of a Drug, device, or product for the prevention of AIDS/HIV, then at least one therapeutically equivalent version will be covered without Precertification or step therapy.

Designated Pharmacy Provider

The Claims Administrator, in its sole discretion, may establish one or more Designated Pharmacy Provider programs which provide specific pharmacy services (including shipment of Prescription Drugs) to Members. An In-Network Provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the In-Network Provider must have signed a Designated Pharmacy Provider Agreement with the Claims Administrator. You or your Provider can contact Member Services to learn which Pharmacy or Pharmacies are part of a Designated Pharmacy Provider program.

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

You may also be required to use a Designated Pharmacy Provider to obtain Prescription Drugs for treatment of certain clinical conditions such as Hemophilia. The Claims Administrator reserves their right to modify the list of Prescription Drugs as well as the setting and/or level of care in which the care is provided to you. The Claims Administrator may, from time to time, change with or without advance notice, the Designated Pharmacy Provider for a Drug, if in their discretion, such a 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 provided at the Out-of-Network level.

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

What’s Not Covered

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

- **Administrative Charges**
  - Charges for the completion of claim forms.
  - Charges to get medical records or reports.
  - Membership, administrative, or access fees charged by Physicians or other Providers. Examples include, but are not limited to, fees charged for educational brochures or calling you to give you the test results.
- **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.
- **Alternative / Complementary Medicine.** Services or supplies related to alternative or complementary medicine. This includes but is not limited to:
  - Acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body.
  - Holistic medicine.
  - Homeopathic medicine.
  - Hypnosis.
  - Aroma therapy.
  - Massage and massage therapy, except for other massage therapy services that are part of a physical therapy treatment plan and covered under the “Therapy Services” section of this Booklet.
  - Reiki therapy,
  - Herbal, vitamin or dietary products or therapies.
  - Naturopathy.
  - Thermography.
  - Orthomolecular therapy.
  - Contact reflex analysis.
  - Bioenergetic synchronization technique (BEST).
  - Iridology-study of the iris.
  - Auditory integration therapy (AIT).
  - Colonic irrigation.
  - Magnetic innervation therapy.
  - Electromagnetic therapy.
  - Neurofeedback / Biofeedback.
- **Autopsies.** Autopsies and post-mortem testing.
- **Before Effective Date or After Termination Date.** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.
- **Certain Providers.** Services you get from Providers that are not licensed by law to provide Covered Services, as defined in this Booklet. Examples include, but are not limited to, masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers.

- **Charges over the Maximum Allowed Amount.** Charges over the Maximum Allowed Amount for Covered Services, except for Surprise Billing Claims as outlined in the "Consolidated Appropriations Act of 2021 Notice" in the front of this Booklet.
- **Charges Not Supported by Medical Records.** Charges for services not described in your medical records.
- **Chats or Texts.** Chats and texting are not a Covered Service unless appropriately provided via a secure and compliant application, according to applicable legal requirements.
- **Clinical Trial Non-Covered Services.** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.
- **Clinically-Equivalent Alternatives.** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. "Clinically equivalent" means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card or visit the website at www.anthem.com/ca/sisc.

  If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with the Claims Administrator. The other Prescription Drug will be covered only if it's agreed that it is Medically Necessary and appropriate over the clinically equivalent Drug. Benefits for the Prescription Drug will be reviewed from time to time to make sure the Drug is still Medically Necessary.
- **Cold Caps.** Any form of cold therapy/scalp cooling including devices for the prevention of hair loss during chemotherapy.
- **Complications of/or Services Related to Non-Covered Services.** Services, supplies, or treatment related to, or for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service. This Exclusion does not apply to problems resulting from pregnancy.
- **Compound Ingredients.** Compound ingredients that are not FDA-approved or do not 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.
- **Cosmetic Services.** Treatments, services, Prescription Drugs, equipment, or supplies given for Cosmetic Services. Cosmetic Services are meant to preserve, change, or improve how you look. This exclusion does not apply to services mandated by federal law, or listed as covered under "What's Covered," "Prescription Drugs Administered by a Medical Provider."
- **Court Ordered Testing.** Court ordered testing or care unless Medically Necessary.
- **Crime.** Treatment of an injury or illness that results from a crime you committed or tried to commit. This Exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence.
- **Custodial Care.** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.
- **Delivery Charges.** Charges for delivery of Prescription Drugs.
- **Dental Devices for Snoring.** Oral appliances for snoring.
- **Dental Treatment.** Excluded dental treatment includes but is not limited to preventive care and fluoride treatments; dental X-rays, supplies, appliances and all associated expenses; and diagnosis and treatment for the teeth, jaw or gums such as:
  - removing, restoration, and replacement of teeth.
  - medical care or surgery for dental problems (unless listed as a Covered Service in this Booklet).
  - services to help dental clinical outcomes.

  This exclusion does not apply to the services that must be covered by law.

- **Doula Services.** The following prenatal and postpartum services and supplies are not covered when provided by a doula:
  - Clinical or medical Services (such as taking blood pressure or temperature, fetal heart tone checks, vaginal examinations, or postpartum clinical care).
  - Assistance with activities of daily living.
  - Alternative or complementary modalities (such as aromatherapy, childbirth education, massage therapy, or placenta encapsulation).
  - Yoga.
  - Birthing ceremonies.
  - Over-the-counter supplies or drugs.
  - Home birth.
- **Drugs Contrary to Approved Medical and Professional Standards.** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- **Drugs Over Quantity or Age Limits.** Drugs which are over any quantity or age limits set by the Plan or the Claims Administrator.
- **Drugs Over the Quantity Prescribed or Refills After One Year.** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications.** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations, and/or certifications, as determined by the Claims Administrator.
- **Drugs That Do Not Need a Prescription.** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin or other Drugs provided in the Preventive Care paragraph of the “What’s Covered” section.
- **Educational 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.
- **Experimental / Investigative Services.** Services or supplies that are found to be Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.

  The fact that a service or supply is the only available treatment for a condition will not make it eligible for coverage if the Claims Administrator deems it to be Experimental / Investigative.
- **Eye Exercises.** Orthoptics and vision therapy.
- **Eye Surgery.** Eye surgery to fix errors of refraction, such as near-sightedness. This includes but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.
- **Eyeglasses and Contact Lenses.** Eyeglasses and contact lenses to correct your eyesight. This exclusion does not apply to lenses needed after a covered eye surgery.
- **Family Members.** Services prescribed, ordered, referred by or given by a member of your family, including your spouse, child, brother, sister, parent, in-law, or self.
- **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removal of corns and calluses; trimming nails; hygienic and preventive foot care, including but not limited to:
  - Cleaning and soaking the feet.
  - Applying skin creams to care for skin tone.
  - Other services that are given when there is not an illness, injury or symptom involving the foot.
- **Foot Orthotics.** Foot orthotics, orthopedic shoes or footwear or support items except as specifically covered under Durable Medical Equipment (DME), Medical Devices and Supplies.

- **Foot Surgery.** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratosis.
- **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.
- **Free Care.** Services you would not have to pay for if you didn't have this Plan. This includes but is not limited to government programs, services received during a jail or prison sentence, services you get from Workers Compensation benefits, and services from free clinics.

  If Worker's Compensation benefits are not available to you, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third-party.
- **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 and Fitness Services.** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Physician. This Exclusion also applies to health spas.
- **Home Health Care.**
  - Services given by registered nurses and other health workers who are not employees or under approved arrangements with a home health care Provider.
  - Food, housing, homemaker services and home delivered meals.
- **Hospital Services Billed Separately.** Services rendered by Hospital resident Doctors or interns that are billed separately. This includes separately billed charges for services rendered by employees of Hospitals, labs or other institutions, and charges included in other duplicate billings.
- **Hyperhidrosis Treatment.** Medical and surgical treatment of excessive sweating (hyperhidrosis).
- **Incarceration.** For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.
- **Infertility Treatment.** Treatment related to infertility.
- **Inpatient Diagnostic Tests.** Inpatient room and board charges in connection with a Hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.
- **In-vitro Fertilization.** Services or supplies for in-vitro fertilization (IVF) for purposes of pre-implant genetic diagnosis (PGD) of embryos, regardless of whether they are provided in connection with infertility treatment.
- **Lifestyle Programs.** Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by us.
- **Lost, Damaged, Destroyed or Stolen Drugs.** Refills of lost, damaged, destroyed or stolen Drugs.
- **Maintenance Therapy.** Rehabilitative treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function but does not result in any change for the better. This Exclusion does not apply to "Habilitative Services" as described in the "What's Covered" section.
- **Medical Equipment, Devices and Supplies.**
  - 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.
  - Non-Medically Necessary enhancements to standard equipment and devices.

- Supplies, equipment and appliances, including hearing aids that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense, including items you purchase with features that exceed what is Medically Necessary, will be limited to the Maximum Allowed Amount for the standard item, and the additional costs will be your responsibility.
- 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 in the “What's Covered” section.

- **Missed or Cancelled Appointments.** Charges for missed or cancelled appointments.
- **New Prescription Drugs, Indications, and/or Dosage Forms.** New Prescription Drugs, new indications and/or new dosage forms will not be covered until the date they are reviewed and determined to be eligible for coverage by our Pharmacy and Therapeutics (P&T) Process.
- **Non-Approved Drugs.** Drugs not approved by the FDA.
- **Non-Approved Facility.** Services from a Provider that does not meet the definition of Facility.
- **Non-Medically Necessary Services.** Services the Claims Administrator concludes are not Medically Necessary This includes services that do not meet medical policy, clinical coverage, or benefit policy guidelines.
- **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Benefit Booklet or that must be covered by law. This Exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that you can buy over-the-counter and those you can get without a written prescription or from a licensed pharmacist.
- **Off Label Use.** Off label use, unless the Plan must cover it by law or if the Plan approves it.
- **Oral Surgery.** Extraction of teeth, surgery for impacted teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Benefit Booklet.
- **Personal Care and Convenience.**
  - Items for personal comfort, convenience, protective, or cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs.
  - First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads).
  - Home workout or therapy equipment, including treadmills and home gyms.
  - Pools, whirlpools, spas, or hydrotherapy equipment.
  - Hypoallergenic pillows, mattresses, or waterbeds, or
  - Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
- **Private Duty Nursing.** Private duty nursing services given in a Hospital or Skilled Nursing Facility. Private duty nursing services are a Covered Service only when given as part of the “Home Health Care Services” benefit.
- **Prescription Drugs.** Prescription Drugs you get at a drugstore, retail pharmacy or mail order pharmacy are not covered under this Plan (carved out). Benefits for prescription drugs that you take yourself are covered by another plan provided by SISC III. Prescription drugs are covered when administered to you by a Medical Provider.
- **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.
- **Prosthetics.** Prosthetics for sports or cosmetic purposes. This includes wigs and scalp hair prosthetics.

- **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.
  - Services or care billed by a program or facility that principally or primarily provides services for individuals with a medical or Mental Health and Substance Use Disorder diagnosis or condition in an outdoor environment, including wilderness, adventure, outdoor programs or camps.

  This Exclusion does not apply to Medically Necessary treatment of Mental Health and Substance Use Disorder as required by law.
- **Routine Physicals and Immunizations.** Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by federal law under the "Preventive Care" benefit. Executive physical examinations and routine full body scans.
- **Services Not Appropriate for Virtual Telemedicine / Telehealth Visits.** Services that the Claims Administrator determines require in-person contact and/or equipment that cannot be provided remotely.
- **Services You Receive for Which You Have No Legal Obligation to Pay.** Services you actually receive for which you have no legal obligation to pay or for which no charge would be made if you did not have health plan or insurance coverage, except services received at a non-governmental charitable research Hospital. Such a Hospital must meet the following guidelines: a) it must be internationally known as being devoted mainly to medical research, and b) at least ten percent of its yearly budget must be spent on research not directly related to patient care, and c) at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care, and d) it must accept patients who are unable to pay, and e) two-thirds of its patients must have conditions directly related to the Hospital research.
- **Services Received from Providers on a Federal or State Exclusion List.** Any service, drug, drug regimen, treatment, or supply furnished, ordered or prescribed by a provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies. This exclusion does not apply to an emergency medical condition.
- **Services Received Outside of the United States.** Services rendered by Providers located outside the United States, unless the services are for Emergency Care, and Emergency Ambulance.
- **Sexual Dysfunction. Services or supplies for male or female sexual problems.** This exclusion does not apply to Medically Necessary services for the treatment of the underlying condition or Mental Health and Substance Use Disorder as required by federal law or listed as covered under the "Gender Affirming Services" provision of "What's Covered."
- **Special Footwear.** Footwear that is needed by persons who suffer from foot disfigurement, except as described elsewhere in this booklet.
- **Stand-By Charges.** Stand-by charges of a Physician or other Provider.
- **Sterilization.** Services to reverse an elective sterilization.
- **Surrogate Services.** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
- **Temporomandibular Joint Treatment.** Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

- **Travel Costs.** Mileage, lodging, meals and other Member-related travel costs except as described in this Plan.
- **Unlisted Services.** Services not specifically listed in this Plan as Covered Services.
- **Vein Treatment.** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
- **Vision Services.** Vision services not described as Covered Services in this Booklet.
- **Waived Cost Shares Out-of-Network.** For any service for which you are responsible under the terms of this Plan to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.
- **Weight Loss Programs.** Programs, whether or not under medical supervision, unless listed as covered in this Benefit Booklet.

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

Claims Payment

This section describes how the Claims Administrator reimburses claims and what information is needed when you submit a claim. When you receive care from an In-Network Provider, you do not need to file a claim because the In-Network Provider will do this for you. If you receive care from an Out-of-Network Provider, you will need to make sure a claim is filed. Many Out-of-Network Hospitals, Doctors and other Providers will file your claim for you, although they are not required to do so. If you file the claim, use a claim form as described later in this section.

Maximum Allowed Amount

General

This section describes the term "Maximum Allowed Amount" as used in this 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 In-Network and Out-of-Network Providers. It is our payment towards the services billed by your Provider combined with any Deductible, Coinsurance 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 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 the Maximum Allowed Amount and the Provider's actual charges. In many situations, this difference could be significant. If you receive services from an In-Network Facility at which, or as a result of which, you receive non-Emergency Covered Services provided by an Out-of-Network Provider, you will pay the Out-of-Network Provider no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider, but you may have to pay the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount, as well as any applicable Coinsurance, Copayment or Deductible. Please see "Member Cost Share" below for more information.

*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.

The Plan has provided three examples below, which illustrate how the Maximum Allowed Amount works. These examples are for illustration purposes only.

Example: The Plan has a Member Coinsurance of 30% for In-Network Provider services after the Deductible has been met.

- The Member receives services from an In-Network surgeon. The charge is $2,000. The Maximum Allowed Amount under the Plan for the surgery is $1,000. The Member's Coinsurance responsibility when an In-Network surgeon is used is 30% of $1,000, or $300. This is what the Member pays. The Plan pays 70% of $1,000, or $700. The In-Network surgeon accepts the total of $1,000 as reimbursement for the surgery regardless of the charges.

Example: The Plan has a Member Coinsurance of 50% for Out-of-Network Provider services after the 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 Coinsurance 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.

Example: The Member receives outpatient surgery services from an Out-of-Network Facility. The Deductible has not been met, which means that the Plan won't cover anything until the Member meets their Deductible.

- The charge is $3,500. The Maximum Allowed Amount under the Plan for the outpatient Facility surgery is $2,000. The outpatient Facility charges are capped at a maximum benefit payable of $380 per admission. The Plan calculates benefits based on 50% of the Maximum Allowed Amount ($1,000), up to the maximum benefit payable of $380, which is the amount applied to the Member's Deductible. Since the Deductible has not been met, the Member is responsible for paying any charges in excess of the $380 maximum benefit payable that the Provider may bill.

When you receive Covered Services, The Plan will, to the extent applicable, apply claim processing rules to the claim submitted. We, on behalf of the Employer use these rules to evaluate the claim information and determine the accuracy and appropriateness of the procedure and diagnosis codes included in the submitted claim. Applying these rules may affect the Maximum Allowed Amount if the Plan determines that the procedure and/or diagnosis codes used were inconsistent with procedure coding rules, reimbursement policies and/or reimbursement requirements. 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 an In-Network Provider or an Out-of-Network Provider.

In-Network Providers: For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for your Plan is the rate the Provider has agreed with the Claims Administrator to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Member Services at the telephone number on the back of your Identification Card for help in finding an In-Network Provider or visit www.anthem.com/ca/sisc.

Out-of-Network Providers or Other Eligible Providers: Providers who have not signed any contract with us and are not in any of our networks are Out-of-Network Providers or Other Eligible Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary Providers. For Covered Services you receive from an Out-of-Network Provider or Other Eligible Provider, other than Emergency Care within California, the Maximum Allowed Amount will be based on the applicable Out-of-Network Provider or Other Eligible Provider rate or fee schedule for your Plan, an amount negotiated by us or a third-party vendor which has been agreed to by the Out-of-Network Provider or Other Eligible Provider, an amount based on or derived from the total charges billed by the Out-of-Network Provider or Other Eligible Provider, 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 & Medicaid Services (“CMS”). When basing the Maximum Allowed Amount upon the level or method of reimbursement used by CMS, the Claims Administrator will update such information, which is adjusted or unadjusted for geographic locality, no less than annually.

Providers who are not contracted for this product but are contracted for other products with us are also considered Out-of-Network. For this Booklet, the Maximum Allowed Amount for services from these Providers will be one of the methods shown above unless the contract between us and that Provider specifies a different amount.

Unlike In-Network Providers, Out-of-Network Providers and Other Eligible Providers may send you a bill and collect for the amount of the Out-of-Network Provider’s or Other Eligible Provider’s charge that exceeds the Maximum Allowed Amount except those charges related to Emergencies, unless your claim involves a Surprise Billing Claim. This amount can be significant.

Note: If you receive services from an In-Network Facility at which, or as a result of which, you receive non-Emergency Covered Services from Out-of-Network Providers, you will pay no more than the same cost sharing that you would pay for those same non-Emergency Covered Services received from an In-Network Provider, and you will not have to pay the Out-of-Network Provider more than the In-Network cost sharing for such non-Emergency Covered Services, but you may have to pay the difference between the Out-of-Network Provider’s charge and the Maximum Allowed Amount, as well as any applicable Coinsurance, Copayment or Deductible. (Please see “Member Cost Share” in the “Claims Payment” section for more information.)

Choosing an In-Network Provider will likely result in lower out-of-pocket costs to you. Please call the Member Services telephone number on the back of your Identification Card for help in finding an In-Network Provider or visit our website at www.anthem.com/ca/sisc. Member Services is also available to assist you in determining your Plan’s Maximum Allowed Amount for a particular Covered Service from an Out-of-Network Provider or Other Eligible Provider. Please see “Inter-Plan Arrangements” later in this section for additional details.

Please see your “Schedule of Benefits” for your payment responsibility.

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

For Prescription Drugs Administered by a Medical Provider, the Maximum Allowed Amount is the amount determined by us using prescription drug cost information provided by the Pharmacy Benefits Manager.

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 (Deductible, Copayment, and/or Coinsurance). Your cost share amount and Out-of-Pocket Limits may be different depending on whether you received Covered Services from an In-Network Provider, Out-of-Network Provider or Other Eligible 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 or Other Eligible Providers. However, if you receive services from an In-Network Facility at which, or as a result of which, you receive non-Emergency Covered Services from Out-of-Network Providers, you will pay no more than the same cost sharing that you would pay for those same non-Emergency Covered Services received from an In-Network Provider, but you may have to pay the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount, as well as any applicable Coinsurance, Copayment or Deductible. Please see Your "Schedule of Benefits" in this Booklet for your cost share responsibilities and limitations or call Member Services at the telephone number on the back of your Identification Card to learn how this Plan's benefits or cost share amounts may vary by the type of Provider you use.

The Claims Administrator will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network Provider, Out-of-Network Provider or Other Eligible 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, benefit caps or day/ visit limits.

In some instances you may be asked to pay only the lower In-Network Provider cost share percentage when you use an Out-of-Network Provider. For example, if you receive services from an In-Network Hospital or Facility in California at which, or as a result of which, you receive non-Emergency Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist providing services at the Hospital or Facility, you will pay no more than the same cost sharing that you would pay for those same non-Emergency Covered Services received from an In-Network Provider and you will not have to pay the Out-of-Network Provider more than the In-Network cost sharing for such non-Emergency Covered Services, but you may have to pay the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount, as well as any applicable Coinsurance, Copayment or Deductible. The In-Network Provider cost share percentage will apply to any In-Network Deductible and the In-Network Out-of-Pocket Limit. However, if you consent in writing to receive non-Emergency Covered Services from an Out-of-Network Provider while you are receiving services from an In-Network Facility, the Plan will pay such Out-of-Network services based on the applicable Out-of-Network cost sharing stated in your "Schedule of Benefits" in this Booklet. The written consent to receive non-Emergency Covered Services from Out-of-Network Providers while you are receiving services from an In-Network Facility must demonstrate satisfaction of all the following criteria:

- At least 24 hours in advance of care, you consent in writing to receive services from the identified Out-of-Network Provider.
- The consent was obtained by the Out-of-Network Provider in a document that is separate from the document used to obtain the consent for any other part of the care or procedure. The consent was not obtained by the Facility or any representative of the Facility at the time of admission or at any time when you were being prepared for surgery or any other procedure.
- At the time of consent, the Out-of-Network Provider gave you a written estimate of your total out-of-pocket cost of care, based on the Provider's billed charges for the services to be provided. The Out-of-Network Provider shall not attempt to collect more than the estimated amount without receiving a separate written consent from you or your authorized representative, unless the Provider was required to make changes to the estimate due to circumstances during the delivery of services that were unforeseeable at the time the estimate was given.

- The consent advises that you may elect to seek care from an In-Network Provider or that you may make arrangements with your Plan to receive services from an In-Network Provider for lower out-of-pocket costs.
- The consent advises you that any costs incurred as a result of your use of the Out-of-Network benefits are in addition to the In-Network cost sharing amounts and may not count toward the annual In-Network Out-of-Pocket Limit or In-Network Deductible.

Authorized Referrals

In some circumstances, the Plan may authorize In-Network Provider cost share amounts (Deductible, Copayment, and/or Coinsurance) 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 us in advance of obtaining the Covered Service. It is your responsibility to ensure that the Plan has been contacted. If the Plan authorizes an In-Network 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, unless your claim involves a Surprise Billing Claim. If you receive prior authorization for an Out-of-Network Provider due to network adequacy issues, you will still be responsible for the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount. Please contact Member Services at the telephone number on the back of your Identification Card for Authorized Referrals information or to request authorization.

It is important to understand that you may be referred by In-Network Providers to other Providers who may be contracted with the Claims Administrator but are not part of your Plan's network of In-Network Providers. In such case, any claims incurred would be paid as Out-of-Network Provider services, even though the Provider may be a participating Provider with the Claims Administrator.

It is your responsibility to confirm that the Provider you are seeing or have been referred to see is an In-Network Provider with your Plan. While your Plan has provided a network of In-Network Providers, it is important to understand that the Claims Administrator has many contracting Providers who are not participating in the network of Providers for your Plan. Any claims incurred with a participating Provider, who is not participating in your network panel of Providers, will be paid as Out-of-Network Provider services, even if you have been referred by another participating Provider.

Federal/State Taxes/Surcharges/Fees

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

Claims Review

The Claims Administrator has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Out-of-Network Providers could be balanced billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

Notice of Claim & Proof of Loss

After you get Covered Services, the Claims Administrator must receive written notice of your claim in order for benefits to be paid.

- In-Network Providers will submit claims for you. They are responsible for ensuring that claims have the information the Claims Administrator needs to determine benefits. If the claim does not include enough information, the Claims Administrator will ask them for more details, and they will be required to supply those details within certain timeframes.

- Out-of-Network claims can be submitted by the Provider if the Provider is willing to file on your behalf. However, if the Provider is not submitting on your behalf, you will be required to submit the claim. Claim forms are usually available from the Provider. If they do not have a claim form, you can send a written request to the Claims Administrator or contact Member Services and ask for a claims form to be sent to you. If you do not receive the claims form, you can still submit written notice of the claim without the claim form. The same information that would be given on the claim form must be included in the written notice of claim, including:
  - Name of patient.
  - Patient's relationship with the Subscriber.
  - Identification number.
  - Date, type, and place of service.
  - Your signature and the Provider's signature.

  Out-of-Network claims must be submitted within 180 days after the date of service. In certain cases, federal law may allow additional time to file a claim, if you could not reasonably file within the 180-day period. The claim must have the information the Plan needs to determine benefits. If the claim does not include enough information, the Claims Administrator will ask you for more details and inform you of the time by which the Plan needs to receive that information. Once the Claims Administrator receives the required information, the Claims Administrator will process the claim according to the terms of your Plan.

  Note: Failure to submit the information the Claims Administrator needs by the time listed in our request could result in the denial of your claim, unless federal law requires an extension. Please contact Member Services if you have any questions or concerns about how to submit claims.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, contact your local Human Resources Department or Member Services and ask for a claim form to be sent to you. If you do not receive the claim form, written notice of services rendered may be submitted without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

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

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, Worker's Compensation or any other governmental program. If you fail to cooperate, you will be responsible for any charge for services.

Payment of Benefits

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 Services, except for claims for Emergency Care or Surprise Billing Claims for ground or air ambulance services or non-Emergency services performed by Out-of-Network Providers at certain In-Network Facilities, which will be paid directly to Providers and Facilities. In the event that payment is made directly to you, you have the responsibility to apply this payment to the claim from the Out-of-Network Provider. Payments and notice regarding the receipt and/or adjudication of claims may also be sent to an Alternate Recipient (which is defined herein as any child of a Subscriber who is recognized under a "Qualified Medical Child Support Order" as having a right to enrollment under the Group'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 Plan'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, 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. Any assignment made without written consent from the Plan will be void and unenforceable.

Inter-Plan Arrangements

Out-of-Area Services

Overview

Anthem has a variety of relationships with other Blue Cross and 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 Anthem serves (the "Anthem 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 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 ("nonparticipating providers") don't contract with the Host Blue. Explained below is how both kinds of Providers are paid.

Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above.

A. BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, Anthem will still fulfill their contractual obligations. But the Host Blue is responsible for: (a) contracting with its Provider; and (b) handling its interactions with those Providers.

When you receive Covered Services outside the Anthem 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.
- The negotiated price that the Host Blue makes available to Anthem.

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 Anthem uses 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 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 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, through average pricing or fee schedule adjustments. Additional information is available upon request.

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

If Anthem has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Plan on your behalf, Anthem 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, Anthem will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

E. Nonparticipating Providers Outside The Service Area

The pricing method used for nonparticipating provider claims incurred outside the Anthem Service Area is described in "Claims Payment."

F. Blue Cross Blue Shield Global Core® Program

If you plan to travel outside the United States, call Member Services to find out your Blue Cross Blue Shield Global Core® benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up-to-date health ID card with you.

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

If you need inpatient hospital care, you or someone on your behalf, should contact us for Precertification. 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 "Getting Approval for Benefits" section in this Booklet for further information. You can learn how to get Precertification 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, Coinsurance or Deductible amounts that may apply.

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

- Doctor services.
- Inpatient hospital care not arranged through Blue Cross Blue Shield Global Core®.
- 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 number above.
- Online at www.bcbsglobalcore.com.

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

Coordination of Benefits When Members Are Insured Under More Than One Plan

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

Definitions

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

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

The following are not Allowable Expense:

1. Use of a private hospital room is not an Allowable Expense unless the patient's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage for hospital private rooms.
2. If you are covered by two plans that calculate benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method, any amount in excess of the higher of the reasonable and customary amounts.
3. If a person is covered by two plans that provide benefits or services on the basis of negotiated rates or fees, an amount in excess of the lower of the negotiated rates.
4. If a person is covered by one plan that calculates its benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method and another plan provides its benefits or services on the basis of negotiated rates or fees, any amount in excess of the negotiated rate.
5. The amount of any benefit reduction by the Principal Plan because you did not comply with the plan’s provisions is not an Allowable Expense. Examples of these types of provisions include second surgical opinions, utilization review requirements, and network provider arrangements.
6. If you advise the Claims Administrator 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, including a self-insured program.

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

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

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

Effect on Benefits

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

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

Order of Benefits Determination

The 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 anyone 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.

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

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

   For example: You are covered as a retired employee under this plan and entitled to Medicare (Medicare would normally pay first). You are also covered as a dependent of an active employee under another plan (in which case Medicare would pay second). In this situation, the plan which covers you as a dependent will pay first, Medicare will pay second, and the plan which covers you as a retired employee would pay last.
3. For a dependent Child covered under plans of two parents, the plan of the parent whose birthday falls earlier in the Calendar Year pays before the plan of the parent whose birthday falls later in the Calendar Year. But if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits.

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

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

5. The plan covering you under a continuation of coverage provision in accordance with 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 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.

The Claims Administrator's Rights Under This Provision

Responsibility For Timely Notice. The Claims Administrator 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, the Claims Administrator has the right to pay that Other Plan any amount they 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 the Claims Administrator's 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, SISC III 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

For Active Subscribers and Dependents. If you are an active Subscriber or a Dependent of an active Subscriber, and eligible for Medicare, you will receive full benefits of this Plan, except for those Members listed below who are eligible for Medicare Part A and Part B.

If you or a covered Dependent and become eligible for Medicare coverage because of end-stage renal disease, this Plan is the primary payor for the individual with end-stage renal disease for the first 30 months the individual is enrolled in or "eligible to enroll" in Medicare. At the end of 30 months, Medicare becomes the primary payor for that individual.

1. If you are eligible for Medicare benefits. Medicare will be the Primary Plan unless you have a "current" employment status as determined by Medicare rules. Medicare coverage is primary for disabled employees.
   - Eligible for Medicare benefits.
   - Not actively working as defined by federal law.

In cases where 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.

For Retired Employees and Their Spouses. Any Member that is enrolled in a retiree SISC Plan is required to enroll in Medicare Part A and B when eligible to enroll and stay enrolled.

- For members that do not enroll in Medicare Part A and/or B when eligible to enroll or members that dis-enroll from Medicare Part A and/or B, SISC III reserves the right to surcharge your fee by an amount necessary to provide the hospital and/or medical benefits of this Plan.
- If you are not eligible to have your fee surcharged or if you decline a fee surcharge, SISC III reserves the right to reduce your benefits. The Plan will not provide benefits that duplicate any benefits to which you would be entitled under full Medicare coverage (Medicare Parts A and B), whether or not you are actually enrolled in Medicare Parts A or B

At the request of SISC III, the Claims Administrator will reduce your benefits by the amount Medicare would have paid. If the benefit reduction occurs, you will be responsible for any deductible and coinsurance amount due plus the reduction made by the Plan due to the absence of Medicare. The benefit reduction will occur in all cases where Medicare is considered the primary plan, even if you are not enrolled in Medicare Parts A and/or B. The Claims Administrator will reduce benefits only if instructed by SISC III.

If you are a retired Employee or the spouse of a retired Employee and you are enrolled in Medicare Part A and/or Part B, your benefits under this Plan will be subject to the section entitled Coordination of Benefits and the provision "Coordinating Benefits With Medicare," below.

Coordinating Benefits With Medicare. The Plan will not provide benefits that duplicate any benefits to which you would be entitled under full Medicare coverage (Medicare Parts A and B), whether or not you are actually enrolled in Medicare Parts A or B, and whether or not the benefits to which you are entitled are actually paid by Medicare.

If you are entitled to Medicare, your Medicare coverage will not affect the services covered under this Plan

except as follows.

1. Medicare must provide benefits first to any services covered both by Medicare and under this Plan.
2. For services you receive that are covered both by Medicare and under this Plan, coverage under this Plan will apply only to Medicare deductibles, coinsurance, and other charges for covered services over and above what Medicare pays.
3. For any given claim, the combination of benefits provided by Medicare and the benefits provided under this

   Plan will not exceed the Maximum Allowed Amount for the covered services.
4. For covered drugs, including drugs covered under the pharmacy Plan. The Plan will pay secondary to Medicare for Medicare Part B drugs.

The Claims Administrator will apply any charges paid by Medicare for services covered under this Plan toward your Plan deductible, if any.

Required Monthly Contributions for Medicare Eligible Members

For Active Subscribers and Dependents Eligible for but not enrolled under Medicare Part A and/or Medicare Part B. Your Medicare eligibility or enrollment does not impact your coverage or the cost of your Plan to the district or the Member's payroll deduction, if any.

For Retired Employees and Their Spouses over the age of 65 and eligible for but not enrolled in Medicare Part A and/or Medicare Part B.

- If you are a retiree that pays monthly contributions for your retiree coverage; the required monthly contribution for coverage under this Plan will be increased (surcharged) by an amount necessary to provide the hospital and/or medical benefits of this Plan.
- If you are not eligible to have your fee surcharged, the Plan will not provide benefits that duplicate any benefits to which you would be entitled under full Medicare coverage (Medicare Parts A and B), whether or not you are actually enrolled in Medicare Parts A or B. At the request of SISC III, the claims administrator will reduce your benefits by the amount Medicare would have paid. Please contact your district for further information.

If you are still employed, in working status, your Medicare eligibility or enrollment will not impact your coverage or the cost of your Plan to your district or the Member's portion, if any.

- **Any Member under the age of 65 that is on a retiree SISC Plan is required to enroll in Medicare Part A and B when eligible to enroll and stay enrolled;** otherwise; a surcharge or a reduction of benefits may apply. If you are a retiree that pays monthly contributions for your retiree coverage; the required monthly contribution for coverage under this Plan will be increased (surcharged) by an amount necessary to provide the hospital and/or medical benefits of this Plan.
- If you are not eligible to have your fee surcharged, the Plan will not provide benefits that duplicate any benefits to which you would be entitled under full Medicare coverage (Medicare Parts A and B), whether or not you are actually enrolled in Medicare Parts A or B. At the request of SISC III, the claims administrator will reduce your benefits by the amount Medicare would have paid.

  Please contact your district for further information.

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 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.
- You are entitled to a full and fair review of the denial or rescission.

The procedure the Claims Administrator will follow will satisfy the requirements for a full and fair review under applicable federal regulations.

Notice of Adverse Benefit Determination

If your claim is denied, the Claims Administrator’s notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved.
- the specific reason(s) for the denial.
- a reference to the specific Plan provision(s) on which the Claims Administrator’s determination is based.
- a description of any additional material or information needed to perfect your claim.
- an explanation of why the additional material or information is needed.
- a description of the Plan’s review procedures and the time limits that apply to them.
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision.
- information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision.
- information regarding your potential right to an External Appeal pursuant to federal law.

For claims involving urgent/concurrent care:

- the Claims Administrator’s notice will also include a description of the applicable urgent/concurrent review process.
- the Claims Administrator’s may notify you or your authorized representative within 24 hours orally and then furnish a written notification.

Appeals (Grievances)

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. Appeals can be in writing or taken over the telephone.

You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. The Claims Administrator’s review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

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

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

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

Appeals can be in writing or taken over the telephone.

When submitting in writing, 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, the Claims Administrator will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination.
- was submitted, considered, or produced in the course of making the benefit determination.
- 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.
- is a statement of the Plan's policy or guidance about the treatment or benefit relative to your diagnosis.

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

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

How Your Appeal will be Decided

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

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

Notification of the Outcome of the Appeal

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

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

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

Appeal Denial

If your appeal is denied, that denial will be considered an adverse benefit determination. The notification from the Claims Administrator will include all of the information set forth in the above subsection entitled “Notice of Adverse Benefit Determination.”

If, after the denial, the Claims Administrator considers, rely on or generate any new or additional evidence in connection with your claim, the Claims Administrator will provide you with that new or additional evidence, free of charge. The Claims Administrator will not base their appeal decision on a new or additional rationale without first providing you (free of charge) with, and a reasonable opportunity to respond to, any such new or additional rationale. If the Claims Administrator fails to follow the Appeal procedures outlined under this section the Appeals process may be deemed exhausted. However, the Appeals process will not be deemed exhausted due to de minimis violations that do not cause, and are not likely to cause, prejudice or harm so long as the error was for good cause or due to matters beyond the Claims Administrator's control.

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, you may do so by calling Customer Service, sending a secure message, or sending a letter via correspondence to the address listed above. Voluntary appeals (Grievances) 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 your coverage, you may be eligible for an independent External Review pursuant to federal law. You must submit your request for External Review to the Claims Administrator within four (4) months of the notice of your final internal adverse determination.

A request for an External Review may be in writing or by phone. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

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

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

All other requests for External Review should be submitted in writing or by phone. Written 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

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

Requirement to file an Appeal before filing a lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within one year of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's decision on the claim or other request for benefits from which the appeal was taken shall be considered the Plan's final decision, and the one-year period in which a lawsuit or legal action must be brought shall run from the date of that final decision, not the date on which Anthem decided the appeal was untimely. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal appeals procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan.

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

Binding Arbitration

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this plan or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort, or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

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

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

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

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

The arbitration is begun by the member making written demand on the plan administrator. Any demand for arbitration must be made within one (1) year from the issuance by the claim's administrator of its decision following appeal. In cases where the amount in controversy is within the jurisdiction of small claims court, suit must be filed within one (1) year from the issuance by the claim's administrator of its decision following appeal. Failure to demand arbitration or file in small claims court within one (1) year of the issuance by the claims administrator of its decision following appeal shall result in the forfeiture of any right to arbitration or to take any other legal action. Any written demand should be sent to the plan administrator at the address shown below:

SISC III
P.O. Box 1847
Bakersfield, CA 93303-1847

The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the member and the plan administrator, or by order of the court, if the member and the plan administrator cannot agree. The arbitration will be held at a time and location mutually agreeable to the member and the plan administrator.

If you choose to retain an attorney, expert, consultant or any other individual to assist in presentation of a claim, it must be at your own expense. Neither the plan nor the Claims Administrator will reimburse you for the costs associated with such a retention or for any other expenses you may incur in connection with such a retention.

Eligibility and Enrollment – Adding Members
Participation Requirements

In this section you will find information on who is eligible for coverage under this Plan and when Members can be added to your coverage. Eligibility requirements are described in general terms below.

Who is Eligible for Coverage

The Subscriber

A Subscriber is

a. A classified non-temporary Subscriber who works the minimum number of hours required by SISC III and the Participating Employer.

b. A certificated Subscriber under contract and who works a minimum of 50% of a certificated job.

c. A retired employee who retired from active employment and was covered under a Plan sponsored by SISC III immediately prior to retirement.

Any Subscriber who works at least 20 hours per week is eligible to enroll. Any Subscriber who works an average of 30 hours per week as defined by federal law must be offered coverage. Any Subscriber who works at least 90% of a 40-hour work week must enroll according to SISC III's eligibility policy.

Dependents

The following persons are eligible to enroll as Dependents: (a) Either the Subscribers spouse or domestic partner; and (b) A child.

A Dependent becomes eligible for coverage on the later of: (a) the date the Subscriber becomes eligible for coverage; or, (b) the date you meet the Dependent definition.

To be eligible to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria established by the Plan Administrator, and be one of the following:

1. The Subscriber's spouse. A Spouse is the subscriber's spouse as recognized under state or federal law. This includes same sex spouses when legally married in a state that recognizes same sex marriages. Spouse does not include any person who is in active service in the armed forces.

   Note: Legally separated spouses are eligible for coverage under this Plan.

   You can enroll both as an employee and a spouse or domestic partner. If you and your spouse, or domestic partner, are both covered as employees under this Plan, your children may be covered as family members of both. However, the total amount of benefits we will pay will not be more than the amount covered.

2. The Subscriber's Domestic Partner. Domestic partner is the subscriber's domestic partner. Domestic partner does not include any person who is in active service in the armed forces. In order for the subscriber to include their domestic partner as a dependent, the subscriber and domestic partner must meet the following requirements:

   a. Both persons have a common residence.

   b. Both persons agree to be jointly responsible for each other's basic living expenses incurred during their domestic partnership.

   c. Neither person is married or a member of another domestic partnership.

   d. The two persons are not related by blood in a way that would prevent them from being married to each other in California.

   e. Both persons are at least 18 years of age.

   f. Both persons are capable of consenting to the domestic partnership.

   g. Neither person has previously filed: (1) a Declaration of Domestic Partnership with the California Secretary of State, or a similar form with another governing jurisdiction, that has not been terminated pursuant to the laws of California, or of that other jurisdiction, or if (1) does not apply, (2) an affidavit with

SISC III declaring they are part of a domestic partnership that they have not been terminated by giving SISC III written notice that it has.

h. It has been at least six months since: (1) the date that the Notice of Termination of Domestic Partnership was filed with the California Secretary of State, or similar form was filed with another governing authority; or, if (1) does not apply, (2) either person has given written notice to SISC III that the domestic partnership they declared in an affidavit, given to SISC III, has terminated. This item does not apply if the previous domestic partnership ended because one of the partners died or married.

i. Both partners:

   i. If they reside in the State of California, must file a Declaration of Domestic Partnership with the California Secretary of State pursuant to Division 2.5 of the California Family Code to establish their domestic partnership. The subscriber must provide SISC III with a certified copy of the Declaration of Domestic Partnership that was filed with the California Secretary of State.

   ii. If they reside in another state or governing jurisdiction that registers domestic partnerships, they must register their domestic partnership with that state or governing jurisdiction. The subscriber must provide SISC III with a certified copy of the document that was filed with the governing jurisdiction registering their domestic partnership; or

   iii. If the subscriber and their domestic partner do not reside in a city, county or state that allows them to register as domestic partners, they must provide SISC III with a signed, notarized, affidavit certifying they meet all of the requirements set forth in 2.a through 2.h above, inclusive.

   Note: For the purposes of 2.i.i above, if the subscriber and their domestic partner registered their relationship prior to July 1, 2000, with a local governing jurisdiction in California, in lieu of supplying SISC III with a certified copy of the Declaration of Domestic Partnership (a State of California form), the subscriber may provide SISC III with a certified copy of the form filed with the local governing jurisdiction.

For the purposes of this provision, the following definitions apply: “Have a common residence” means that both domestic partners share the same residence. It is not necessary that the legal right to possess the common residence be in both of their names. Two people have a common residence even if one or both have additional residences. Domestic partners do not cease to have a common residence if one leaves the common residence but intends to return. “Basic living expenses” means shelter, utilities, and all other costs directly related to the maintenance of the common household of the common residence of the domestic partners. It also means any other cost, such as medical care, if some or all of the cost is paid as a benefit because a person is another person's domestic partner. “Joint responsibility” means that each partner agrees to provide for the other partner's basic living expenses if the partner is unable to provide for herself or himself. Persons to whom these expenses are owed may enforce this responsibility if, in extending credit or providing goods or services, they relied on the existence of the domestic partnership and the agreement of both partners to be jointly responsible for those specific expenses.

3. Child is the subscriber's, spouse's or domestic partner's, natural child, stepchild, legally adopted child, or a child for whom the subscriber, spouse or domestic partner has been appointed legal guardian by a court of law or has legal custody according to 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) continues to be dependent on the subscriber, spouse or domestic partner for financial support and maintenance as defined by IRS rules. A child is considered chiefly dependent for support and maintenance if he or she is claimed as a dependent for federal income tax purposes; and (ii) is incapable of self-sustaining employment due to a physical or mental condition and the disability existed prior to reaching age 26 and has remained continuously disabled since age 26, as certified by a licensed physician. A licensed physician must certify in writing that the child is incapable of self-sustaining employment due to a physical or mental condition and that the child has remained continuously disabled since age 26. SISC III must receive the certification, at no expense to itself, within 60-days of the date the subscriber receives the request from SISC III. SISC III may request proof of continuing dependency and that a physical or mental condition still exists, but not more often than once each year after the initial certification. This exception will last until the child is no longer chiefly dependent on the subscriber, spouse or domestic partner for financial support as defined by IRS rules and maintenance due to a continuing physical or mental condition. A child is considered chiefly dependent for support and maintenance if he or she is claimed 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 SISC III receives legal evidence of both: (i) the intent to adopt; and (ii) that the subscriber, spouse or domestic partner have either: (a) the right to control the health care of the child; or (b) assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption.

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

   d. A Child for whom the subscriber, spouse or domestic partner is a legal guardian is considered eligible on the date of the court decree. SISC III must receive legal evidence of the decree. Such Child must be enrolled as set forth in the Eligibility Section.

For purposes of this Plan, a Domestic Partner shall be treated the same as a spouse, and a Domestic Partner's child, adopted child, or child for whom a Domestic Partner has legal guardianship shall be treated the same as any other child.

Any federal or state law that applies to a Member who is a spouse or child under this Plan shall also apply to a Domestic Partner or a Domestic Partner's child who is a Member under this Plan. This includes but is not limited to, COBRA, FMLA, and COB. A Domestic Partner's or a Domestic Partner's child's coverage ends on the date of dissolution of the Domestic Partnership.

Note: Before a Dependent's enrollment is processed, SISC III reserves the right to request documentation or proof of his or her eligibility (that is a marriage certificate, a birth certificate, a court decree, adoption papers or any other documentation that SISC III deems relevant and appropriate). SISC also reserves the right to request any relevant and appropriate documentation at any time to confirm a Dependent's continued eligibility. In addition, before you can enroll your Domestic Partner, SISC III reserves the right to request documentation or proof to support the Domestic Partnership (that is a Declaration of Domestic Partnership or properly executed affidavit as noted above under Domestic Partner).

No one shall be eligible as a Dependent if they are denied enrollment in their employer sponsored medical Plan and alternatively required to be covered by their employer's MERP (Medical Expense Reimbursement Plan) or other Plan whose design shifts all comprehensive medical care to the SISC medical Plan and which does not have standard Coordination of Benefits Rules.

All enrolled eligible children will continue to be covered until the age limit listed in the Schedule of Benefits.

The Plan may require you to give proof of continued eligibility for any enrolled child. Your failure to give this information could result in termination of a child's coverage.

To obtain coverage for children, the Plan may require you to give the Claims Administrator a copy of any legal documents awarding guardianship of such child(ren) to you.

Types of Coverage

The types of coverage available to the Employee are indicated at the time of enrollment through the Employer.

When You Can Enroll

Enrollment

Your Employer offers an enrollment period to Subscribers and their Dependents who are eligible for coverage in accordance with rules established by SISC III. Your effective date of coverage is subject to the timely payment of required monthly contributions as stated in the participation agreement. The date you become covered is determined as follows:

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

Note: Disenrollment is not allowed for qualified subscribers. Disenrollment of dependents outside of the open enrollment period is only allowed due to a qualifying event.

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

Important Note for Newborn and Newly Adopted Children. If the subscriber (or spouse or domestic partner, if the spouse or domestic partner is enrolled) is already covered: (1) any child born to the subscriber, spouse or domestic partner will be covered from the moment of birth; and (2) any child being adopted by the subscriber, spouse or domestic partner will be covered from the date on which either: (a) the adoptive child's birth parent, or other appropriate legal authority, signs a written document granting the subscriber, spouse or domestic partner the right to control the health care of the child (in the absence of a written document, other evidence of the subscriber's, spouse's or domestic partner's right to control the health care of the child may be used); or (b) the subscriber, spouse or domestic partner assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption. The written document referred to above includes, but is not limited to, a health facility minor release report, a medical authorization form, or relinquishment form. In both cases, coverage will be in effect for 31 days. For coverage to continue beyond this 31-day period, the subscriber must enroll the child within the 31-day period by submitting a membership change form to SISC III. Any membership change form not filed within the 31-day period must be submitted to SISC III during the Open Enrollment Period generally held during September of each year for an effective date of October 1.

Open Enrollment

Open Enrollment refers to a period of time, usually the month of September, during which eligible Subscribers and Dependents can apply for or change coverage. Open Enrollment occurs only once per year. Your Employer will notify you when Open Enrollment is available.

Special Enrollment Periods

If a Subscriber or Dependent does not apply for coverage when they were first eligible, they may be able to join the Plan prior to Open Enrollment if they qualify for Special Enrollment. Except as noted otherwise below, the Subscriber or Dependent must request Special Enrollment within 31 days of a qualifying event.

Special Enrollment is available for eligible individuals who:

- Lost eligibility under a prior health plan for reasons other than non-payment of Fees or due to fraud or intentional misrepresentation of a material fact.
- Exhausted COBRA benefits or Employer contributions toward coverage were terminated.
- Lost employer contributions towards the cost of the other coverage.
- Are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.

Note on Special Enrollment:

- Members who enroll during Special Enrollment are **not** considered Late Enrollees.
- Individuals must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).

Medicaid and Children's Health Insurance Program Special Enrollment

Eligible Subscribers and Dependents may also enroll under two additional circumstances.

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility.
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program)

The Subscriber or Dependent must request Special Enrollment within 31 days of the above events.

Late Enrollees

If the Subscriber does not enroll themselves and/or their Dependents when first eligible or during a Special Enrollment period, they will not be eligible to enroll until the next Open Enrollment Period.

Members Covered Under the Plan Administrator's Prior Plan

Members who were previously enrolled under another plan offered by the Employer that is being replaced by this Plan are eligible for coverage on the Effective Date of this coverage.

Enrolling Dependent Children

Newborn Children

Newborn children are covered automatically for 31 days from the moment of birth. Following the birth a child, you should submit an application / change form to the Plan Administrator within 31 days to add the newborn to your Plan.

Even if no additional Fees are required, you should still submit an application / change form to the Plan Administrator to add the newborn to your Plan, to make sure records are accurate and the Plan is able to cover your claims.

Adopted Children

A child will be considered adopted from the earlier of: (1) the moment of placement in your home; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Your Dependent's Effective Date will be the date of the adoption or placement for adoption if you send the Plan the completed application / change form within 31 days of the event. If, however, additional Fees are required for the adopted Dependent, your Dependent's Effective Date will be the date of the adoption or placement for adoption, only if you notify the Plan of the adoption and pay any required additional Fees within 31 days of the adoption.

Adding a Child due to Award of Legal Custody or Guardianship

If you or your spouse is awarded legal custody or guardianship for a child, an application must be submitted within 31 days of the date legal custody or guardianship is awarded by the court. Coverage will be effective on the date the court granted legal custody or guardianship.

Qualified Medical Child Support Order

If you are required by a qualified medical child support order or court order, as defined by applicable state or federal law, to enroll your child in this Plan, the Claims Administrator will permit the child to enroll at any time without regard to any Open Enrollment limits and will provide the benefits of this Plan in accordance with the applicable requirements of such order. However, a child's coverage will not extend beyond any Dependent Age Limit listed in the “Schedule of Benefits.”

Updating Coverage and/or Removing Dependents

You are required to notify the Plan Administrator of any changes that affect your eligibility or the eligibility of your Dependents for this Plan. When any of the following occurs, contact the Plan Administrator and complete the appropriate forms.

- Changes in address.
- Marriage or divorce.
- Death of an enrolled family member (a different type of coverage may be necessary).
- Enrollment in another health plan or in Medicare.
- Eligibility for Medicare.
- Dependent child reaching the Dependent Age Limit (see “Termination and Continuation of Coverage”).
- Enrolled Dependent child either becomes totally or permanently disabled or is no longer disabled.
  - Overage disabled children must be claimed as a tax dependent by either you or your spouse/domestic partner.

    Documentation for the appropriate child type (as noted above) and a copy of the front page of the employee/retiree’s most recent federal tax return that includes the child.
  - Licensed physician certification certifying that the child is incapable of self-sustaining employment due to a physical or mental condition and that the disability existed prior to reaching age 26 and has remained continuously.

Failure to notify the Plan Administrator of individuals no longer eligible for services will not obligate the Plan to cover such services, even if Fees are received for those individuals. All notifications must be in writing and on approved forms.

Note: Disenrollment is not allowed for qualified Subscribers. Disenrollment of Dependents outside of the Open Enrollment Period is only allowed due to a qualifying event.

Nondiscrimination

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

Statements and Forms

All Members must complete and submit applications, or other forms or statements that the Plan may reasonably request.

Any rights to benefits under this Plan are subject to the condition that all such information is true, correct, and complete. Any material misrepresentation by you may result in termination of coverage as provided in the “Termination and Continuation of Coverage” section. The Plan will not use a statement made by you to void your coverage after that coverage has been in effect for two years. This does not apply, however, to fraudulent misstatements.

Termination and Continuation of Coverage

Termination of Coverage

Coverage may be cancelled without notice from SISC III for any of the reasons listed below. SISC III does not provide notice of cancellation to members but will notify the participating employer.

1. Subscriber

a. If the participation agreement between the participating Employer and SISC III terminates, the subscriber's coverage ends at the same time. Either the participating employer or SISC III may cancel or change the participation agreement without notice to subscribers.

b. If the participating employer no longer provides coverage for the class of members to which the subscriber belongs, the subscriber's coverage ends when coverage for that class ends.

c. If the subscriber no longer meets the eligibility requirements established by SISC III in the participation agreement, the subscriber's coverage ends as of the next required monthly contribution due date. This is usually the first of the month.

d. If required monthly contributions are not paid on the subscriber's behalf, the subscriber's coverage will end on the first day of the period for which required monthly contributions are not paid.

e. If less than full-time subscribers or subscribers who receive less than the amount contributed toward the cost of a full-time subscriber voluntarily cancel coverage, coverage ends on the first day of the month following a 30-day notice.

f. If a retired employee does not elect coverage upon his or her retirement, coverage ends on the first day of the month immediately following his or her retirement date. If a retired employee declines district coverage, the retired employee may not elect coverage at a future date.

Exception to item c.

If required monthly contributions are paid, coverage may continue for a subscriber who is granted a temporary leave of absence up to six months, a sabbatical year's leave of absence of up to 12 months, or an extended leave of absence due to illness certified annually by the participating employer.

2. Dependents

a. If coverage for the subscriber ends coverage for dependents ends at the same time.

b. If coverage for dependents ceases to be available to the subscriber, dependent's coverage ends on that date.

c. If the participating employer fails to pay the required monthly contributions on behalf of a dependent, coverage ends on the last date for which the participating employer made this payment.

d. If a dependent's coverage is canceled, coverage ends on the first day of the month following a written notice within 31 days of a qualifying event.

e. If a dependent no longer meets the requirements set forth in the "Eligibility Section" provision of HOW COVERAGE BEGINS, coverage ends on the first day of the month following that date.

Exceptions to item e: Handicapped Children: If a child reaches the age limits shown in the "Eligibility Section" provision of this section, the child will continue to qualify as a dependent if he or she is (i) covered under this plan, (ii) still chiefly dependent on the subscriber, spouse or domestic partner for support and maintenance as defined by IRS rules, and (iii) incapable of self-sustaining employment due to a physical or mental condition.

A physician must certify in writing that the child has a physical or mental condition that makes the child incapable of obtaining self-sustaining employment. The Plan Administrator will notify the subscriber that the child's coverage will end when the child reaches the plan's upper age limit at least 90-days prior to the date the child reaches that age. The subscriber must send SISC III proof of the child's physical or mental condition within 60-days of the date the subscriber receives The Plan Administrators notice. If SISC III does not complete their determination of the child's continuing eligibility by the date the child reaches the plan's upper age limit, the child will remain covered pending determination by SISC III. When a period of two years has passed, SISC III may request proof of continuing dependency due to a continuing physical or mental condition, but not more often than once each year. This

exception will last until the child is no longer chiefly dependent on the subscriber, spouse or domestic partner for support and maintenance or a physical or mental condition no longer exists. A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

All conditions of eligibility shall be in accordance with the eligibility rules adopted by SISC III.

Note: If a marriage or domestic partnership terminates, the subscriber must give or send to SISC III written notice of the termination. Coverage for a former spouse or domestic partner, if any, ends according to the “Eligible Status” provisions. If SISC III suffers a loss as a result of the subscriber failing to notify them of the termination of their marriage or domestic partnership, SISC III may seek recovery from the subscriber for any actual loss resulting thereby. Failure to provide written notice to SISC III will not delay or prevent termination of the marriage or domestic partnership. If the subscriber notifies the plan administrator in writing to cancel coverage for a former spouse or domestic partner and the children of the spouse or domestic partner, if any, immediately upon termination of the subscriber’s marriage or domestic partnership, such notice will be considered compliance with the requirements of this provision.

Coverage of an enrolled child ceases at the end of the month when the child attains the age limit shown in the Eligibility section.

Coverage of the Spouse of a Subscriber terminates at the end of the month as of the date of divorce or death. Dependents no longer eligible due to divorce may have their coverage terminated retroactively up to 12 to the end of the month following the date of the divorce.

If you perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan, your coverage and the coverage of your Dependents can be retroactively terminated or rescinded. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a 30 -calendar day advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayments made, Fees or Premium paid for such services.

If you permit the use of your or any other Member’s Plan Identification Card by any other person; use another person’s Identification Card; or use an invalid Identification Card to obtain services, your coverage will terminate immediately upon written notice to the Group. Anyone involved in the misuse of a Plan Identification Card will be liable to and must reimburse the Claims Administrator for the Maximum Allowed Amount for services received through such misuse.

Coverage for inpatient admissions is provided only while the Member is active under the group plan.

Removal of Members

Disenrollment is not allowed for qualified Subscribers. Disenrollment of Dependents outside of the Open Enrollment Period is only allowed due to a qualifying event.

Continuation of Coverage Under Federal Law (COBRA)

If your coverage ends under the Plan, you may be entitled to elect continuation coverage in accordance with federal law. If your Employer normally employs 20 or more people, and your employment is terminated for any reason other than gross misconduct you may elect from 18-36 months of continuation benefits. You should contact your Employer or SISC III if you have any questions about your COBRA rights.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when your group coverage would otherwise end because of certain “qualifying events.” After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your Spouse and your Dependent children could become qualified beneficiaries if covered on the day before the qualifying event and group coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each member of your family who is enrolled in the company's Employee welfare benefit plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Subscribers may elect COBRA continuation coverage on behalf of their Spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Subscriber during the period of continuation coverage is also eligible for election of continuation coverage.

Qualifying Event	Length of Availability of Coverage
For Employees.	
Voluntary or Involuntary Termination (other than gross misconduct) or Loss of Coverage Under an Employer's Health Plan Due to Reduction In Hours Worked	18 months
For Spouses/ Dependents.	
A Covered Employee's Voluntary or Involuntary Termination (other than gross misconduct) or Loss of Coverage Under an Employer's Health Plan Due to Reduction In Hours Worked	18 months
Covered Subscriber's Entitlement to Medicare	36 months
Divorce or Legal Separation	36 months
Death of a Covered Employee	36 months
For Dependent Children.	
Loss of Dependent Child Status	36 months

Continuation coverage stops before the end of the maximum continuation period if the Member becomes entitled to Medicare benefits. If a continuing beneficiary becomes entitled to Medicare benefits, then a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. (For example, if you become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for your Spouse and children can last up to 36 months after the date of Medicare entitlement.)

If the Plan Administrator Offers Retirement Coverage

If you are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code may be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Employer or SISC III, and that bankruptcy results in the loss of coverage, you will become a qualified beneficiary with respect to the bankruptcy. Your surviving Spouse and Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life. His or her Spouse and Dependents may continue coverage for a maximum period of up to 36 months following the date of the retiree's death.

Second qualifying event

If your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA continuation coverage, your Dependents can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused your Dependents to lose coverage under the Plan had the first qualifying event not occurred. A qualified beneficiary must give timely notice to the Plan Administrator in such a situation.

Notification Requirements

In the event of your termination, lay-off, reduction in work hours or Medicare entitlement, your Employer must notify the SISC III within 30-days. You must notify your employer within 31 days of your divorce or the failure of your enrolled Dependents to meet the program's definition of Dependent. This notice must be provided in writing to SISC III.

Electing COBRA Continuation Coverage

To continue enrollment, you or an eligible family member must make an election within 60 days of the date your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies you or your family member of this right, whichever is later. You must pay the total Fees appropriate for the type of benefit coverage you choose to continue. If the Fees rate changes for active associates, your monthly premium will also change. The Fees you must pay cannot be more than 102% of the Fees charged for Employees with similar coverage, and it must be paid to the company's benefit Plan Administrator within 30-days of the date due, except that the initial Fees payment must be made before 45 days after the initial election for continuation coverage, or your continuation rights will be forfeited.

Disability extension of 18-month period of continuation coverage

For Employees who are determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Employees who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Employees' Dependents are also eligible for the 18 to 29-month disability extension. (This provision also applies if any covered family member is found to be disabled.) This provision would only apply if the qualified beneficiary provides notice of disability status within 60 days of the disabling determination. In these cases, the Employer can charge 150% of Fees for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled at 29 months. (If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30-days after the Social Security Administration's determination.)

Trade Adjustment Act Eligible Individual

If you don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused you to be eligible initially for COBRA coverage under this Plan, you will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which you become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period.

When COBRA Coverage Ends

COBRA benefits are available without proof of insurability and coverage will end on the earliest of the following.

- A covered individual reaches the end of the maximum coverage period.
- A covered individual fails to pay a required Fees on time.
- A covered individual becomes covered under any other group health plan after electing COBRA.
- A covered individual becomes entitled to Medicare after electing COBRA.
- The Group terminates all of its group welfare benefit plans.

Other Coverage Options Besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Continuation of Coverage Due To Military Service

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Member may have a right to continuation of benefits subject to the conditions described below.

Under USERRA, if the Employee (or his or her Dependents) is covered under this Plan, and if the Employee becomes absent from employment by reason of military leave, the Employee (or his or her Dependents) may have the right to elect to continue health coverage under the plan. In order to be eligible for coverage during the period that the Employee is gone on military leave, the Employee must give reasonable notice to the Employer of his or her military leave and the Employee will be entitled to COBRA-like rights with respect to his or her medical benefits in that the Employee and his or her Dependents can elect to continue coverage under the plan for a period of 24 months from the date the military leave commences or, if sooner, the period ending on the day after the deadline for the Employee to apply for or return to work with the Employer. During military leave the Employee is required to pay the Employer for the entire cost of such coverage, including any elected Dependents' coverage. However, if the Employee's absence is less than 31 days, the Employer must continue to pay its portion of the premiums or fees and the Employee is only required to pay his or her share of the premiums or fees without the COBRA-type 2% administrative surcharge.

Also, when the Employee returns to work, if the Employee meets the requirements specified below, USERRA states that the Employer must waive any exclusions and waiting periods, even if the Employee did not elect COBRA continuation. These requirements are (i) the Employee gave reasonable notice to his or her Employer of military leave, (ii) the military leave cannot exceed a prescribed period (which is generally five (5) years, except in unusual or extraordinary circumstances) and the Employee must have received no less than an honorable discharge (or, in the case of an officer, not been sentenced to a correctional institution), and (iii) the Employee must apply for reemployment or return to work in a timely manner upon expiration of the military leave (ranging from a single day up to 90-days, depending upon the period that he or she was gone). The Employee may also have to provide documentation to the Employer upon reemployment that would confirm eligibility. This protection applies to the Employee upon reemployment, as well as to any Dependent who has become covered under the Plan by reason of the Employee's reinstatement of coverage.

Benefits After Termination Of Coverage

Any benefits available under this section are subject to all the other terms and conditions of this Plan.

If you are Totally Disabled on the Employer's termination date, and you are not eligible for regular coverage under another similar health plan, benefits will continue for treatment of the disabling condition(s). Benefits will continue until the earliest of.

- The date you cease to be Totally Disabled.
- The end of a period of 12 months in a row that follows the Employer termination date.
- The date you become eligible for regular coverage under another health plan.
- The payment of any benefit maximum.

Benefits will be limited to coverage for treatment of the condition or conditions causing Total Disability and in no event will include benefits for any dental condition.

Extension of benefits is subject to the following conditions:

If you are confined as an inpatient in a hospital or skilled nursing facility, you are considered totally disabled as long as the inpatient stay is medically necessary, and no written certification of the total disability is required. If you are discharged from the hospital or skilled nursing facility, you may continue your total disability benefits by submitting written certification by your physician of the total disability within 90-days of the date of your discharge. Thereafter, the claims administrator must receive proof of your continuing total disability at least once every 90-days while benefits are extended.

If you are not confined as an inpatient but wish to apply for total disability benefits, you must do so by submitting written certification by your physician of the total disability. The claims administrator must receive this certification within 90-days of the date coverage ends under the participation agreement. At least once every 90-days while benefits are extended, the claims administrator must receive proof that your total disability is continuing.

Continuation For Disabled District Members

If you become disabled as a result of a violent act directed at you while performing duties in the scope of employment as a district Member, your benefits under this Plan may be continued.

Eligibility. You must be a Member of the State Teachers' Retirement System or a classified school Subscriber Member of the Public Employees' Retirement System and be covered under the Participation Agreement at the time of the violent act causing the disability.

Cost of Coverage. The Participating Employer may require that you pay the entire cost of your continuation coverage. This cost (called the “required monthly contribution”) must be remitted to the Participating Employer each month during your continuation. SISC III must receive payment of the required monthly contribution each month from the Participating Employer in order to maintain the coverage in force. SISC III will accept required monthly contributions only from the Participating Employer. Payment made by you directly to SISC III will not continue coverage.

When Continuation Coverage Begins. When continuation coverage is elected and the required monthly contribution is paid, coverage is reinstated back to the date you became disabled, so that no break in coverage occurs, but only if you elect to continue coverage within sixty (60) days after your coverage terminates. For Dependents acquired and properly enrolled during the continuation, coverage begins according to the enrollment provisions of the Participation Agreement.

When Continuation Coverage Ends. This continuation coverage ends for the Subscriber on the earliest of.

- The date the Participation Agreement terminates.
- The end of the period for which required monthly contributions are last paid.
- The date the maximum benefits of this Plan are paid.

For Dependents, this continuation coverage ends according to the provisions of the section entitled Eligibility and Enrollment – Adding Members. See section for further details.

Coverage For Surviving Spouse Of Certified Members

If the Subscriber dies while covered under this Plan as a certificated Subscriber or a certificated retired employee.

coverage continues for an enrolled spouse until one of the following occurs.

- The spouse becomes covered under another group health plan, or
- The spouse’s coverage ends as described under Eligibility and Enrollment – Adding Members.

Exception: If the Subscriber dies while covered under this Plan as a classified Subscriber or a classified retired employee, the enrolled spouse may be eligible to continue coverage under this benefit. Please consult your Participating Employer for details regarding their policy.

Continuation During Labor Dispute

If you are an eligible Subscriber who stops working because of a labor dispute, the Participating Employer may arrange for coverage to continue as follows.

- **Required Monthly Contributions:** Required monthly contributions are determined by SISC III as stated in the Participation Agreement. These required monthly contributions become effective on the required monthly contribution due date after work stops.
- **Collection of Required Monthly Contributions:** The Participating Employer is responsible for collecting required monthly contributions from those Subscribers who choose to continue coverage. The Participating Employer is also responsible for submitting required monthly contributions to SISC III on or before each required monthly contribution due date.

- **Cancellation if participation falls below 75%:** SISC III must receive fees for at least 75% of the Subscribers who stop work because of the labor dispute. If at any time participation falls below 75%, coverage may be cancelled. This cancellation is effective 10 days after written notice to the Participating Employer. The Participating Employer is responsible for notifying the Subscribers.
- **Length of coverage:** Coverage during a labor dispute may continue up to six months. After six months, coverage is cancelled automatically without notice from SISC III.

General Provisions

Acts Beyond Reasonable Control (Force Majeure)

Should the performance of any act required by this coverage be prevented or delayed by reason of any act of God, strike, lock-out, labor troubles, restrictive government laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties shall use reasonable efforts to perform their respective obligations.

The Claims Administrator will adhere to SISC III's instructions and allow SISC III to meet all of SISC III's responsibilities under applicable state and federal law. It is SISC III's responsibility to adhere to all applicable state and federal laws and the Claims Administrator does not assume any responsibility for compliance.

Care Coordination

The Claims Administrator pays In-Network Providers in various ways to provide Covered Services to you. For example, sometimes they may pay In-Network Providers a separate amount for each Covered Service they provide. The Claims Administrator may also pay them one amount for all Covered Services related to treatment of a medical condition. Other times, the Claims Administrator may pay a periodic, fixed pre-determined amount to cover the costs of Covered Services. In addition, the Claims Administrator may pay In-Network 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 In-Network Providers for coordination of Member care. In some instances, In-Network Providers may be required to make payment to the Claims Administrator because they did not meet certain standards. You do not share in any payments made by In-Network Providers to the Claims Administrator under these programs.

Circumstances Beyond the Control of the Plan

If circumstances arise that are beyond the control of the Plan, we will make a good-faith effort to ensure Covered Services are available to you as required by state law. Circumstances that may occur, but are not within the control of the Plan, include but are not limited to, a major disaster, epidemic, and war, when health care services covered under this Plan are delayed or rendered impractical, or other events beyond our control. Under such circumstances, we will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

Clerical Error

A clerical error will never disturb or affect your coverage, as long as your coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Plan or the Claims Administrator.

Confidentiality and Release of Information

Applicable state and federal law requires us to undertake efforts to safeguard your medical information, which includes Mental Health, reproductive or sexual health application information.

For informational purposes only, please be advised that a statement describing our policies and procedures regarding the protection, use and disclosure of your medical information, which includes Mental Health, reproductive or sexual health application information, is available on the website and can be furnished to you upon request by contacting the Member Services department.

Obligations that arise under federal law and policies and procedures relating to privacy that are referenced but not included in this Booklet are not part of the contract between the parties and do not give rise to contractual obligations.

Conformity with Law

Any term of the Plan which is in conflict with federal law, will hereby be automatically amended to conform with the minimum requirements of such laws.

Contract with Anthem

The Employer, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan constitutes a contract solely between the Employer and us, Anthem Blue Cross Life and Health (Anthem), and that we are an independent corporation licensed to use the Blue Cross name and mark in the state of California. The Blue Cross Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, we are not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. The Employer, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this contract based upon representations by any person other than Anthem and that no person, entity, or organization other than Anthem shall be held accountable or liable to the Employer for any of Anthem's obligations to the Employer created under the contract. This paragraph shall not create any additional obligations whatsoever on our part other than those obligations created under other terms of this agreement.

Entire Agreement

This Benefit Booklet, the Administrative Services Agreement, the Employer's application, any Riders, Endorsements, or attachments, and the individual applications of the Subscribers and Members, if any, constitute the entire agreement between the Claims Administrator and SISC III and As of the Effective Date, supersede all other agreements between the parties. Any and all Statements made to the Claims Administrator by the SISC III, and any and all statements made SISC III by the Claims Administrator, are representations and not warranties, and no such statement unless it is contained in a written application for coverage under the Plan, shall be used in defense to a claim under the Plan.

Form or Content of Booklet

No agent or employee of the Claims Administrator is authorized to change the form or content of this Benefit Booklet. Such changes can be made only through an endorsement authorized and signed by an officer of SISC III.

Government Programs

The benefits under this Plan shall not duplicate any benefits that you are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require the Plan to be the primary payer. If duplication of such benefits occurs, all money paid by such programs to you for services you have or are receiving, shall be returned by or on your behalf to the Plan.

Medical Policy and Technology Assessment

The Claims Administrator reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental / Investigational status or Medical Necessity of new technology. Guidance and external validation of the Claims Administrator's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including the Claims Administrator's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

Medicare

Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payer legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict between Booklet terms, and federal law.

Except when federal law requires the Plan to be the primary payer, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Part B. Where Medicare is the responsible payer, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to the Plan, to the extent the Plan has made payment for such services. If you do not enroll in Medicare Part B when you are eligible, you may have large out-of-pocket costs. Please refer to Medicare.gov for more details on when you should enroll, and when you are allowed to delay enrollment without penalties.

Member Rights and Responsibilities

The delivery of quality healthcare requires cooperation between patients, their Providers and their healthcare benefit plans. One of the first steps is for patients and Providers to understand Member rights and responsibilities. Therefore, Anthem has adopted a Members' Rights and Responsibilities statement.

It can be found on our website FAQs. To access, go to www.anthem.com/ca/sisc and select Member Support. Under the Support column, select FAQs and your state, then the "Laws and Rights That Protect You" category. Then click on the "What are my rights as a member?" question. Members or Providers who do not have access to the website can request copies by contacting Anthem, or by calling the number on the back of the Member ID card.

Modifications

SISC III may change the benefits described in this Benefit Booklet and the Member will be informed of such changes as required by law. This Benefit Booklet shall be subject to amendment, modification, and termination in accordance with any of its provisions by SISC III, or by mutual agreement between the Claims Administrator and the SISC III without the consent or concurrence of any Member. By electing medical and Hospital benefits under the Plan or accepting the Plan benefits, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, and provisions hereof.

Not Liable for Provider Acts or Omissions

The Claims Administrator is not responsible for the actual care you receive from any person. This Booklet does not give anyone any claim, right, or cause of action against the Plan Administrator based on the actions of a Provider of health care, services, or supplies.

Payment Innovation Programs

The Claims Administrator pays In-Network Providers through various types of contractual arrangements. Some of these arrangements – Payment Innovation Programs (Program(s)) – may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner.

These Programs may vary in methodology and subject area of focus and may be modified by the Claims Administrator from time to time, but they will be generally designed to tie a certain portion of an In-Network Provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, In-Network Providers may be required to make payment to the Claims Administrator under the Program as a consequence of failing to meet these pre-defined standards.

The Programs are not intended to affect your access to health care. The Program payments are not made as payment for specific Covered Services provided to you, but instead, are based on the In-Network Provider's achievement of these pre-defined standards. You are not responsible for any Copayment or Coinsurance amounts related to payments made by the Claims Administrator or to the Claims Administrator under the Program(s), and you do not share in any payments made by Network Providers to the Claims Administrator under the Program(s).

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 Services Agreement, we, on behalf of the Employer, have the authority, in our discretion, to institute from time to time, pilot or test programs for utilization management, care management, case management, clinical quality**,** disease management or wellness initiatives in certain designated geographic areas. These pilot initiatives are part of our ongoing effort to find innovative ways to make available high quality and more affordable healthcare. A pilot initiative may affect some, but not all Members under the Plan. These programs will not result in the payment of benefits which are not provided in the Employer's Group Health Plan, unless otherwise agreed to by the Employer. We reserve the right to discontinue a pilot initiative at any time without advance notice to Employer.

Program Incentives

The Claims Administrator may offer incentives from time to time in order to introduce you to covered 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, health related merchandise, and discounts on fees or Member cost shares. Acceptance of these incentives is voluntary as long as the Claims Administrator offers the incentives program. Motivational rewards, awards or points for achieving certain milestones may be a feature of the program. The Claims Administrator may discontinue a program or an incentive for a particular covered program or service at any time. If you have any questions about whether receipt of an incentive or retailer coupon results in taxable income to you, it's recommended that you consult your tax advisor.

Protected Health Information Under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Privacy Regulations issued under HIPAA, contain provisions designed to protect the privacy of certain individually identifiable health information. Your Employer's Group Health Plan has a responsibility under the HIPAA Privacy Regulations to provide you with a Notice of Privacy Practices. This notice sets forth the Employer's rules regarding the disclosure of your information and details about a number of individual rights you have under the Privacy Regulations. As the Claims Administrator of your Employer's Plan, Anthem has also adopted a number of privacy practices and has described those in its Privacy Notice. If you would like a copy of Anthem's Notice, contact the Member Services number on the back of your Identification Card.

Protecting Your Privacy

Where to find our Notice of Privacy Practices.

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

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

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

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

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

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

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

You may obtain a copy of our Notice of Privacy Practices on our website at www.anthem.com/ca/sisc **or you may contact Member Services using the contact information on your identification card.**

Relationship of Parties (Employer-Member-Anthem)

SISC III is the fiduciary agent of the Member. The Claims Administrator's notice to SISC III will constitute effective notice to the Member. It is SISC III's duty to notify the Claims Administrator of eligibility data in a timely manner. The Claims Administrator is not responsible for payment of Covered Services of Members if SISC III fails to provide the Claims Administrator with timely notification of Member enrollments or terminations.

Relationship of Parties (Anthem and In-Network Providers)

The relationship between Anthem Blue Cross Life and Health (Anthem) and In-Network Providers is an independent contractor relationship. In-Network Providers are not agents or employees of ours, nor is Anthem, or any employee of Anthem, an employee or agent of In-Network Providers.

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

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

Reservation of Discretionary Authority

We, as the Claims Administrator, shall have all the powers necessary or appropriate to enable us to carry out our duties in connection with the operation of the Plan and interpretation of the Benefit Booklet. This includes, without limitation, the power to construe the Administrative Services Agreement, to determine questions arising under the Plan, to resolve Member Appeals and to make, establish and amend the rules, regulations, and procedures with regard to the interpretation of the Benefit Booklet of the Plan. A specific limitation or exclusion will override more general benefit language. We have complete discretion to interpret the Benefit Booklet. Our determination may include, without limitation, determination of whether the services, treatment, or supplies are Medically Necessary, Experimental/Investigative, whether surgery is cosmetic, and whether charges are consistent with the Plan's Maximum Allowed Amount. A Member may utilize all applicable Appeals procedures.

Right of Recovery and Adjustment

Whenever payment has been made in error, the Plan will have the right to recover such payment from you or, if applicable, the Provider or otherwise make appropriate adjustments to claims. In most instances such recovery or adjustment activity shall be limited to the calendar year in which the error is discovered.

The Claims Administrator has oversight responsibility for compliance with Provider and vendor contracts. The Claims Administrator may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, the Claims Administrator has established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery and adjustment amounts. The Claims Administrator will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or under payment amount.

The Claims Administrator reserves the right to deduct or offset, including cross plan offsetting on In-Network claims and on Out-of-Network claims where the Out-of-Network Provider agrees to cross plan offsetting, any amounts paid in error from any pending or future claim.

Unauthorized Use of Identification Card

If you permit your Identification Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Value-Added Programs

The Claims Administrator may offer health or fitness related programs to Members, through which you may access discounted rates from certain vendors for products and services available to the general public. The Claims Administrator may also offer value-added services that include discounts on pharmacy products (over-the-counter drugs, consultations and biometrics). In addition, you may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

Products and services available under this program are not Covered Services under your Plan but are in addition to Plan benefits and may include giveaways that promote a healthy lifestyle. As such, program features are not guaranteed under your health Plan’s Administrative Services Agreement and could be discontinued at any time. The Claims Administrator does not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Value of Covered Services

For purposes of subrogation, reimbursement of excess benefits, or reimbursement under any Worker's Compensation or Employer Liability Law, the value of Covered Services shall be the amount paid for the Covered Services.

Voluntary Clinical Quality Programs

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

receipt of a gift card or retailer coupon results in taxable income to you, the Claims Administrator recommends that you consult your tax advisor.

Voluntary Wellness Incentive Programs

The Claims Administrator may offer health or fitness related program options for purchase by your Employer to help you achieve your best health. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed under this Plan and could be discontinued at any time. If your Employer 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. (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.)

Waiver

No agent or other person, except an authorized officer of SISC III, is able to disregard any conditions or restrictions contained in this Booklet, to extend the amount of time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Worker’s Compensation

The benefits under this Plan are not designed to duplicate benefits that you are eligible for under Worker’s Compensation Law. All money paid or owed by Worker’s Compensation for services provided to you shall be paid back by, or on your behalf to the Plan if it has made payment for the services received. It is understood that coverage under this Plan does not replace or affect any Worker’s Compensation coverage requirements.

Definitions

If a word or phrase in this Benefit Booklet has a special meaning, such as Medical Necessity or Experimental / Investigational, it will start with a capital letter and be defined below. If you have questions on any of these definitions, please call Member Services at the number located on the back of your Identification Card.

Accidental Injury

An unexpected Injury for which you need Covered Services while enrolled in this Plan. It does not include injuries that you get benefits for under any Workers' Compensation, Employer's liability or similar law.

Administrative Services Agreement

The agreement between the Claims Administrator and SISC III regarding the administration of certain elements of the health care benefits of the HealthPlan.

Agreement Date

The Agreement Date is the date the Participation Agreement between SISC III and the Participating Employer comes into effect.

Ambulatory Surgery Center

A facility licensed as an Ambulatory Surgery Center as required by law that must satisfy our accreditation requirements and be approved by us.

Approved In-Network Provider

Please see the "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services" benefit in the "What's Covered" section.

Authorized Service(s)

A Covered Service you get from an Out-of-Network Provider that the Claims Administrator has agreed to cover at the In-Network level. You will have to pay any In-Network Deductible, Coinsurance, and/or Copayment(s) that apply, and may also have to pay the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

Please see the "Claims Payment" section as well as the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet for more details.

Bariatric Blue Distinction (BD) and Blue Distinction+ (BD+) Coverage Area

Is the area within the 50-mile radius surrounding a designated bariatric Blue Distinction (BD) or a Blue Distinction+ (BD+).

Benefit Booklet

This document. The Benefit Booklet provides you with a description of your benefits while you are enrolled under the Plan.

Benefit Period

The length of time the Plan will cover benefits for Covered Services. For Calendar Year plans, the Benefit Period starts on January 1 and ends on December 31. For Plan Year plans, the Benefit Period starts on your employer's effective or renewal date and lasts for 12 months. (See your employer for details.) The "Schedule of Benefits" shows if your Plan's Benefit Period is a Calendar Year or a Plan Year. If your coverage ends before the end of the year, then your Benefit Period also ends.

Benefit Period Maximum

The maximum amount that the Plan will pay for specific Covered Services during a Benefit Period.

Blue Distinction (BD)

Are health care providers designated by the Claims Administrator as a selected facility for specified medical services. A provider participating in a Blue Distinction (BD) network has an agreement in effect with the Claims Administrator at the time services are rendered or is available through their affiliate companies or their relationship with the Blue Cross and Blue Shield Association. Blue Distinction (BD) agree to accept the Maximum Allowed Amount as payment in full for covered services.

Blue Distinction

The Blue distinction requirement does not apply to the following.

- Members under the age of 18
- Emergencies
- Urgent surgery to treat a recent fracture
- Additional complications such as cancer
- You have primary coverage with Medicare or another carrier
- You live outside of the state of California

Benefits for services performed at a designated BD will be the same as for participating providers. A participating provider in the Plan is not necessarily a Blue Distinction (BD) facility.

Blue Distinction+ (BDC+) Facility

Blue Distinction+ facilities have met or exceeded national quality standards for care delivery AND have demonstrated that they operate more efficiently (quality and cost).

Blue Distinction Centers for Specialty Care (BDCSC)

Health care providers designated by us as a selected facility for specified medical services. A provider participating in a BDCSC network has an agreement in effect with the Claims Administrator at the time services are rendered. BDCSC agree to accept the Maximum Allowed Amount as payment in full for covered services. An In-Network Provider is not necessarily a BDCSC.

Booklet

This document (also called the Benefit Booklet), which describes the terms of your benefits. It is part of the Plan offered by your Employer.

Centers of Medical Excellence (CME)

A network of health care facilities, which have been selected to give specific services to Members based on their experience, outcomes, efficiency, and effectiveness. An In-Network Provider under this Plan is not necessarily a CME. To be a CME, the Provider must have a Center of Excellence Agreement with the Claims Administrator.

Claims Administrator

Anthem Blue Cross Life and Health (“Anthem”) was chosen to administer this Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after you meet your Deductible. For example, if your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is $100, your Coinsurance would be $20 after you meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the “Schedule of Benefits” for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments.

Community Paramedicine Program

A program developed by a local EMS agency and approved by the Emergency Medical Services Authority to provide community paramedicine services consisting of one or more of the program specialties described below under the direction of medical protocols developed by the local EMS agency that are consistent with the minimum medical protocols established by the authority. Community paramedicine services may consist of the following program specialties:

- Providing directly observed therapy (DOT) to persons with tuberculosis in collaboration with a public health agency to ensure effective treatment of the tuberculosis and to prevent spread of the disease.
- Providing case management services to frequent Emergency Services users in collaboration with, and by providing referral to, existing appropriate community resources.
- Providing short-term, post discharge follow-up for persons recently discharged from a Hospital due to a serious health condition, including collaboration with, and by providing referral to, home health services when eligible.

Consolidated Appropriations Act of 2021

Please refer to the “Consolidated Appropriations Act of 2021 Notice” at the front of this Booklet for details.

Controlled Substances

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

Copayment

A fixed amount you pay toward a Covered Service. You normally have to pay the Copayment when you get health care. The amount can vary by the type of Covered Service you get. For example, you may have to pay a $15 Copayment for an office visit, but a $150 Copayment for Emergency Room Services. See the “Schedule of Benefits” for details. Your Copayment will be the lesser of the amount shown in the “Schedule of Benefits” or the Maximum Allowed Amount.

Cosmetic Services

Any type of care performed to alter or reshape normal structure of the body in order to improve appearance.

Covered Procedure

Please see the “Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services” under the “What’s Covered” section for details.

Covered Services

Health care services, supplies, or treatment as described in this Booklet which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or specifically included as a benefit under this Benefit Booklet.
- Within the scope of the Provider’s license.
- Given while you are covered under the Plan.
- Not Experimental / Investigative, excluded, or limited by this Benefit Booklet, or by any amendment or rider to this Benefit Booklet.
- Approved by the Claims Administrator before you get the service if Precertification is needed.

A charge for a Covered Service will only apply on the date the service, supply, or treatment was given to you.

The date for applying Deductible and other cost shares for an Inpatient stay is the date you enter the Facility except as described in the “Termination and Continuation of Coverage” section.

Covered Services do not include services or supplies not described in the Provider records.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical workers; (b) is not given to you or supervised by such workers or does not meet the rules for post-Hospital Skilled Nursing Facility care; (c) is given when you have already reached the greatest level of physical or Mental Health and are not likely to improve further.

Custodial Care includes any type of care meant to help you with activities of daily living that does not require the skill of trained medical or paramedical workers. Examples of Custodial Care include:

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet.
- Changing dressings of non-infected wounds, after surgery or chronic conditions.
- Preparing meals and/or special diets.
- Feeding by utensil, tube, or gastrostomy.
- Common skin and nail care.
- Supervising medicine that you can take yourself.
- Catheter care, general colostomy or ileostomy care.
- Routine services which the Plan decides can be safely done by you or a non-medical person without the help of trained medical and paramedical workers.
- Residential care and adult day care.
- Protective and supportive care, including education.
- Rest and convalescent care.

Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as in a Hospital or Skilled Nursing Facility, or at home.

Deductible

The amount you must pay for Covered Services before benefits begin under this Plan. For example, if your Deductible is $1,000, your Plan won't cover anything until you meet the $1,000 Deductible. The Deductible may not apply to all Covered Services. Please see the "Schedule of Benefits" for details.

Dependent

A Member of the Subscriber's family who meets the rules listed in the "Eligibility and Enrollment – Adding Members" section of this Benefit Booklet and who has enrolled in the Plan. Eligible Dependents are also referred to as Members.

Designated Orthopedic Provider

Is a provider who has achieved designation as a Blue Distinction+ hospital for Knee/Hip Replacement or Spine Surgery.

Designated Pharmacy Provider

An In-Network Pharmacy that has executed a Designated Pharmacy Provider Agreement with us or an In-Network Provider that is designated to provide Prescription Drugs, including Specialty Drugs, to treat certain conditions.

Diabetes Equipment and Supplies

The following items for the treatment of Insulin-using diabetes or non-Insulin-using diabetes and gestational diabetes as Medically Necessary or medically appropriate:

- glucose monitors
- blood glucose testing strips
- glucose monitors designed to assist the visually impaired
- Insulin pumps and related necessary supplies

- ketone urine testing strips
- lancets and lancet puncture devices
- pen delivery systems for the administration of Insulin
- podiatric devices to prevent or treat diabetes-related complications
- Insulin syringes
- visual aids, excluding eyewear, to assist the visually impaired with proper dosing of Insulin

Diabetes Outpatient Self-Management Training Program

Training provided to a qualified Member after the initial diagnosis of diabetes in the care and management of that condition, including nutritional counseling and proper use of Diabetes Equipment and Supplies; additional training authorized on the diagnosis of a Physician or other health care practitioner of a significant change in the qualified Member's symptoms or condition that requires changes in the qualified Member's self-management regime; and periodic or episodic continuing education training when prescribed by an appropriate health care practitioner as warranted by the development of new techniques and treatments for diabetes. Diabetes Outpatient Self-Management Training must be provided by a health care practitioner or Provider who is licensed, registered or certified in California to provide appropriate health care services.

Doctor

See the definition of "Physician."

Domestic Partner (Domestic Partnership)

Both persons have filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code and, at the time of filing, all additional requirements of Domestic Partnership under the California Family Code have been met.

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the "What's Covered" section.

Emergency Care

Please see the "What's Covered" section.

Employee

A person who is engaged in active employment with the Participating Employer and is eligible for Plan coverage under the employment regulations of the Employer. The Employee is also called the Subscriber.

Employer

Is an employer that has a Participation Agreement in effect with SISC as of the subscriber's effective date.

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental or Investigational (Experimental / Investigational)

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 "What's Covered" section.

Facility

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.

Fee(s)

The amount you must pay to be covered by this Plan.

Gender Dysphoria

A formal diagnosis used by psychologists and Physicians to describe people who experience significant dysphoria (discontent) with the sex they were assigned at birth and/or the gender roles associated with that sex.

Gender Transition

The process of changing one's outward appearance, including physical sex characteristics, to accord with his or her actual gender identity.

Generally Accepted Standards of Mental Health and Substance Use Disorder Care

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.

Health Plan or Plan

The Plan is the set of benefits described in this benefit booklet or as amended hereafter and adopted by the participating employer through its participation agreement with Self-Insured Schools of California. These benefits are subject to the terms and conditions of the plan. If changes are made to the plan, an amendment or revised benefit booklet will be issued to each participating employer affected by the change.

Home Health Care Agency

A Provider, licensed when required by law and approved by us, that:

1. Gives skilled nursing and other services on a visiting basis in your home.
2. Supervises the delivery of such services under a plan prescribed and approved in writing by the attending Physician.

Hospice

A Provider which provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient’s Physician. It must be licensed by the appropriate agency.

Hospital

A facility licensed as a Hospital as required by law that must satisfy our accreditation requirements and be approved by us. The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial Care
- Educational care
- Subacute care

Identification Card (ID Card)

The latest card given to you showing your identification and group numbers, the type of coverage you have and the date coverage became effective

In-Network Provider

A Provider that has a contract, either directly or indirectly, with the Claims Administrator, or another organization, to give Covered Services to Members through negotiated payment arrangements. A Provider that is In-Network for one plan may not be In-Network for another. Please see “How to Find a Provider in the Network” in the section “How Your Plan Works” for more information on how to find an In-Network Provider for this Plan.

Infusion Therapy

The administration of Drugs (Prescription substances) by the intravenous (into a vein), intramuscular (into a muscle), subcutaneous (under the skin), and intrathecal (into the spinal canal) routes. For the purpose of this Booklet, it shall also include Drugs administered by aerosol (into the lungs) and by a feeding tube.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Intensive In-Home Behavioral Health Program

A range of therapy services provided in the home to address symptoms and behaviors that, as the result of a mental disorder or Substance Use Disorder, put the Members and others at risk of harm.

Intensive Outpatient Program

Structured, multidisciplinary treatment for Mental Health and Substance Use Disorders that provides a combination of individual, group and family therapy to Members who require a type or frequency of treatment that is not available in a standard outpatient setting.

Investigational Procedures (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.
- 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.
- be proven materially to improve the net health outcome.
- be as beneficial as any established alternative.
- 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.

Late Enrollees

Employees or Dependents who enroll in the Plan after the initial enrollment period. A person will not be considered a Late Enrollee if he or she enrolls during a Special Enrollment period. Please see the “Eligibility and Enrollment – Adding Members” section for further details.

Maximum Allowed Amount

The maximum payment that the Claims Administrator will allow for Covered Services. For more information, see the “Claims Payment” section.

Medical Necessity (Medically Necessary)

Medically Necessary shall mean health care services that a Physician, exercising professional clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease.
- Not primarily for the convenience of the patient, Physician or other health care Provider.
- Not more costly than an alternative services, including no service or the same service in an alternative setting or sequence of services that is medically appropriate and is likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's injury, disease, illness or condition. For example, the Plan will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a hospital if the drug could be provided in a Physician's office of the home setting.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician specialty society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

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

People, including the Subscriber and his or her Dependents, who have met the eligibility rules, applied for coverage, and enrolled in the Plan. Members are called "you" and "your" in this Benefit Booklet.

Mental Health and Substance Use Disorder

A Mental Health Condition or Substance Use Disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of Mental Health and Substance Use Disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this Plan as long as a condition is commonly understood to be a Mental Health condition or Substance Use Disorder by health care Providers practicing in relevant clinical specialties.

Mobile Integrated Health Program

A team of licensed health care practitioners, operating within their scope of practice, who provide mobile health services to support the emergency medical services system.

Open Enrollment

A period of time in which eligible people or their dependents can enroll without penalty after the initial enrollment. See the "Eligibility and Enrollment – Adding Members" section for more details.

Other Eligible Providers

Nurse anesthetists and blood banks that do not enter into participating agreements with us, and these Providers must be licensed according to state and local laws to provide covered medical services.

Out-of-Network Provider

A Provider that does *not* have an agreement or contract with us, or our subcontractor(s), to give services to our Members under this Plan.

You will often get a lower level of benefits when you use Out-of-Network Providers.

Note: If you receive services from an In-Network Facility at which, or as a result of which, you receive non-Emergency Covered Services provided by an Out-of-Network Provider, you will pay the Out-of-Network Provider no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider, but you may have to pay the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount, as well as any applicable Coinsurance, Copayment or Deductible. (Please see "Member Cost Share" in the "Claims Payment" section for more information.)

Out-of-Pocket Limit

The most you pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket Limit does not include your Fees, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn't cover. Please see the "Schedule of Benefits" for details.

Partial Hospitalization Program

Structured, multidisciplinary treatment for Mental Health and Substance Use Disorders, including nursing care and active individual, group and family treatment for Members who require more care than is available in an Intensive Outpatient Program.

Participating Employer

Is an employer that has a Participation Agreement in effect with SISC as of the subscriber's effective date.

Participation Agreement

Is the agreement between Self-Insured Schools of California and the Participating Employer providing for the participation of specified employees in this Plan.

Physician (Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery.
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor.
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry.
- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.

Optometrists, Clinical Psychologists (PhD), and surgical chiropodists are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Plan

The arrangement chosen by the participating employer through its participation agreement with Self-Insured Schools of California to fund and provide for delivery of the Employer's health benefits.

Plan administrator

The person or entity named by the Plan Sponsor to manage the Plan and answer questions about Plan details. ***The Plan Administrator is not the Claims Administrator.***

Plan Sponsor

SISC III is the legal entity that has adopted the Plan and has authority regarding its operation, amendment and termination. ***The Plan Sponsor is not the Claims Administrator.***

Precertification

Please see the section “Getting Approval for Benefits” for details.

Primary Care Physician (“PCP”)

A Physician who gives or directs health care services for you. The Physician may work in family/general practice, internal medicine, pediatrics, obstetrics, gynecologist, OB/GYN and nurse practitioner .

Provider

A professional or Facility licensed when required by law that gives health care services within the scope of that license, must satisfy our accreditation requirements and be approved by us on behalf of the Employer. Details on our accreditation requirements can be found at https://www.anthem.com/provider/individual-commercial/join-our-network. This includes any Provider that state law says must be covered under the Plan when they give you Covered Services. Providers that deliver Covered Services are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.

Psychiatric Emergency Medical Condition

A mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

- An immediate danger to himself or herself or to others.
- Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

Qualifying Payment Amount

The median Plan In-Network contract rate we pay In-Network Providers for the geographic area where the service is provided for the same or similar services.

Recognized Amount

For Surprise Billing Claims, the Recognized Amount is calculated as follows:

- For Air Ambulance services, the Recognized Amount is equal to the lesser of the Qualifying Payment Amount as determined under applicable law (generally, the median Plan In-Network contract rate we pay In-Network Providers for the geographic area where the service is provided for the same or similar services) or the amount billed by the Out-of-Network Air Ambulance service provider.
- For all other Surprise Billing Claims, the Recognized Amount is the lesser of the Qualifying Payment Amount or the amount billed by the Out-of-Network Provider or Out-of-Network Facility; or the amount approved under an applicable All-Payer Model Agreement under section 1115A of the Social Security Act.

Recovery

Please see the “Subrogation and Reimbursement” section for details.

Referral

Please see the “How Your Plan Works” section for details.

Residential Treatment Center(s)

An Inpatient Facility that provides multidisciplinary treatment for Mental Health and Substance Use Disorder conditions. The Facility must be licensed as a residential treatment center in the state in which it is located, satisfy our accreditation requirements and be approved by us.

The 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

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. Medical services are typically provided by Physician Assistants and nurse practitioners.

Retired Employee

Meets the Plan’s eligibility requirements for retired employees as outlined. Please see the “Eligibility and Enrollment – Adding Members” section for further details.

Service Area

The geographical area where you can get Covered Services from an In-Network Provider and the Claims Administrator is approved to arrange healthcare services consistent with network adequacy requirements.

SISC

Is Self-Insured Schools of California joint powers authority.

SISC III

Means the medical benefit Plans developed by SISC. SISC III is the legal entity that has adopted the Plan and has authority regarding its operation, amendment and termination.

Skilled Nursing Facility

An Inpatient Facility that provides multidisciplinary treatment for convalescent and rehabilitative care. It must be licensed as a skilled nursing facility in the state in which it is located that must satisfy our accreditation requirements and be approved by us.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, or a place for rest, educational, or similar services.

Special Enrollment

A period of time in which eligible people or their dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc. See the “Eligibility and Enrollment – Adding Members” section for more details.

Specialist (Specialty Care Physician \ Provider or SCP)

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

Specialty Drugs

Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

Subscriber

An employee or member of the Employer who is eligible for and has enrolled in the Plan.

Surprise Billing Claim

Please refer to the “Consolidated Appropriations Act of 2021 Notice” at the front of this Booklet for details.

Total Disability (or Totally Disabled)

A person who is unable because of the disability to engage in any occupation to which he or she is suited by reason of training or experience, and is not in fact employed.

Triage to Alternate Destination Program

A program developed by a local EMS agency and approved by the Emergency Medical Services Authority to provide triage paramedic assessments consisting of one or more specialties described below operating under triage and assessment protocols developed by the local EMS agency that are consistent with the minimum triage and assessment protocols established by the authority. Triage paramedic assessments may consist of the following program specialties:

- Providing care and comfort services to hospice patients in their homes in response to 911 calls by providing for the patient’s and the family’s immediate care needs, including grief support in collaboration with the patient’s Hospice agency until the Hospice nurse arrives to treat the patient. This paragraph does not impact or alter existing authorities applicable to a licensed paramedic operating under the medical control policies adopted by a local EMS agency medical director to treat and keep a hospice patient in the patient’s current residence or otherwise require transport to an acute care Hospital in the absence of an approved triage to alternate destination Hospice program.
- Providing patients with advanced life support triage and assessment by a triage paramedic and transportation to an alternate destination Facility.

Providing transport services for patients who identify as veterans and desire transport to a local veteran’s administration emergency department for treatment, when appropriate.

Urgent Care Center

A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent care.

Utilization Review

Evaluation of the necessity, quality, effectiveness, or efficiency of medical or behavioral health services, Prescription Drugs (as set forth in the section Prescription Drugs Administered by a Medical Provider), procedures, and/or facilities.

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish
Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

Chinese
您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

Vietnamese
Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

Korean
귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

Tagalog
May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

Russian
У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

French Creole
Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòma nan dokiman sa a.

Arabic
لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

French
Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

Persian
شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

Armenian
Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցո՞ղ եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

Japanese
あなたにはあなたの言語で無料で支援を受ける権利があります。IDカードに記載されている会員サービス番号にお電話ください」視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

Italian
Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

German
Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

Polish
Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

Pennsylvania Dutch
Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differnter Weg griege so as du's besser sehne kannscht.

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed
in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Notice of Protection Provided by the Health Insurance Portability and Accountability Act Of 1996 (HIPAA)

Effective April 14, 2003, a Federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires that health plans like the Self-Insured Schools of California (SISC) group health plan (hereafter referred to as the "Plan"), maintain the privacy of your personally identifiable health information (called **Protected Health Information or PHI**).

- The term "**Protected Health Information" (PHI)** includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.
- **PHI does not include** health information contained in employment records held by your employer in its role as an employer, including but not limited to health information on disability, work-related illness/injury, sick leave, Family and Medical leave (FMLA), life insurance, dependent care FSA, drug testing, etc.

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was distributed to you upon enrollment in the Plan and is available from the SISC website at www.anthem.com/ca/sisc. Information about HIPAA in this document is not intended and cannot be construed as the Plan's Notice of Privacy Practices.

The Plan, and the Plan Sponsor, will not use or further disclose information that is protected by HIPAA ("protected health information or PHI") except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law. **In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment- related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor**.

Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim or for other reasons related to the administration of the Plan.

A. **The Plan's Use and Disclosure of PHI:** The Plan will use protected health information (PHI), without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.

- **Treatment** is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and Referrals between one or more of your health care providers. The Plan rarely, if ever, uses or discloses PHI for treatment purposes.
- **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following.

  a. Determination of eligibility, coverage, cost sharing amounts (e.g., cost of a benefit, Plan maximums, and copayments as determined for an individual's claim), and establishing employee contributions for coverage.

  b. Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of benefits, subrogation of health benefit claims, billing, collection activities and related health care data processing, and claims auditing.

  c. Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization review, including Precertification, concurrent review and/or retrospective review.

- **Health Care Operations** includes, but is not limited to.

  a. Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies, quality assessment, patient safety activities.

  b. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions.

  c. Underwriting (the Plan does not use or disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), enrollment, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities.

  d. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs.

  e. Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, Member Services, resolution of internal grievances, or the provision of data analyses for policyholders, Plan sponsors, or other customers.

B. **When an Authorization Form is Needed:** Generally, the Plan will require that you sign a valid authorization form (available from the SISC Privacy Officer) in order for the Plan to use or disclose your PHI **other** than when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations or other instance in which HIPAA explicitly permits the use or disclosure without authorization. The Plan's Notice of Privacy Practices also discusses times when you will be given the opportunity to agree or disagree before the Plan uses and discloses your PHI. The Notice is available on the SISC website at www.anthem.com/ca/sisc **or** from the SISC Privacy Officer.

C. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agrees to:

  1. Not use or disclose the information other than as permitted or required by the Plan Document or as required by law.

  2. Ensure that any agents, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules.

  3. Not use or disclose the information for employment-related actions and decisions.

  4. Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor, (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices).

  5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.

  6. Make PHI available to the individual in accordance with the access requirements of HIPAA.

  7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA.

  8. Make available the information required to provide an accounting of PHI disclosures.

  9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of the Dept. of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA.

10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction if feasible.

D. In order to ensure that adequate separation between the Plan and the Plan Sponsor is maintained in accordance with HIPAA, only the following employees or classes of employees may be given access to use and disclose PHI.

1. The Plan's Privacy Officer.
2. SISC Health Benefits staff involved in the administration of this Plan.
3. Business Associates under contract to the Plan including but not limited to the PPO medical, dental and vision plan claims administrator, preferred provider organization (PPO) networks, retail prescription drug benefit plan administrator, the Wellness program, the telemedicine program, the Medicare supplement administrator, the COBRA administrator, Health Flexible Spending Account (FSA) administrator, the Plan's attorneys, accountants, consultants and actuaries.

E. The persons described in the section may only have access to and use and disclose PHI for Plan administration functions for the Plan. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution of noncompliance. Issues of noncompliance (including disciplinary sanctions as appropriate) will be investigated and managed by the Plan's Privacy Officer (the Coordinator Health Benefits) at the address noted here.

Self-Insured Schools of California (SISC)
2000 "K" Street P.O. Box 1847
Bakersfield, CA 93303-1847
Phone: 661-636-4410

F. Effective April 21, 2005 in compliance with **HIPAA Security** regulations, the Plan Sponsor will.

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan.
2. Ensure that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures.
3. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI.
4. Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

Hybrid Entity: For purposes of complying with the HIPAA Privacy rules, this Plan is a "hybrid entity" because it has both group health plan functions (a health care component of the entity) and non-group health plan functions. The Plan designates that its health care group health plan functions are covered by the privacy rules. The health care group health plan functions include the services related to the "Plan."