UNIVERSITY OF CALIFORNIA

Effective January 1, 2025

(Revised through September 1, 2025)

UC Health Savings Plan

Plan ID#280509

Benefit Booklet

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

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

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

Many words used in this Benefit Booklet have special meanings (e.g., Covered Services and Medically Necessary). These words are capitalized and are defined in the "DEFINITIONS" section. See these definitions for the best understanding of what is being stated. Throughout this Benefit Booklet you may also see references to “we,” “us,” “our,” “you,” and “your.” The words “we,” “us,” and “our” refers to Anthem, the Claims Administrator. The Plan Administrator is the University of California Executive Steering Committee on Health Benefits Programs, which has delegated certain duties to Anthem Blue Cross Life and Health Insurance Company (Anthem) or any of our subsidiaries, affiliates, subcontractors, or designees. This booklet explains the plan's provisions and the policies and rules that govern them. The Plan Administrator has the authority to interpret disputed provisions. The words “you” and “your” mean the Member, Employee and each covered Dependent. **All capitalized words in this benefit booklet are in the DEFINITIONS section starting at page 93.**

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

Prescription Drug Benefits are provided separately, visit www.UChealthplans.com for details.

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

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

COMPLAINT NOTICE

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

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

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SUMMARY OF BENEFITS

Note: The following SUMMARY OF BENEFITS contains the Benefits and applicable Copayments of your medical Plan only. The SUMMARY OF BENEFITS represents only a brief description of the Benefits. Please read this booklet carefully for a complete description of Covered Services and exclusions of the Plan. Your prescription drug benefits are administered by a different plan administrator. For further information, refer to www.UChealthplans.com.

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

In-Network Providers: Services by any combination of Anthem Prudent Buyer PPO Providers and Other Health Care Providers

Many words or phrases in this Benefit Booklet have special meanings. Whenever any key terms are shown, the first letter of each word will be capitalized. When you see these capitalized words, you should refer to this "DEFINITIONS" section starting at page 93.

Health Savings Plan

Member Calendar Year Deductible Responsibility	**Deductible Amount**	
	Services by In-Network Providers	Services by Out-of-Network Providers*
	For Covered Services from Out-of-Network Providers, you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount, except for Surprise Billing Claims.	
Calendar Year Deductible Please refer to the Member Deductible in the "Medical Benefit Summary Notes" section for information on how your Calendar Year Deductible works. For additional details about how your non-embedded Deductibles work, please refer to the "Deductibles, Copayments, Out-of-Pocket Amounts and Medical Benefit Maximums" section.	$1,650 Individual / $3,300 family	$2,600 Individual / $5,200 family

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

Member Calendar Year Out-of-Pocket Responsibility	Out-of-Pocket Amount	
	Services by In-Network Providers	Services by Out-of-Network Providers*
	For Covered Services from Out-of-Network Providers, you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount, except for Surprise Billing Claims.	
Calendar Year Out-of-Pocket Maximum When you meet your Out-of-Pocket Maximum amount, you will no longer have to pay the cost shares during the remainder of your Calendar Year. Your Deductible is included in your Out-of-Pocket Maximum. Pharmacy Copayments will apply towards your Out-of-Pocket Maximum, unless otherwise noted. Please refer to the Member Out-of-Pocket Maximum in the "Medical Benefit Summary Notes" section for information on how your Out-of-Pocket Maximum works. For additional details about how non-embedded Out-of-Pocket Maximums work, please refer to the "Deductibles, Copayments, Out-of-Pocket Amounts and Medical Benefit Maximums" section.	$4,000 Individual / $6,400 family	$8,000 Individual / $16,000 family

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

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

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

In-Network Providers: Services by any combination of Anthem Prudent Buyer PPO and Other Health Care Providers

Benefit	Member Copayment/Coinsurance	
	Services by In-Network Providers	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers, you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount, except for Surprise Billing Claims*.	
Acupuncture Benefits		
• Acupuncture services – office location The Plan will pay for up to 24 visits per Member during a Calendar Year (visits are combined with "Chiropractic Benefits"). Please refer to Medical Benefit Maximums in the Medical Benefit Summary Notes section for maximums that apply to your Plan. Office visit Benefits will apply to an office visit when billed along with the services. Since your Plan has a Calendar Year Deductible, the number of visits will start counting toward the maximum when services are first provided even if the Calendar Year Deductible has not been met.	20%	20%
Advanced Imaging Procedure Benefits		
Advanced imaging procedure services are subject to pre-service review to determine whether Medically Necessary. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.		
• Physician services – office location	20%	40%
• Freestanding facility	20%	40%
• Outpatient Hospital Advanced imaging procedures, when performed by an Out-of-Network Provider, will have a maximum payment of **$210** per visit. Please refer to Medical Benefit Maximums in the Medical Benefit Summary Notes section for maximums that apply to your Plan.	20%	40%

Benefit	Member Copayment/Coinsurance	
	Services by In-Network Providers	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers, you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount, except for Surprise Billing Claims*.	
Allergy Testing and Treatment Benefits		
• Testing and treatment, includes serum and serum injections	20%	40%
• Allergy serum purchased separately for treatment	20%	40%
Ambulance Benefits		
• Emergency or authorized transport (ground, air or water) by In-Network or Out-of-Network Providers will apply to the In-Network Deductible and Out-of-Pocket Maximum	20%	20%
Ambulatory Surgery Center Benefits Ambulatory Surgical Center services are subject to pre-service review to determine whether Medically Necessary. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.		
• Outpatient services (Hospital or freestanding surgical center) For the services of an Out-of-Network Provider, the Plan's maximum payment is limited to **$210** per visit. Please refer to "Medical Benefit Maximums in the Medical Benefit Summary Notes" section for maximums that apply to your Plan.	20%	40%
• Physician services	20%	40%

Benefit	Member Copayment/Coinsurance	
	Services by In-Network Providers	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers, you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount, except for Surprise Billing Claims*.	
Bariatric Surgery Benefits Services and supplies in connection with Medically Necessary surgery for weight loss, only for morbid obesity. These procedures are covered only when performed at a BDCSC. See page 36 under "Medical Care That Is Covered" for details. You must obtain pre-service review for all bariatric surgical procedures. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.		
• Hospital inpatient services	20%	Not covered
• Hospital outpatient surgery services	20%	Not covered
• Physician inpatient services	20%	Not covered
• Bariatric Travel Expenses The Plan's maximum payment will not exceed **$5,000** per surgery. Please refer to "Medical Benefit Maximums in the Medical Benefit Summary Notes" section for maximums that apply to your Plan. **No Copayment will be required for bariatric travel expenses authorized by Anthem once your Calendar Year Deductible is met.	No charge**	Not covered
Cardiac Rehabilitation If rendered in Outpatient Hospital setting, for services of an Out-of-Network Provider, the Plan's maximum payment is limited to **$210** per visit.	20%	40%

Benefit	Member Copayment/Coinsurance	
	Services by In-Network Providers	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers, you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount, except for Surprise Billing Claims*.	
Chiropractic Benefits		
• Chiropractic Services – office location The Plan will pay for up to 24 visits per Member during a Calendar Year (visits are combined with "Acupuncture Benefits"). Please refer to Medical Benefit Maximums in the Medical Benefit Summary Notes section for maximums that apply to your Plan. Since your Plan has a Calendar Year Deductible, the number of visits will start counting toward the maximum when services are first provided even if the Calendar Year Deductible has not been met.	20%	40%
Clinical Trial of Cancer and Other Life Threatening Conditions Benefits		
Coverage is provided for routine patient costs you receive as a Member in an approved clinical trial. The services must be those that are listed as covered by this Plan for Members who are not enrolled in a clinical trial.	20%	40%
Contraceptive Benefits Certain contraceptives are covered under the "Preventive Care Benefits". Please see that provision for further details. The Calendar Year Deductible will not apply to services provided by Anthem Preferred Providers. See page 39 under "Medical Care That Is Covered" for details for information about your "Contraceptives Benefits"		
• Diaphragm fitting procedure	No charge	40%
• Implantable and injectable contraceptives	No charge	40%
• Insertion and/or removal of intrauterine device (IUD)	No charge	40%

Benefit	Member Copayment/Coinsurance	
	Services by In-Network Providers	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers, you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount, except for Surprise Billing Claims*.	
• Intrauterine device (IUD)	No charge	40%
Diabetes Care Benefits		
• Devices, equipment and supplies	20%	40%
• Diabetes self-management training – office location	20%	40%
Durable Medical Equipment Benefits		
• Breast Pump	No charge	Not covered
• Other Durable Medical Equipment Specific durable medical equipment is subject to pre-service review to determine whether Medically Necessary. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.	20%	40%
Emergency Room Benefits Services by In-Network or Out-of-Network Providers will apply to the In-Network Deductible and Out-of-Pocket Maximum		
• Emergency room facility services not resulting in an admission	20%	20%
• Emergency room facility services resulting in an admission	20%	20%
• Physician services	20%	20%

Benefit	Member Copayment/Coinsurance	
	Services by In-Network Providers	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers, you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount, except for Surprise Billing Claims*.	
Family Planning Benefits Certain contraceptives are covered under the "Preventive Care Benefits". Please see that provision for further details. The Calendar Year Deductible will not apply to contraceptive or tubal ligation services provided by Anthem Prudent Buyer Providers. See page 41 under Medical Care That Is Covered for details for information about your "Family Planning Benefits".		
• Counseling and consulting (including Physician office visits for diaphragm fitting, injectable contraceptives, or implantable contraceptives)	No charge	40%
• Tubal ligation	No charge	40%
• Vasectomy	No charge after deductible is met	40%
Abortion/ Abortion Related Services	No charge after deductible is met	No charge after deductible is met
Gender Affirming Benefits Gender affirming services are subject to prior authorization in order for coverage to be provided. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.		
• Hospital inpatient services	20%	40%
• Hospital outpatient surgery services	20%	40%
• Physician services	20%	40%

Benefit	Member Copayment/Coinsurance	
	Services by In-Network Providers	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers, you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount, except for Surprise Billing Claims*.	
• Gender affirming Travel Expenses The Plan's maximum payment will not exceed **$10,000** per surgery or series of surgeries. Please refer to "Medical Benefit Maximums in the Medical Benefit Summary Notes" section for maximums that apply to your Plan. *No Copayment will be required for gender affirming travel expenses authorized by Anthem once your Calendar Year Deductible is met.		
Hearing Aid Benefits		
• Hearing aids and ancillary equipment up to a maximum of **$2,000** every 36 months. Please refer to Medical Benefit Maximums in the Medical Benefit Summary Notes section for maximums that apply to your Plan.	50%	50%
Hemodialysis Benefits		
• Hemodialysis services For the services of an Out-of-Network Provider, the Plan's maximum payment is limited to **$210** per visit. Please refer to "Medical Benefit Maximums in the Medical Benefit Summary Notes" section for maximums that apply to your Plan.	20%	40%

Benefit	Member Copayment/Coinsurance	
	Services by In-Network Providers	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers, you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount, except for Surprise Billing Claims*.	
• Outpatient services For the services of an Out-of-Network Provider, the Plan's maximum payment is limited to **$210** per visit. Please refer to Medical Benefit Maximums in the "Medical Benefit Summary Notes" section for maximums that apply to your Plan.	20%	40%
Home Health Care Benefits		
• Home health care agency services Benefits are provided for up to a maximum of 100 visits per Calendar Year. Please refer to Medical Benefit Maximums in the Medical Benefit Summary Notes section for maximums that apply to your Plan. Since your Plan has a Calendar Year Deductible, the number of visits will start counting toward the maximum when services are first provided even if the Calendar Year Deductible has not been met. ** For an Out-of-Network Provider, services may be covered if preauthorized. Please refer to Copayments in the Medical Benefit Summary Notes section for additional Benefit information. Home health care services are subject to pre-service review to determine whether Medically Necessary. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.	20%	Not covered**
• Medical supplies	20%	Not covered**

Benefit	Member Copayment/Coinsurance	
	Services by In-Network Providers	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers, you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount, except for Surprise Billing Claims*.	
Hospice Care Benefits		
The services and supplies are covered when provided by a Hospice for the palliative treatment of pain and other symptoms associated with a terminal disease. ** For an Out-of-Network Provider, services may be covered if preauthorized. Please refer to Copayments in the Medical Benefit Summary Notes section for additional Benefit information.	20%	Not covered**
Hospital Benefits		
• Inpatient services – resulting from an Emergency Services by In-Network or Out-of-Network Providers will apply to the In-Network Deductible and Out-of-Pocket Maximum	20%	20%
• Inpatient services and supplies, provided by a Hospital, including services in Special Care Units. For the services of an Out-of-Network Provider, there is an additional **$250** Copayment if prior authorization is not obtained For the services of an Out-of-Network Provider, the Plan's maximum payment is limited to **$360** per day. Please refer to "Medical Benefit Maximums in the Medical Benefit Summary Notes" section for maximums that apply to your Plan. Hospital services are subject to pre-service review to determine whether Medically Necessary. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.	20%	40%
• Inpatient Physician services	20%	40%

Benefit	Member Copayment/Coinsurance	
	Services by In-Network Providers	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers, you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount, except for Surprise Billing Claims*.	
• Outpatient surgery including freestanding facilities For the services of an Out-of-Network Provider, the Plan's maximum payment is limited to **$210** per visit. Please refer to "Medical Benefit Maximums in the Medical Benefit Summary Notes" section for maximums that apply to your Plan. Hospital services are subject to pre-service review to determine whether Medically Necessary. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.	20%	40%
• Outpatient Physician services	20%	40%
• Outpatient diagnostic services including freestanding facilities For the services of an Out-of-Network Provider, the Plan's maximum payment is limited to **$210** per visit. Please refer to Medical Benefit Maximums in the "Medical Benefit Summary Notes" section for maximums that apply to your Plan. **Note:** Professional (Physician) reading charge may apply. Hospital services are subject to pre-service review to determine whether Medically Necessary. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.	20%	40%
Infertility Benefits		
• Diagnosis of cause of Infertility provided you are under the direct care and treatment of a Physician.	20%	40%

Benefit	Member Copayment/Coinsurance	
	Services by In-Network Providers	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers, you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount, except for Surprise Billing Claims*.	
• IVF, ZIFT, and/or GIFT, and all other authorized Infertility Treatment Services Limited to 2 cycles per lifetime. **Note:** Once a member has completed Two (2) cycles of IVF-Egg Retrievals, the lifetime benefit maximum has been reached for all infertility related services, including Intrauterine Insemination (IUI) services. A ”cycle” is defined by this plan as ovarian stimulation with egg(s) retrieval. Member’s will have coverage for two (2) egg retrieval cycles with fertilization of eggs and subsequent embryo transfer for all embryos created form a covered cycle. Coinsurance for these services does not apply towards Calendar Year Out-of-Pocket Limit. **Prior authorization by WINFertility’s Medical Management Program is required prior to initiation of medical treatment for family building.** Contact WINFertility for more information at (877) 451-3077. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.	50%	50%
Infusion / Injectable Therapy Benefits		
Services and supplies when provided by an Infusion Therapy Provider/Injectable Therapy Provider in your home or in any other outpatient setting by a qualified health care provider * For an Out-of-Network Provider, services may be covered if preauthorized. Please refer to Copayments in the “Medical Benefit Summary Notes” section for additional Benefit information. Oncology and transplant related Infusion / Injection therapy services are subject to pre-service review to determine whether Medically Necessary. Please refer to the	20%	Not covered*

Benefit	Member Copayment/Coinsurance	
	Services by In-Network Providers	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers, you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount, except for Surprise Billing Claims*.	
section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.		
Jaw Joint Disorder Benefits		
• Inpatient Hospital services For the services of an Out-of-Network Provider, there is an additional **$250** Copayment if prior authorization is not obtained For the services of an Out-of-Network Provider, the Plan's maximum payment is limited to **$360** per day. Please refer to Medical Benefit Maximums in the "Medical Benefit Summary Notes" section for maximums that apply to your Plan Hospital services are subject to pre-service review to determine whether Medically Necessary. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.	20%	40%
• Outpatient surgery facility services For the services of an Out-of-Network Provider, the Plan's maximum payment is limited to **$210** per visit. Please refer to Medical Benefit Maximums in the Medical Benefit Summary Notes section for maximums that apply to your Plan. Hospital services are subject to pre-service review to determine whether Medically Necessary. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.	20%	40%
• Physician services	20%	40%

Benefit	Member Copayment/Coinsurance	
	Services by In-Network Providers	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers, you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount, except for Surprise Billing Claims*.	
Mental Health and Substance Use Disorder		
• Inpatient Hospital services For the services of an Out-of-Network Provider, there is an additional **$250** Copayment if prior authorization is not obtained Hospital services are subject to pre-service review to determine whether Medically Necessary. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.	20%	40%
• Outpatient facility services Hospital services are subject to whether Medically Necessary necessity. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.	20%	40%
• Physician services including psychiatrists, psychologists, MFTs, MFCCs, etc. office visit or telehealth visit	20%	40%
Physical Therapy, Physical Medicine, Occupational and Speech Therapy Services, including Habilitation and Rehabilitation		
• Physician services – office location	20%	40%
• Outpatient Hospital For the services of an Out-of-Network Provider, the Plan's maximum payment is limited to **$210** per visit. Please refer to "Medical Benefit Maximums in the Medical Benefit Summary Notes" section for maximums that apply to your Plan.	20%	40%
• Speech therapy-office location	20%	20%

Benefit	Member Copayment/Coinsurance	
	Services by In-Network Providers	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers, you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount, except for Surprise Billing Claims*.	
Pregnancy and Maternity Care Benefits		
• Inpatient Hospital services For the services of an Out-of-Network Provider, the Plan's maximum payment is limited to **$360** per day. Please refer to "Medical Benefit Maximums in the Medical Benefit Summary Notes" section for maximums that apply to your Plan. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.	20%	40%
• Prenatal and postnatal Physician office visits	20%	40%
Preventive Care Benefits		
• Preventive care services See page 50 under Medical Care That Is Covered for details for information about your Preventive Care Services. The Calendar Year Deductible will not apply to services provided by Anthem Prudent Buyer Providers.	No charge	40%
• Travel Immunizations Benefits		
ACA Travel Vaccinations		
Hepatitis A	No charge	40%
Hepatitis B	No charge	40%
Meningitis	No charge	40%
Polio	No charge	40%
• Other Travel Vaccinations		
Japanese Encephalitis	20%	40%
Rabies	20%	40%
Typhoid	20%	40%
Yellow Fever	20%	40%
Professional (Physician) Benefits		
• Inpatient Physician services	20%	40%

Benefit	Member Copayment/Coinsurance	
	Services by In-Network Providers	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers, you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount, except for Surprise Billing Claims*.	
• Outpatient Physician services, other than an office setting	20%	40%
• Physician home visits	20%	40%
• Physician office visit or telehealth visit	20%	40%
• Online visits (LiveHealth Online)	20%	Not covered
• Chemotherapy and radiation therapy services Chemotherapy and radiation therapy services are subject to pre-service review to determine whether Medically Necessary. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.	20%	40%
• Hemodialysis services	20%	40%
• Office based injectable service	20%	40%
• Retail Health Clinic	20%	40%
• Urgent Care services	20%	40%
Prosthetic Devices Benefits		
• Physician services	20%	40%
• Prosthetic Devices	20%	40%

Benefit	Member Copayment/Coinsurance	
	Services by In-Network Providers	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers, you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount, except for Surprise Billing Claims*.	
Skilled Nursing Facility Benefits		
• Inpatient Hospital services Benefits are provided for up to a maximum of 100 visits per Calendar Year. Please refer to Medical Benefit Maximums in the Medical Benefit Summary Notes section for maximums that apply to your Plan. For the services of an Out-of-Network Provider, there is an additional **$250** Copayment if prior authorization is not obtained For the services of an Out-of-Network Provider, the Plan's maximum payment is limited to **$360** per day. Please refer to "Medical Benefit Maximums in the Medical Benefit Summary Notes" section for maximums that apply to your Plan. Since your Plan has a Calendar Year Deductible, the number of visits will start counting toward the maximum when Services are first provided even if the Calendar Year Deductible has not been met. Please refer to Copayments in the Medical Benefit Summary Notes section for additional Benefit information. Skilled Nursing Facility services are subject to pre-service review to determine whether Medically Necessary. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.	20%	40%

Benefit	Member Copayment/Coinsurance	
	Services by In-Network Providers	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers, you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount, except for Surprise Billing Claims*.	
• Services by a free-standing Skilled Nursing Facility Benefits are provided for up to a maximum of 100 visits per Calendar Year. Please refer to Medical Benefit Maximums in the Medical Benefit Summary Notes section for maximums that apply to your Plan. For the services of an Out-of-Network Provider, there is an additional **$250** Copayment if prior authorization is not obtained Since your Plan has a Calendar Year Deductible, the number of visits will start counting toward the maximum when Services are first provided even if the Calendar Year Deductible has not been met. Please refer to Copayments in the Medical Benefit Summary Notes section for additional Benefit information. Skilled nursing facility services are subject to pre-service review to determine whether Medically Necessary. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.	20%	20%
Transplant Benefits Services and supplies provided in connection with a non-Investigative organ or tissue transplant. These procedures are covered only when performed at a CME or BDCSC. See page 53 under “Medical Care That Is Covered” for details. Transplant services, excluding cornea transplant, are subject to pre-service review to determine whether Medically Necessary. Please refer to the section UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.		

Benefit	Member Copayment/Coinsurance	
	Services by In-Network Providers	Services by Out-of-Network Providers*
	* For Covered Services from Out-of-Network Providers, you are responsible for any Deductible, Copayment and all charges above the Maximum Allowed Amount, except for Surprise Billing Claims*.	
• Hospital inpatient services	20%	Not covered
• Hospital outpatient surgery services	20%	Not covered
• Physician services	20%	Not covered
• Transplant Travel Expenses The Plan's maximum payment will not exceed **$10,000** per surgery. Please refer to "Medical Benefit Maximums in the Medical Benefit Summary Notes" section for maximums that apply to your Pan. *No Copayment will be required for transplant travel expenses authorized by Anthem once your Calendar Year Deductible is met.	No charge	Not covered
• Unrelated Donor Search service The Plan's maximum payment will not exceed **$30,000** per transplant. Please refer to "Medical Benefit Maximums in the Medical Benefit Summary Notes" section for maximums that apply to your Plan.		

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

Medical Benefit Summary Notes

Member Deductible

The Calendar Year Deductible per Individual is shown on the SUMMARY OF BENEFITS. Each year, you will be responsible for satisfying the Member Calendar Year Deductible amount before the Plan begins to pay Benefits. The family Deductible is non-embedded meaning the cost shares of all Family Members apply to one shared family Deductible. The Individual Deductible only applies to Individuals enrolled under single coverage. If Members of an enrolled family pay Deductible expense in a year equal to the family Deductible, the Calendar Year Deductible for all Family Members will be considered to have been met. For additional information about Deductibles please see the "Deductibles, Copayments, Out-of-Pocket Amounts and Medical Benefit Maximums" section of this booklet.

Member Out-of-Pocket Maximum

1. The per Individual and per family Out-of-Pocket Maximum responsibility each Calendar Year for Covered Services rendered by an Anthem Prudent Buyer Providers and Other Healthcare Providers is shown on the SUMMARY OF BENEFITS.
2. The per Individual and per family Out-of-Pocket Maximum responsibility each Calendar Year for Covered Services rendered by Out-of-Network Providers is shown on the SUMMARY OF BENEFITS.

After a Member has made the total out-of-pocket payments for covered medical and prescription drug services and supplies during a Calendar Year, the Member will no longer be required to pay a Copayment for the remainder of that Year, unless otherwise stated, but will remain responsible for costs in excess of the Maximum Allowed Amount. The family Out-of-Pocket Maximum is non-embedded meaning the cost shares of all Family Members apply to one shared family Out-of-Pocket Maximum. The Individual Out-of-Pocket Maximum only applies to Individuals enrolled under single coverage.

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

Copayments

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

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

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

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

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

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

INTRODUCTION

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

The Benefits of this Plan are provided only for those services that are considered to be Medically Necessary. The fact that a Physician prescribes or orders a service does not, in itself, mean that the services is Medically Necessary or that the service is covered under this Plan. Consult this Benefit Booklet or contact the Member Services number on the back of the identification card if you have any questions regarding whether services are covered.

This Plan contains many important terms (such as "Medically Necessary" and "Maximum Allowed Amount") that are defined in the DEFINITIONS section starting at page 93. When reading through this booklet, consult the DEFINITIONS section to be sure that you understand the meaning of these words.

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

If you have questions about your Benefits, contact the Member Services number on the back of the identification card before Hospital or medical services are received.

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

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

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

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

1. You or your Physician must obtain Accolade's approval at least 48 hours before Hospital or Skilled Nursing Facility admissions for all non-Emergency inpatient Hospital or Skilled Nursing Facility services.
2. You or your Physician must notify Accolade within 48 hours or by the end of the first business day following Emergency admissions, or as soon as it is reasonably possible to do so.
3. You or your Physician must obtain prior authorization in order to determine if contemplated services are covered. See "Types of Reviews" in the UTILIZATION REVIEW section for a listing of services requiring prior authorization.

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

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

Mental Health Parity and Addiction Equity Act. The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance use disorder Benefits with day or visit limits on medical and surgical benefits. In general,

group health plans offering mental health and substance use disorder benefits cannot set day/visit limits on mental health or substance use disorder benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on mental health and substance use disorder benefits offered under the plan.

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

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

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

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

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

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

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

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

TYPES OF PROVIDERS

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

Introduction

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

Anthem Prudent Buyer Providers in California. Anthem has made available to Members a network of various types of In-Network Providers. Anthem Prudent Buyer Providers are called 'participating' because they have agreed to participate in Anthem's preferred provider organization program (PPO), called the Prudent Buyer Plan. Anthem Prudent Buyer Providers have agreed to a rate they will accept as reimbursement for Covered Services. The amount of Benefits payable under this Plan will be different for Out-of-Network Providers than for Anthem Prudent Buyer Providers. See the definition of "Anthem Prudent Buyer Providers" in the DEFINITIONS section starting at page 93, for a complete list of the types of Providers which may be participating providers.

A directory of Anthem Prudent Buyer Providers is available upon request. The directories list In-Network Providers in your area, including health care facilities such as Hospitals and Skilled Nursing Facilities, Physicians, laboratories, and diagnostic x-ray and imaging providers. You may call the Member Services number on the back of the identification card and request for a directory to be sent to you. A member services representative will be able to assist you with locating a provider online.
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 the identification card.

How to Access Primary and Specialty Care Services

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

To make an appointment call your Physician's office:

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

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

After hours care is provided by your Physician who may have a variety of ways of addressing your needs. Call your Physician for instructions on how to receive medical care after their normal business hours, on weekends and holidays. This includes information about how to receive non-Emergency care and non-

Urgent Care within the service area for a condition that is not life threatening, but that requires prompt medical attention. If you have an Emergency, call 911 or go to the nearest emergency room.

In-Network Providers Outside of California

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

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

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

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

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

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

Other Health Care Providers. "Other Health Care Providers" are neither Physicians nor Hospitals. They are mostly free-standing facilities or service organizations, such as a certified registered nurse anesthetist or a blood bank. See the definition of "Other Health Care Providers" in the DEFINITIONS section starting at page 93, for a complete list of those providers. Other Health Care Providers are not part of the Prudent Buyer Plan Provider network or the Blue Cross and/or Blue Shield Plan.

Reproductive Health Care Services. Some Hospitals and other Providers do not provide one or more of the following services that may be covered under your Plan and that you or your Family Member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; Infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective Physician or clinic, or call the Member Services number on the back of the identification card to ensure that you can obtain the health care services that you need.

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

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

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

An Anthem Prudent Buyer Provider in the Prudent Buyer Plan or the Blue Cross and/or Blue Shield Plan network is not necessarily a CME or BDCSC Facility. For additional information, please see the DEFINITIONS section of this book or call the Member Services number on the back of the identification card.

YOUR MEDICAL BENEFITS

Maximum Allowed Amount

General

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

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

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

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

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

Example: The Plan has a Member Copayment of 40% for Out-of-Network Provider services after the Calendar Year Deductible has been met.

- The Member receives services from an out-of-network surgeon. The charge is $2,000. The Maximum Allowed Amount under the Plan for the surgery is $1,000. The Member's Copayment responsibility when an out-of-network surgeon is used is 40% of $1,000, or $400. The Plan pays the remaining 60% of $1,000, or $600. 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 $400 plus an additional $1,000, for a total of $1,400.

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

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an Anthem Prudent Buyer Provider, an Out-of-Network Provider or Other Health Care Provider.

Anthem Prudent Buyer Providers. For Covered Services performed by an Anthem Prudent Buyer Provider, the Maximum Allowed Amount for this Plan will be the rate the Anthem Prudent Buyer Provider has agreed with Anthem to accept as reimbursement for the Covered Services. Because Anthem Prudent Buyer 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 Calendar Year Deductible or have a Copayment. Please call the Member Services number on the back of the identification card for help in finding an Anthem Prudent Buyer Provider.

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

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

Note: If an Other Health Care Provider is participating in a Blue Cross and/or Blue Shield Plan at the time you receive services, such Provider will be considered an Anthem Prudent Buyer Provider for the purposes of determining the Maximum Allowed Amount.

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

Out-of-Network Providers and Other Health Care Providers.*

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

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

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

Unlike an Anthem Prudent Buyer Provider, Out-of-Network Providers and Other Health Care Providers may send you a bill and collect for the amount of the Out-of-Network Provider's or Other Health Care Provider's charge that exceeds the Maximum Allowed Amount under this Plan. You may be responsible for paying the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider or Other Health Care Provider charges. This amount can be significant. Choosing an Anthem Prudent Buyer Provider will likely result in lower out of pocket costs to you. Please call the Member Services number on the back of the identification card for help in finding an Anthem Prudent Buyer Provider. Member Services is also available to assist you in determining this Plan's Maximum Allowed Amount for a particular Covered Service from an Out-of-Network Provider or Other Health Care Provider.

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

***Exceptions:**

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

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

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

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

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

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

- **Surprise Billing Claims.** Surprise Billing Claims are described in the “Consolidated Appropriations Act of 2021 Notice” at the end of this Booklet. Please refer to that section for further details.

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

Member Cost Share

For certain Covered Services, and depending on your plan design, you may be required to pay all or a part of the Maximum Allowed Amount as your cost share amount (Deductibles or Copayments). Your cost share amount and the Out-Of-Pocket Amounts may be different depending on whether you received Covered Services from an Anthem Prudent Buyer Provider or Out-of-Network Provider. Specifically, you may be required to pay higher cost-sharing amounts or may have limits on your Benefits when using Out-of-Network Providers. Please see the SUMMARY OF BENEFITS section for your cost share responsibilities and limitations, or call the member Services number on the back of the identification card to learn how this Plan’s Benefits or cost share amount may vary by the type of Provider you use. For additional details about Deductibles or Copayments please refer to the “Deductibles, Copayments, Out-of-Pocket Amounts and Medical Benefit Maximums” section.

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

Authorized Referrals

In some circumstances Accolade may authorize Anthem Prudent Buyer Provider cost share amounts (Deductibles or Copayments) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstance, you or your Physician must contact Accolade in advance of obtaining the Covered Service. It is your responsibility to ensure that Accolade has been contacted. If Accolade authorizes an Anthem Prudent Buyer 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. If you receive prior authorization for an Out-of-Network Provider due to network adequacy issues, **you** will not be responsible for the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount. Please call the Member Services number on the back of the identification card for Authorized Referral information or to request authorization.

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

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

Deductibles

The In-Network and Out-of-Network Deductibles under this Plan are separate and distinct from the other. Only the covered charges that make up the Maximum Allowed Amount will apply toward the satisfaction of any Deductible except as specifically indicated in this booklet.

Calendar Year Deductible. Each Year, you will be responsible for satisfying the Member's Calendar Year Deductible before Benefits are paid. The family Deductible is non-embedded meaning the cost shares of all Family Members apply to one shared family Deductible. The Individual Deductible only applies to Individuals enrolled under single coverage. If Members of an enrolled family pay Deductible expense in a Year equal to the family Deductible, the Calendar Year Deductible for all Family Members will be considered to have been met.

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

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

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

Copayments

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

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

Anthem Prudent Buyer Provider and Out-of-Network Provider Out-of-Pocket-Amounts

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

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

Anthem Prudent Buyer Provider, In-Network Pharmacies, Home Delivery Pharmacies and Other Health Care Providers. Only covered charges up to the Maximum Allowed Amount for the services of an Anthem Prudent Buyer Provider, In-Network Pharmacy, Home Delivery Pharmacy or Other Health Care Provider will be applied to the Anthem Prudent Buyer Provider, In-Network Pharmacy, Home Delivery Pharmacy and Other Health Care Provider Out-of-Pocket Amount.

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

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

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

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

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

Medical Benefit Maximums

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

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

Crediting Prior Plan Coverage

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

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

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

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

This Section Does Not Apply To You If:

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

Conditions of Coverage

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

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

Contact the Member Services number on the back of the identification card if you have any questions.

Medical Care That Is Covered

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

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

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

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

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

Advanced Imaging Procedure Benefits. Imaging procedures, including, but not limited to, Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET scan), and Magnetic Resonance Angiogram (MRA scan) are subject to pre-service review to determine whether Medically Necessary. You may call the Member Services number on the back of the identification card to find out if an imaging procedure requires pre-service review. See UTILIZATION REVIEW PROGRAM for details.

Advanced imaging procedures, when performed by an Out-of-Network Provider, will have a maximum payment of **$210** per visit.

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

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

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

Emergency ground ambulance services do not require pre-service review. Pre-service review is required for air ambulance in a non-medical Emergency. When using an air ambulance in a non-Emergency situation, Accolade reserves the right to select the air ambulance provider. If you do not use the air ambulance Accolade selects in a non-Emergency situation, no coverage will be provided by the Plan and Members will be responsible for the entire cost of transport.

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

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

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

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

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

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

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

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

* If you have an Emergency medical condition that requires an emergency response, please call the "911" emergency response system if you are in an area where the system is established and operating. At your earliest opportunity, call the Member Services number on the back of the identification card to discuss plan benefits for Ambulance services.

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

For the services of an Out-of-Network Provider Facility only, the Plan's maximum payment is limited to **$210** per visit each time you have outpatient surgery at an Ambulatory Surgical Center.

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

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

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

Bariatric Travel Expense Benefits. Certain travel expenses Incurred in connection with an approved, specified bariatric surgery, performed at a designated BDCSC that is fifty (50) miles or more from the Member's place of residence, are covered, provided the expenses are authorized by Accolade in advance. The fifty (50) mile radius around the BDCSC will be determined by the Bariatric BDCSC Coverage Area (See

DEFINITIONS). The Plan's maximum payment will not exceed **$5,000** per surgery for the following travel expenses Incurred by the Member and/or one companion:

- Transportation for the Member and/or one companion to and from the BDCSC.
    - Mileage is reimbursed equal to one round trip to the medical care facility. Mileage is reimbursed per Internal Revenue Service (IRS) Guidelines for medical related mileage. See http:///www.irs.gov/ for details on the mileage rate applicable to the year of service on the claim. Additional commuting to and from the medical care facility is not a reimbursable expense. Fees for parking, tolls, gas, car maintenance, repairs, or the like are not covered.

- Coach airfare to and from the Hospital when it is 300 miles or more from your residence.
    - Charges for baggage are reimbursable if a receipt is provided. Mileage to and from the member's permanent residence and the member's home city airport is a reimbursable expense. Mileage to and from the airport nearest to the medical care facility and the medical care facility is a reimbursable expense. Coverage can be provided for alternate sources of transportation from the airport to the medical care facility and back to the airport after treatment has been completed. These can include taxi, shuttle, and car rental. This benefit is only for arrival and departure days.

- Lodging, limited to one room, double occupancy.
    - Lodging is reimbursed at the lesser of the actual lodging charges or $50 for the member and $50 for each covered caregiver for a maximum of $100 per night. Minor patients are eligible to have two caregivers. In this situation a maximum of $150 per night would be reimbursable. Lodging can be in the form of a hotel, motel, Airbnb, or short-term apartment rental. Service and cleaning charges are not covered. Receipts must be itemized and contain the number of guests listed. Short term apartment rental must include a copy of the signed lease. Credit card receipts are not an acceptable form of documentation or proof of payment.

- Other reasonable expenses. Tobacco, alcohol, drug expenses, and meals are excluded from coverage.

Member Services will confirm if the "Bariatric Travel Expense Benefit" is available in connection with access to the selected bariatric BDCSC. Details regarding reimbursement can be obtained by calling the Member Services number on the back of the identification card. A travel reimbursement form will be provided and will include instructions for submission of legible copies of all applicable receipts in order to obtain reimbursement.

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

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

1. Diagnostic mammogram examinations in connection with the treatment of a diagnosed illness or injury. Routine mammograms will be covered initially under the "Preventive Care Benefits". A follow-up mammogram may be considered diagnostic or treatment of a diagnosed illness or injury. Please talk with your treating Physician to understand what care is being provided so you will know which coverage applies.

2. Breast cancer (BRCA) testing, if appropriate, in conjunction with genetic counseling and evaluation. When done as a preventive care service, BRCA testing will be covered under the "Preventive Care Benefits".

3. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.

4. Reconstructive surgery of both breasts performed to restore and achieve symmetry following a Medically Necessary mastectomy.

5. Breast prostheses following a mastectomy (see “Prosthetic Devices Benefits”).

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

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

Chemotherapy Benefits. This includes the treatment of disease using chemical or antineoplastic agents and the cost of such agents in a professional or Facility setting. Chemotherapy services are subject to pre-service review to determine whether Medically Necessary, please refer to UTILIZATION REVIEW PROGRAM for details.

Chiropractic Benefits. Chiropractic Services for manual manipulation of the spine to correct subluxation demonstrated by Physician-read x-ray. The Plan will pay for up to 24 visits (combined with “Acupuncture Benefits”) during a Calendar Year.

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

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

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

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

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

2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration.

3. Studies or investigations done for drug trials that are exempt from the investigational new drug application.

Participation in the clinical trial must be recommended by your Physician after determining participation has a meaningful potential to benefit you. All requests for clinical trials services, including requests that are not part of approved clinical trials, will be reviewed according to the Plan's Clinical Coverage Guidelines, related policies and procedures. If you have any questions about the information in this section, please refer to the Member Services number on the back of the identification card.

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

1. The investigational item, device, or service.

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

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

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

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

Contraceptive Benefits

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

- Injectable drugs and implants for birth control, administered in a Physician's office, if Medically Necessary.

- Intrauterine contraceptive devices (IUDs) and diaphragms, dispensed by a Physician if Medically Necessary.

- Professional services of a Physician in connection with the prescribing, fitting, and insertion of intrauterine contraceptive devices or diaphragms.

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

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

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

Dental Care Benefits

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

2. **General Anesthesia.** General anesthesia and associated Facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a Hospital or Ambulatory

Surgical Center. This applies only if (a) the Member is less than seven years old, (b) the Member is developmentally disabled, or (c) the Member's health is compromised and general anesthesia is Medically Necessary. Charges for the dental procedure itself, including professional fees of a dentist, may not be covered.

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

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

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

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

Designated Pharmacy Provider Benefits

Anthem may establish one or more Designated Pharmacy Provider programs which provide specific pharmacy services (including shipment of Prescription Drugs) to Members. A participating provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the participating provider must have signed a Designated Pharmacy Provider agreement with the Plan. You or your Physician can contact the Member Services number on the back of the identification card to learn which Pharmacy or pharmacies are part of a Designated Pharmacy Provider program.

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

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

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

You can get the list of the Prescription Drugs covered under this section by calling the Member Services number on the back of the identification card.

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

1. The following equipment and supplies:

    a. Blood glucose monitors, including monitors designed to assist the visually impaired, and blood glucose testing strips.

b. Insulin pumps.

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

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

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

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

2. Diabetes education program which:

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

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

   c. Is supervised by a Physician.

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

3. The following items are covered as medical supplies:

   a. Insulin syringes, disposable pen delivery systems for insulin administration. Charges for insulin and other prescriptive medications are not covered.

   b. Testing strips, lancets, and alcohol swabs.

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

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

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

1. Of no further use when medical needs end;

2. For the exclusive use of the patient;

3. Not primarily for comfort or hygiene;

4. Not for environmental control or for exercise; and

5. Manufactured specifically for medical use.

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

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

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, after the Calendar Year Deductible has been met, 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 Health Care Provider in the case of Emergency Medical Condition and/or if no In-Network Health Care Provider is available to ensure timely access.

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

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

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

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

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

- Ground transportation to and from the Hospital when it is 75 miles or more from your place of residence.
    - Mileage is reimbursed equal to one round trip to the medical care facility. Mileage is reimbursed per Internal Revenue Service (IRS) Guidelines for medical related mileage. See http:///www.irs.gov/ for details on the mileage rate applicable to the year of service on the claim. Additional commuting to and from the medical care facility is not a reimbursable expense. Fees for parking, tolls, gas, car maintenance, repairs, or the like are not covered.
- Coach airfare to and from the Hospital when it is 300 miles or more from your residence.
    - Charges for baggage are reimbursable if a receipt is provided. Mileage to and from the member's permanent residence and the member's home city airport is a reimbursable expense. Mileage to and from the airport nearest to the medical care facility and the medical care facility is a reimbursable expense. Coverage can be provided for alternate sources of transportation from the airport to the medical care facility and back to the airport after treatment has been completed. These can include taxi, shuttle, and car rental. This benefit is only for arrival and departure days.
- Lodging, limited to one room, double occupancy.

- Lodging is reimbursed at the lesser of the actual lodging charges or $50 for the member and $50 for each covered caregiver for a maximum of $100 per night. Minor patients are eligible to have two caregivers. In this situation a maximum of $150 per night would be reimbursable. Lodging can be in the form of a hotel, motel, Airbnb, or short-term apartment rental. Service and cleaning charges are not covered. Receipts must be itemized and contain the number of guests listed. Short term apartment rental must include a copy of the signed lease. Credit card receipts are not an acceptable form of documentation or proof of payment.

- Other reasonable expenses. Tobacco, alcohol, drug, and meal expenses are excluded.

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

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

Hearing Aid Benefits. The following hearing aid services are covered when provided by or purchased as a result of a written recommendation from an otolaryngologist or a state-certified audiologist. The Plan's payment will not exceed of **$2,000** every 36 months.

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

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

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

No Benefits will be provided for the following:

1. Charges for a hearing aid which exceeds specifications prescribed for the correction of hearing loss, or for more than $2000 every 36 months.

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

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

The following renal dialysis services are covered:

- Outpatient maintenance dialysis treatments in an outpatient dialysis Facility;

- Home dialysis; and

- Training for self-dialysis at home including the instructions for a person who will assist with self-dialysis done at a home setting.

Treatment provided by a freestanding outpatient hemodialysis center which is an Out-of-Network Provider is limited to **$210** per visit.

Home Health Care Benefits. The following services provided by a Home Health Agency:

1. Services of a registered nurse or licensed vocational nurse under the supervision of a registered nurse or a Physician.

2. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy, or respiratory therapy.
3. Services of a medical social service worker.
4. Services of a health aide who is employed by (or who contracts with) a Home Health Agency. Services must be ordered and supervised by a registered nurse employed by the Home Health Agency as professional coordinator. These services are covered only if you are also receiving the services listed in 1 or 2 above.
5. Medically Necessary supplies provided by the Home Health Agency.

Benefits are also available for Intensive In-Home Behavioral Health Services. These do not require confinement to the home. Please see the “Mental Health and Substance Use Disorder” for a description of this coverage.

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

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

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

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

Hospice Care Benefits. The services and supplies listed below are covered when provided by a Hospice for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care is care that controls pain and relieves symptoms but is not intended to cure the illness. You must be suffering from a terminal illness for which the prognosis of life expectancy is one year or less, as certified by your Physician and submitted to Anthem. Covered Services are available on a 24-hour basis for the management of your condition.

1. Interdisciplinary team care with the development and maintenance of an appropriate plan of care.
2. Short-term inpatient Hospital care when required in periods of crisis or as respite care. Coverage of inpatient respite care is provided on an occasional basis and is limited to a maximum of five consecutive days per admission.
3. Skilled nursing services provided by or under the supervision of a registered nurse. Certified home health aide services and homemaker services provided under the supervision of a registered nurse.
4. Social services and counseling services provided by a qualified social worker.
5. Dietary and nutritional guidance. Nutritional support such as intravenous feeding or hyperalimentation.
6. Physical therapy, occupational therapy, speech therapy, and respiratory therapy provided by a licensed therapist.
7. Volunteer services provided by trained Hospice volunteers under the direction of a Hospice staff member.
8. Pharmaceuticals, medical equipment, and supplies necessary for the management of your condition. Oxygen and related respiratory therapy supplies.
9. Bereavement services, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following the Member’s or the Dependent’s death. Bereavement services are available to surviving Members of the immediate family for a period of one year after the death. Your immediate family means your Spouse, children, step-children, parents, and siblings.

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

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

This Plan's Hospice benefit will meet or exceed Medicare's Hospice benefit. If you use an Out-of-Network, that provider may also bill you for any charges over Medicare's Hospice benefit.

Hospital Benefits

1. Inpatient services and supplies, provided by a Hospital. The Maximum Allowed Amount will not include charges in excess of the Hospital's prevailing two-bed room rate unless there is a negotiated per diem rate between Anthem and the Hospital, or unless your Physician orders, and Anthem authorizes, a private room as Medically Necessary. For inpatient services and supplies provided by an Out-of-Network Provider Facility, the Plan's maximum payment is limited to **$360*** per day.

2. Services in Special Care Units.

3. Outpatient services and supplies provided by a Hospital, including outpatient surgery. For outpatient services and supplies provided by an Out-of-Network Provider, the Plan's maximum payment is limited to **$210*** per day.

   *The Out-of-Network Provider Facility maximums do not apply to Emergency Services or Mental Health or Substance Use Disorder services.

Hospital services are subject to pre-service review to determine whether medical necessity.

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

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

Additional Covered Services include in-vitro fertilization, GIFT (gamete intrafallopian transfer), ZIFT (zygote intra-fallopian transfer), supplies, appliances and Drugs administered in a Physician's office, up to Two (2) "Cycles" as lifetime maximum for Eligible Covered Members.

Eligible Covered Members, with a diagnosis of infertility, in need of medical services to achieve pregnancy can access the infertility treatment benefits. Prior authorization by WINFertility's Medical Management Program is required prior to initiation of medical treatment for family building. Failure to initiate preauthorization of services for each service will result in a denial of benefits. Coverage is subject to available benefits at time of claim submission. Out of pocket cost shares are applicable and should be verified prior to initiating services.

Included – Subject to medical necessity and prior authorization, the following are covered under this benefit: timed intercourse and intrauterine insemination (IUI) cycles, assisted reproductive technologies (ART) (lifetime maximum of two in vitro fertilization (IVF) oocyte retrievals), and ART related services.

Note: Once a member has completed Two (2) cycles of IVF-Egg Retrievals, the lifetime benefit maximum has been reached for all infertility related services, including Intrauterine Insemination (IUI) services.

Your Plan includes coverage for Infertility services outside the United States, including IVF, ZIFT, and/or GIFT treatments. Diagnosis of cause of infertility is not a covered benefit outside the United States. **Prior authorization by WINFertility's Medical Management Program is required prior to initiation of medical treatment for family building. Contact WINFertility for more information at (877) 451-3077.**

Exclusions: The following services are not covered:

a. Gonadotropin or menotropin stimulated ovulation induction cycles including monitoring of timed intercourse and IUI cycles unless member has a diagnosis of hypogonadotropic anovulatory disorders or hypopituitarism, or after member has not ovulated or conceived after a prior trial of 3 cycles or clomiphene citrate or letrozole.

b. If a member or the member's partner has undergone an elective sterilization procedure, they are not eligible for benefits unless they undergo a successful reversal and thereafter meet DOI; Or WIN's consulting medical director determines that the reversal of the elective sterilization procedure is not medically indicated or will not improve the likelihood of conception due to multifactorial causes of infertility. Reversal of a sterilization procedure is not covered.

c. Experimental or Investigational medical and surgical procedures.

d. Services which are not medically appropriate.

e. Expenses for Surrogacy and fees associated with surrogacy.

f. Expenses for procuring Donated Oocytes or Sperm, including all medical expenses, travel expenses, agency, laboratory and donor fees, psychological screening, FDA testing for the donor and partner, genetics screening and all medications for the donor (e.g., suppression medications, stimulation medications)

g. Services which are not listed as covered in this benefit.

h. Diagnosis of cause of Infertility outside the United States.

For more information or to initiate prior authorization, contact WINFertility at (877) 451-3077.

WINFertility Pre-Service and Post-Service Appeals Process

- If a member is questioning a denial from WINFertility, and they have new or additional information, they are able to open a new review with WIN. The provider's office may submit a request for authorization review again, with the dates desired, and WIN will review the new documents received with that request.
- If a member wishes to submit an appeal (pre-service or post-service), WINFertility will direct the member to Accolade for guidance on submitting the appeal to Anthem.
- WINFertility remains responsible for benefit eligibility verification and pre-authorization reviews for infertility services.

How to Submit an Appeal

1. File the appeal with Anthem. Designation of Representative is required if someone else is representing the member.
2. Include the following information in the written appeal request:
    - Member name, member ID number, group number, phone number, address
    - The name of the provider who will or has provided care; the date(s) of service; the claim or reference number for the specific decision that you don't agree with; and the specific reason(s) why you don't agree with the decision
    - Any information or evidence (documents, medical records) to support the member's appeal
3. Mail the appeal to:
   Anthem Blue Cross Life and Health Insurance Company
   ATTN: Appeals
   P.O. Box 4310, Woodland Hills, CA 91365-4310

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

1. Medication, ancillary medical supplies and supply delivery, (not to exceed a 14-day supply); however, medication which is delivered but not administered is not covered;

2. Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications (if outpatient prescription drug benefits are provided under this Plan, Compound Medications must be obtained from an In-Network Pharmacy);

3. Hospital and home clinical visits related to the administration of infusion therapy, including skilled nursing services including those provided for: (a) patient or alternative caregiver training; and (b) visits to monitor the therapy;

4. Rental and purchase charges for durable medical equipment; maintenance and repair charges for such equipment;

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

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

Oncology and Transplant related infusion / injectable therapy services are subject to pre-service review to determine whether Medically Necessary. (See UTILIZATION REVIEW PROGRAM.)

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

Mental Health and Substance Use Disorder Benefits. This Plan provides coverage for the Medically Necessary treatment of Mental Health and Substance Use Disorder. This coverage is provided according to the terms and conditions of this Plan that apply to all other medical conditions, except as specifically stated in this section. Medically Necessary services are a Benefit only when the procedure is in accordance with Medical Policy. (See UTILIZATION REVIEW PROGRAM)

Services for the treatment of Mental Health and Substance Use Disorder covered under this Plan are subject to the same Deductible and Copayments that apply to services provided for other covered medical conditions and prescription drugs.

Covered Services shown below for the Medically Necessary treatment of Mental Health and Substance Use Disorder, or to prevent the deterioration of chronic conditions.

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

2. Outpatient Office Visits for the following:

   - individual and group mental health evaluation and treatment,
   - nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa,
   - drug therapy monitoring,
   - individual and group chemical dependency counseling,
   - medical treatment for withdrawal symptoms,
   - methadone maintenance treatment,
   - Behavioral health treatment for autism spectrum disorders delivered in an office setting.

- Other Outpatient Items and Services:

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

3. Behavioral health treatment for autism spectrum disorders. Inpatient services, office visits, and other outpatient items and services are covered under this section. See the section BENEFITS FOR AUTISM SPECTRUM DISORDERS for a description of the services that are covered by this Plan (see UTILIZATION REVIEW PROGRAM for details).

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

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

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

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

Online Visits. When available in your area, your coverage will include visits from a LiveHealth Online Provider. Covered services include medical consultations using the internet via webcam, chat, or voice. Online visits are covered under Plan only from Providers who contract with LiveHealth Online.

Non-Covered Services include, but are not limited to, the following:

- Reporting normal lab or other test results.
- Office visit appointment requests or changes.
- Billing, insurance coverage, or payment questions.
- Requests for referrals to other Physicians or healthcare practitioners.
- Benefit precertification.

- Consultations between Physicians.
- Consultations provided by telephone, electronic mail, or facsimile machines.

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

For Mental Health or substance use disorder online care visits, please see the SUMMARY OF BENEFITS under “Online visits (LiveHealth Online)” section for a description of this coverage.

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

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

1. Nebulizers, including face masks and tubing, inhaler spacers, and peak flow meters. These items are covered under the Plan's medical Benefits and are not subject to any limitations or maximums that apply to coverage for durable medical equipment (see "Durable Medical Equipment Benefits").
2. Education for pediatric asthma, including education to enable the child to properly use the items listed above. This education will be covered under the Plan's Benefits for office visits to a Physician.

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

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

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

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

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

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

1. Physical therapy and physical medicine provided on an outpatient basis for the treatment of illness or injury including the therapeutic use of heat, cold, exercise, electricity, ultra violet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care which are customarily provided by chiropractors, physical therapists and osteopaths. It does not include massage therapy services at spas, health clubs or by standalone massage therapists.)

2. Occupational therapy provided on an outpatient basis when the ability to perform daily life tasks has been lost or reduced by, or has not been developed due to, illness or injury including programs which are designed to rehabilitate mentally, physically or emotionally handicapped persons. Occupational therapy programs are designed to maximize or improve a patient's upper extremity function, perceptual motor skills and ability to function in daily living activities.

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

Pregnancy and Maternity Care Benefits

1. All medical Benefits for an enrolled Member when provided for pregnancy or maternity care, including the following services:

   a. Prenatal, postnatal and postpartum care;

   b. Ambulatory care services (including ultrasounds, fetal non-stress tests, Physician office visits, and other Medically Necessary maternity services performed outside of a Hospital);

   c. Involuntary complications of pregnancy;

   d. Diagnosis of genetic disorders in cases of high-risk pregnancy; and

   e. Inpatient Hospital care including labor and delivery.

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

2. Medical Hospital Benefits for routine nursery care of a newborn child, if the child's natural mother is an enrolled Member. Routine nursery care of a newborn child includes screening of a newborn for genetic diseases, congenital conditions, and other health conditions provided through a program established by law or regulation.

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

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

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

Benefits for drugs that you inject or get at a retail pharmacy (i.e., self-administered drugs) are not covered under this section. Benefits for these and other covered drugs are administered by a different plan administrator. For further information, refer to www.UChealthplans.com.

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

Preventive Care Benefits. Preventive care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA) and applicable state law. This means for Preventive Care Services, the Calendar Year Deductible will not apply to these services or supplies when they are provided by an Anthem Prudent Buyer Provider. No Copayment will apply to these services or supplies when they are provided by an Anthem Prudent Buyer Provider. The claim must be billed with a procedure code and diagnosis code combination that is identified or listed as preventive by the ACA.

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

1. A Physician's services for routine physical examinations.

2. Immunizations prescribed by the examining Physician.

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

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

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

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

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

    a. All FDA-approved contraceptive drugs, devices and other products for women, including over-the-counter FDA-approved contraceptive drugs, devices, and other products, if 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, intra uterine devices (IUDs) and implants, as well as voluntary sterilization procedures, contraceptive education and counseling. It also includes follow-up services related to the drugs, devices, products and procedures, including but not limited to management of side effects, counseling for continued adherence, and device insertion and removal.

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

        In order to be covered as preventive care, contraceptive prescription drugs must be either a generic or Single-Source Brand Name Drug (those without a generic equivalent). Multi-Source Brand Name Drugs (those with a generic equivalent) will be covered under your Plan’s prescription drug Benefits.

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

    c. Gestational diabetes screening.

d. Preventive prenatal care.

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

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

See the definition of "Preventive Care Services" in the DEFINITIONS section starting at page 93, for more information about services that are covered by this Plan.

Preventive Care for Chronic Conditions (per IRS guidelines)

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

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

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

Professional Services Benefit

1. Services of a Physician.

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

Prosthetic Devices Benefits

1. Breast prostheses following a mastectomy.

2. Prosthetic devices to restore a method of speaking when required as a result of a covered Medically Necessary laryngectomy.

3. The Plan will pay for other Medically Necessary prosthetic devices, including:

   a. Surgical implants;

   b. Artificial limbs or eyes;

   c. Therapeutic shoes and inserts only for the prevention and treatment of diabetes-related foot complications;

   d. Benefits are available for certain types of orthotics (braces, boots, splints). Covered services include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities, or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part; and

   e. Cochlear implants.

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

to pre-service review to determine whether Medically Necessary. Please refer to UTILIZATION REVIEW PROGRAM for details.

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

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

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

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

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

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

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

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

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

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

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

1. The recipient; or
2. The donor.

Benefits for an organ donor are as follows:

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

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

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

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

To maximize your Benefits, you should call Accolade as soon as you think you may need a transplant to talk about your Benefit options. You must do this before you have an evaluation or work-up for a transplant. Accolade will help you maximize your Benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, Centers of Medical Excellence (CME) or Blue Distinction Centers for Specialty Care (BDCSC) rules, or exclusions apply. Call the Member Services number on the back of the identification card.

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

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

Specified Transplant Benefits

You must obtain Accolade's prior authorization for all services including, but not limited to, preoperative tests and postoperative care related to the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. Specified transplants must be performed at Centers of Medical Excellence (CME) or Blue Distinction Centers for Specialty Care (BDCSC). **Charges for services provided for or in connection with a specified transplant performed at a Facility other than a CME or BDCSC will not be considered covered.** Call the Member Services number on the back of the identification card if your Physician recommends a specified transplant for your medical care. A case manager transplant coordinator will assist in facilitating your access to a CME or BDCSC. See UTILIZATION REVIEW PROGRAM for details.

Transplant Travel Expense Benefits

Certain travel expenses Incurred in connection with an approved, specified transplant (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures) performed at a designated CME, BDCSC, or other approved facility that is 75 miles or more from the recipient's or donor's place of residence are covered, provided the expenses are authorized by Accolade in advance.

Evaluations: Reimbursement of travel expenses associated with one round trip to the medical facility for transplant evaluation. This benefit does not apply to services related to the treatment of the disease leading to the need for a transplant. However, if the member is required to travel a distance for the evaluation and is advised to remain at the medical transplant facility for the treatment of the disease prior to the transplant, this will be considered on a case by case basis and determined by Accolade.

Transplant: Reimbursement of travel expenses associated with one round trip for the actual transplant procedure for the member and the caregiver(s).

Post-Transplant Follow-up: Reimbursement of travel expenses associated with medically necessary post-transplant visit(s) when the member is required to remain within close proximity of the medical facility for a short period of time. This is considered on a case by case basis.

Outpatient Post Transplant Follow-up visits: Reimbursement of travel expenses associated with medically necessary post-transplant visit(s) for the member when the member commutes from their permanent residence to an approved medical facility for follow-up visits.

The Plan's maximum payment will not exceed **$10,000** per transplant for the following travel expenses Incurred by the recipient and one companion* or the donor:

- Ground transportation to and from the CME, BDCSC, or other approved facility when the facility is 75 miles or more from the recipient's or donor's place of residence.
    - Mileage is reimbursed equal to one round trip to the medical care facility. Mileage is reimbursed per Internal Revenue Service (IRS) Guidelines for medical related mileage. See http:///www.irs.gov/ for details on the mileage rate applicable to the year of service on the claim. Additional commuting to and from the medical care facility is not a reimbursable expense. Fees for parking, tolls, gas, car maintenance, repairs, or the like are not covered.
- Coach airfare to and from the CME or BDCSC when the designated CME or BDCSC is 300 miles or more from the recipient's or donor's residence
    - Charges for baggage are reimbursable if a receipt is provided. Mileage to and from the member's permanent residence and the member's home city airport is a reimbursable expense. Mileage to and from the airport nearest to the medical care facility and the medical care facility is a reimbursable expense. Coverage can be provided for alternate sources of transportation from the airport to the medical care facility and back to the airport after treatment has been completed. These can include taxi, shuttle, and car rental. This benefit is only for arrival and departure days.
- Lodging, limited to one room, double occupancy
    - Lodging is reimbursed at the lesser of the actual lodging charges or $50 for the member and $50 for each covered caregiver for a maximum of $100 per night. Minor donor recipients are eligible to have two caregivers. In this situation a maximum of $150 per night would be reimbursable. Lodging can be in the form of a hotel, motel, Airbnb, or short-term apartment rental. Service and cleaning charges are not covered. Receipts must be itemized and contain the number of guests listed. Short term apartment rental must include a copy of the signed lease. Credit card receipts are not an acceptable form of documentation or proof of payment.
- Other reasonable expenses. Tobacco, alcohol, drug expenses, and meals are excluded.

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

No Copayments will be required for transplant travel expenses authorized in advance by Accolade.

Expense Incurred for the following is not covered: interim visits to a medical care Facility while waiting for the actual transplant procedure; travel expenses for a companion and/or caregiver for a transplant donor;

return visits for a transplant donor for treatment of a condition found during the evaluation; rental cars, buses, taxis or shuttle services; and mileage within the city in which the medical transplant Facility is located.

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

Living Donor Benefits

The following benefits apply to living donors:

Evaluations: Benefits for travel expenses associated with one round trip for the medical donor evaluation is covered. This benefit applies to the donor only.

Actual Donor Organ Acquisition: Benefits for travel expenses associated with one round trip for the actual donor organ acquisition procedure is covered. This benefit applies to the donor only.

Post-Donor Organ Acquisition: Benefits for travel expenses for donor for post organ acquisition procedure is covered for a maximum of up to six weeks after the organ acquisition.

Stem Cell Donor

Stem cell donor charges for travel are reimbursable if a written letter stating the medically necessity from Accolade for travel expenses is provided and pre-approved.

Travel Immunization Benefits

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

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

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

Medical Care That Is NOT Covered

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

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

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

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

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

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

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

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

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

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

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

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

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

This exclusion does not apply to the following:

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

Educational or Academic Services. This Plan does not cover:

1. Educational or academic counseling, remediation, or other services that are designed to increase academic knowledge or skills.
2. Educational or academic counseling, remediation, or other services that are designed to increase socialization, adaptive, or communication skills.
3. Academic or educational testing.
4. Teaching skills for employment or vocational purposes.
5. Teaching art, dance, horseback riding, music, play, swimming, or any similar activities.
6. Teaching manners and etiquette or any other social skills.
7. Teaching and support services to develop planning and organizational skills such as daily activity planning and project or task planning.

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

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

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

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

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

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

Gene Therapy. Gene therapy as well as any drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

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

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

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

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

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

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 Accolade.

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

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

- Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
- Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
- Enhancements to standard equipment and devices that is not Medically Necessary.
- Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation.

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

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

Not Medically Necessary. Services or supplies that are not Medically Necessary, as defined. This includes services that do not meet Anthem's medical policy, clinical coverage, or benefit policy guidelines. See pages 97-98 in the DEFINITIONS section for more information.

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

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

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

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

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specifically stated in the "Infusion Therapy" / Injectable Therapy Benefits", "Prescription Drug for Abortion Benefits", or "Preventive Care Benefits" provisions of Medical Care That Is Covered.

Cosmetics, health or beauty aids. However, health aids that are Medically Necessary and meet the requirements for durable medical equipment as specified under the “Durable Medical Equipment Benefits” provision of Medical Care That Is Covered, are covered, subject to all terms of this Plan that apply to that benefit. Your benefits for prescription drug coverage are administered by a different plan administrator. For further information, refer to www.UChealthplans.com.

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

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

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

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

Residential accommodations. Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility or short term services in a Residential Treatment Center.

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

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

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

Speech Therapy. Speech therapy except as stated in the "Speech Therapy and Speech language pathology (SLP) Benefits" provision of Medical Care That Is Covered. This exclusion also does not apply the Medically Necessary treatment of autism spectrum disorders, to the extent stated in the section BENEFITS FOR AUTISM SPECTRUM DISORDERS.

Sterilization Reversal. Reversal of an elective sterilization.

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

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

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

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

1. It must be internationally known as being devoted mainly to medical research;

2. At least **10%** of its yearly budget must be spent on research not directly related to patient care;

3. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;

4. It must accept patients who are unable to pay; and

5. Two-thirds of its patients must have conditions directly related to the Hospital's research.

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

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

BENEFITS FOR AUTISM SPECTRUM DISORDERS

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 Disorders 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, and

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

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

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

Our network of In-Network Providers is limited to licensed Qualified Autism Service Providers who contract with Anthem and who may supervise and employ Qualified Autism Service Professionals or Paraprofessionals who provide and administer behavioral health treatment.

For purposes of this section, the following definitions apply:

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

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

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

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

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

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

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

Qualified Autism Service Provider is either of the following:

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

You must obtain precertification for all behavioral health treatment services for the treatment of autism spectrum disorders in order for these services to be covered (see the “Utilization Review Program” section for details).

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. Consequently, a third Party may be liable, or legally or equitably responsible, for payment of charges incurred in connection with Your injury or illness. If so, You may have a claim against that third party for payment of the medical or other charges. In that event, the Plan will be secondary payer, not primary, and the Plan will be subrogated (i.e., substituted in to, or put in, your place as to) to all rights You may have against that third party.

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.

The Plan Administrator may, in its discretion, designate a third party service provider or other person or entity to exercise the rights described in these Subrogation and Reimbursement provisions on behalf of the Plan.

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

You hereby automatically grant an equitable lien to the Plan to be imposed upon and against all rights of Recovery with respect to Third Parties, as described as follows. 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

The Plan's equitable lien supersedes any right that You may have to be "made whole." 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. In other words, the Plan's right of first and primary reimbursement will not be reduced for any reason, including Your attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. The Plan is not responsible for Your legal fees and costs, is not required to share in any way for any payment of such fees and costs, and its equitable lien will not be reduced by any such fees and costs. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

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 authorize the Plan to sue, compromise and settle in Your name to the extent of the amount of medical or other benefits paid for Your injury or illness under the Plan and the expenses incurred by the Plan in collecting this amount, and assign to the Plan Your rights to Recovery when the provisions of these Subrogation and Reimbursement provisions apply.

- 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 authorize the Plan to join or intervene into any action by You against a third party.
- 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 are hereby notified that the Plan Administrator will have the power and authority, in its sole discretion, to (i) deny payment of any claims for benefits by or on behalf of the Participant and (ii) deny or reduce future benefits payable (including payment of future benefits for the same or other injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for the same or other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement. If the Plan must bring an action against You to enforce the provisions of these Subrogation and Reimbursement provisions, You will be obligated to pay the Plan's attorneys' fees and costs regardless of the action's outcome.

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.

COORDINATION OF BENEFITS

If you are covered by more than one group medical plan, your benefits under this Plan (referred to as "This Plan" under this section) will be coordinated with the benefits of those Other Plans, as shown below. These coordination provisions apply separately to each member, per calendar year, and are largely determined by California law. 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 Allowable Expense.

The following are not Allowable Expense:

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

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

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

4. If a person is covered by one plan that calculates its benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method and another plan provides its benefits or services on the basis of negotiated rates or fees, any amount in excess of the negotiated rate.

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

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

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage;

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

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

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

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

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

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

EFFECT ON BENEFITS

This provision will apply in determining a person's benefits under This Plan for any 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. Benefits of This Plan cannot be determined until the Principal Plan has completed processing.
3. The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if you were covered under This Plan only.

ORDER OF BENEFITS DETERMINATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

OUR RIGHTS UNDER THIS PROVISION

Responsibility For Timely Notice. UC is not responsible for coordination of benefits unless timely information has been provided by the requesting party regarding the application of this provision. In addition to the provisions outlined under Notice of Claim, a copy of the Other Plan Explanation of Benefits is required for coordination of benefits.

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

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

Right of Recovery. If payments made under This Plan exceed the maximum payment necessary to satisfy the intent of this provision, Anthem or this Plan 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

If you are entitled to Medicare, you will receive the full Benefits of this Plan, except as listed below:

1. You are receiving treatment for end-stage renal disease following the first 30 months you are entitled to end-stage renal disease benefits under Medicare; or

2. You are entitled to Medicare benefits as a disabled person, unless you have a current employment status as determined by Medicare rules through a group of 100 or more employees (according to federal OBRA legislation).

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

Coordinating Benefits With Medicare. Benefits will not be provided under this Plan that duplicate any benefits to which you would be entitled under Medicare. This exclusion applies to all parts of Medicare in which you can enroll without paying additional premium. If you are required to pay additional premium for any part of Medicare, this exclusion will apply to that part of Medicare only if you are enrolled in that part.

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 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.

Anthem will apply any charges paid by Medicare for services covered under this Plan toward your Plan Deductible, if any.

UTILIZATION REVIEW PROGRAM

Your Plan includes the process of utilization review to decide when services are Medically Necessary, Experimental, or Investigative as those terms are defined in this booklet. Utilization review aids the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed. A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is part of the review, services in a higher level of care or higher cost setting / place of care will not be Medically Necessary if they can be safely given to you in a lower level of care or lower cost setting / place of care.

Certain services must be reviewed to determine medical necessity in order for you to get Benefits. Utilization review criteria will be based on many sources including medical policy and clinical guidelines. Accolade may decide that a service that was asked for is not Medically Necessary if you have not tried other treatments that are more cost-effective.

If you have any questions about the information in this section, you may call the Member Services number on the back of the identification card.

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

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

TYPES OF REVIEWS

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

    For admissions following an Emergency, you, your authorized representative or Physician must tell the Plan within 48 hours or as soon as it is possible within a reasonable period of time.

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

    For inpatient Hospital Stays for mastectomy surgery, including the length of Hospital Stays associated with mastectomy, precertification is not needed.
- **Continued Stay / Concurrent Review –** A utilization review of a service, treatment or admission for a Benefit coverage determination which must be done during an ongoing Stay in a Facility or course of treatment.
  - Both pre-service and continued Stay / concurrent reviews may be considered urgent when, in the view of the treating Provider or any Physician with knowledge of your medical condition, without such care or treatment, your life or health or your ability to regain maximum function could be seriously threatened or you could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.

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

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

- Scheduled, non-Emergency inpatient Hospital Stays and Residential Treatment Center admissions, including detoxification and rehabilitation.

  Exceptions: Pre-service review is not required for inpatient Hospital Stays for the following service:

  - Maternity care of 48 hours or less following a normal delivery or 96 hours or less following a cesarean section
- Specific non-Emergency outpatient services, including diagnostic treatment and other services.
- Specific outpatient surgeries performed in an outpatient Facility or a doctor's office.
- Transplant services, excluding cornea transplant, including transplant travel expense. The following criteria must be met for certain transplants, as follows:

  - For bone or skin transplants, if the Physicians on the surgical team and the Facility in which the transplant is to take place are approved for the transplant requested.
  - For transplantation of heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney or bone marrow/stem cell and similar procedures, if the Providers of the related preoperative and postoperative services are approved and the transplant will be performed at a Centers of Medical Excellence (CME) or a Blue Distinction Centers for Specialty Care (BDCSC) Facility.
- Air ambulance in a non-medical Emergency.
- Specific durable medical equipment.
- Oncology and Transplant related infusion therapy / injectable therapy, if the attending Physician has submitted both a prescription and a plan of treatment before services are rendered.
- Home health care. The following criteria must be met:

  - The services can be safely provided in your home, as certified by your attending Physician;
  - Your attending Physician manages and directs your medical care at home; and
  - Your attending Physician has established a definitive treatment plan which must be consistent with your medical needs and lists the services to be provided by the Home Health Agency.
- Admissions to a Skilled Nursing Facility if you require daily skilled nursing or rehabilitation, as certified by your attending Physician.
- Bariatric surgical services, such as gastric bypass and other surgical procedures for weight loss, including bariatric travel expense, if:

  - The services are to be performed for the treatment of morbid obesity;
  - The Physicians on the surgical team and the Facility in which the surgical procedure is to take place are approved for the surgical procedure requested; and
  - The bariatric surgical procedure will be performed at a BDCSC Facility.

- Advanced imaging procedures, including but not limited to: Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET scan), Magnetic Resonance Angiogram (MRA scan). You may call the Member Services number on the back of the identification card to find out if an imaging procedure requires pre-service review.
- Partial hospitalization, Intensive Outpatient Programs.
- Gender affirming services, including gender affirming travel expense, as specified under the "Gender Affirming Benefits" provision of YOUR MEDICAL BENEFITS - Medical Care That Is Covered. You must be diagnosed with gender identity disorder or gender dysphoria by a Physician.

For a list of current procedures requiring precertification, please call the Member Services number on the back of the identification card.

Infertility Treatment - prior authorization by WINFertility's Medical Management Program is required prior to initiation of medical treatment for family building. Contact WINFertility for more information at (877) 451-3077.

Who is Responsible for Precertification?

Typically, Anthem Prudent Buyer Providers know which services need precertification and will get any precertification when needed. Your Physician and other Anthem Prudent Buyer Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering provider, Hospital or attending Physician ("requesting provider") will get in touch with the Plan to ask for a precertification. However, you may request a precertification or you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for precertification and under what circumstances.

Provider Network Status	**Responsibility to Get Precertification**	**Comments**
All	Member	• Member must get precertification for Infertility Treatment regardless of provider network status. (Call WINFertility at (877) 451-3077)
Anthem Prudent Buyer Providers	Provider	• The Provider must get precertification when required.
Out-of-Network Providers	Member	• Member must get precertification when required. (Call the Pre-Authorization phone number on the back of the identification card) • Member should contact the Pre-Authorization phone number on the back of the identification card before seeking care with an Out-of-Network Provider when outside of the U.S. • Member may be financially responsible for charges or costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary.
Blue Card Provider	Member **(Except for Inpatient Admissions)**	• Member must get precertification when required. (Call the Pre-Authorization phone number on the back of the identification card) • Member may be financially responsible for charges or costs related to the service and/or setting in whole or in part if the service and or setting is found to not be Medically Necessary. • **Blue Card Providers must obtain precertification for all Inpatient Admissions.**
NOTE: For an Emergency admission, precertification is not required. However, you, your authorized representative or Physician must notify Accolade within 48hours or as soon as it is possible within a reasonable period of time.		

How Decisions Are Made

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

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, please call the Member Services number on the back of the identification card.

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

Decision Notice and Requirements

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

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

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

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

For a copy of the medical necessity review process, please contact the Member Services number on the back of the identification card.

Revoking or modifying a Precertification Review decision. Accolade will determine **in advance** whether certain services (including procedures and admissions) are Medically Necessary and are the appropriate

length of Stay, if applicable. These review decisions may be revoked or modified prior to the service being rendered for reasons including but not limited to the following:

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

How Accolade Case Management Works

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

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

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

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

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

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

Employees

Information pertaining to your eligibility, enrollment, cancellation or termination of coverage and conversion options can be found in the “Complete Guide to Your UC Health Benefits”. A copy of this booklet is available in the HR Forms & Publications section of UCnet (ucnet.universityofcalifornia.edu). Additional resources are also available in the Compensation and Benefits section of UCnet to help you with your health and welfare plan decisions.

Retirees

Information pertaining to your eligibility, enrollment, cancellation or termination of coverage and conversion options can be found in the “Group Insurance Eligibility Fact Sheet for Retirees and Eligible Family Members”. A copy of this fact sheet is available in the HR Forms & Publications section of UCnet (ucnet.universityofcalifornia.edu). Additional resources are also available in the Compensation and Benefits section of UCnet to help you with your health and welfare plan decisions.

CONTINUATION OF COVERAGE

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

DEFINITIONS

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

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

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

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

1. **For Members and Dependents:**
    a. The Member’s termination of employment, for any reason other than gross misconduct; or
    b. Loss of coverage under an Employer’s health plan due to a reduction in the Member’s work hours.
2. **For Retired Employees and their Dependents.** Cancellation or a substantial reduction of retiree Benefits under the Plan due to the Plan’s filing for Chapter 11 bankruptcy, provided that:
    a. The Plan expressly includes coverage for retirees; and
    b. Such cancellation or reduction of Benefits occurs within one Year before or after the Plan’s filing for bankruptcy.
3. **For Dependents:**
    a. The death of the Member;
    b. The Spouse’s divorce or legal separation from the Member;
    c. The end of a Domestic Partner’s partnership with the Member;
    d. The end of a child’s status as a Dependent child, as defined by the Plan; or
    e. The Member’s entitlement to Medicare.

ELIGIBILITY FOR COBRA CONTINUATION

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

TERMS OF COBRA CONTINUATION

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

1. For Qualifying Events 1, or 2, UC will notify the Member of the right to continue coverage.

2. For Qualifying Events 3(a) or 3(e) above, a Dependent will be notified of the COBRA continuation right.

3. You must inform UC within 60 days of Qualifying Events 3(b), 3(c), or 3(d) above, if you wish to continue coverage. UC, in turn, will promptly give you official notice of the COBRA continuation right.

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

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

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

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

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

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

1. A Spouse whose COBRA continuation began due to divorce, separation or death of the Member;

2. A Domestic Partner whose COBRA continuation began due to the end of the domestic partnership or death of the Member;

3 A child, if neither the Member nor the Spouse has enrolled for this COBRA continuation coverage (if more than one child is so enrolled, the required monthly contribution will be the two-party or three-party rate depending on the number of children enrolled); and

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

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

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

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

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

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

1. The end of 18 months from the Qualifying Event, if the Qualifying Event was termination of employment or reduction in work hours;*
2. The end of 36 months from the Qualifying Event, if the Qualifying Event was the death of the Member, divorce or legal separation, the end of a domestic partnership, or the end of Dependent child status;*
3. The end of 36 months from the date the Member became entitled to Medicare, if the Qualifying Event was the Member's entitlement to Medicare. If entitlement to Medicare does not result in coverage terminating and Qualifying Event 1 occurs within 18 months after Medicare entitlement, coverage for Qualified Beneficiaries other than the Member will end 36 months from the date the Member became entitled to Medicare;
4. The date the Plan terminates;
5. The end of the period for which required monthly contributions are last paid;
6. The date, following the election of COBRA, the Member first becomes covered under any other group health plan; or
7. The date, following the election of COBRA, the Member first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

Subject to the Plan remaining in effect, a retired employee whose COBRA continuation coverage began due to Qualifying Event 2 may be covered for the remainder of his or her life; that person's covered Dependents may continue coverage for 36 months after the Member's death. However, coverage could terminate prior to such time for either Member or Dependent in accordance with items 4, 5 or 6 above.

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

EXTENSION OF CONTINUATION DURING TOTAL DISABILITY

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

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

1. Satisfy the legal requirements for being totally and permanently disabled under the Social Security Act; and
2. Be determined and certified to be so disabled by the Social Security Administration.

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

1. The date of the Social Security Administration's determination of the disability;
2. The date on which the original Qualifying Event occurs;
3. The date on which the Qualified Beneficiary loses coverage; or
4. The date on which the Qualified Beneficiary is informed of the obligation to provide the disability notice.

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

1. If the disabled Member continues coverage during this extension, this charge shall be **150%** of the applicable rate for the length of time the disabled Member remains covered, depending upon the number of covered Dependents. If the disabled Member does not continue coverage during this extension, this charge shall remain at **102%** of the applicable rate.

2. The cost for extended continuation coverage must be remitted to UC or its administrator each month during the period of extended continuation coverage. UC or its administrator must receive timely payment of the required monthly contribution in order to maintain the extended continuation coverage in force.

3. You may be required to pay the entire cost of the extended continuation coverage.

If a second Qualifying Event occurs during this extended continuation, the total COBRA continuation may continue for up to 36 months from the date of the first Qualifying Event. The required monthly contribution shall then be **150%** of the applicable rate for the 19th through 36th months if the disabled Member remains covered. The charge will be **102%** of the applicable rate for any periods of time the disabled Member is not covered following the 18th month.

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

1. The end of the month following a period of 30 days after the Social Security Administration's final determination that you are no longer totally disabled;

2. The end of 29 months from the Qualifying Event*;

3. The date the Plan terminates;

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

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

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

You must inform UC within 30 days of a final determination by the Social Security Administration that you are no longer totally disabled.

GENERAL PROVISIONS

Providing of Care. We are not responsible for providing any type of Hospital, medical or similar care, nor are we responsible for the quality of any such care received.

Independent Contractors. Anthem's relationship with Providers is that of an independent contractor. Physicians, and other health care professionals, Hospitals, Skilled Nursing Facilities and other community agencies are not Anthem's agents nor are they, or any of their employees, an employee or agent of any Hospital, medical group or medical care Provider of any type.

Non-Regulation of Providers. The Benefits of this Plan do not regulate the amounts charged by Providers of medical care, except to the extent that the rates for Covered Services are regulated with Anthem Prudent Buyer Providers.

Inter-Plan Arrangements

Out-of-Area Services

Overview. We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements". These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area we serve (the "Anthem Blue Cross Service Area"), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of the Anthem Blue Cross Service Area, you will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some providers ("non-participating providers") do not contract with the Host Blue. We explain below how we pay both kinds of providers.

Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are prescription drugs that you obtain from a pharmacy and most dental or vision benefits.

A. BlueCard® Program

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

When you receive Covered Services outside the Anthem Blue Cross Service Area and the claim is processed through the BlueCard Program, the amount you pay is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to 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 we used for your claim because they will not be applied after a claim has already been paid.

B. Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, Anthem Blue Cross may process your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or the negotiated price (refer to the description of negotiated price under Section A. BlueCard Program) made available to Anthem Blue Cross by the Host Blue.

C. Special Cases: Value-Based Programs

BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's Service Area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Anthem Blue Cross through average pricing or fee schedule adjustments. Additional information is available upon request.

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

If Anthem Blue Cross has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the group on your behalf, Anthem Blue Cross will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

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

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

E. Non-participating Providers Outside Our Service Area

1. Allowed Amounts and Member Liability Calculation

When Covered Services are provided outside of Anthem Blue Cross's Service Area by non-participating providers, we may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services as a Deductible or Copayment will be based on that allowed amount. Also, you may be responsible for the difference between the amount that the non-participating provider bills and the payment we will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network Emergency Services.

2. Exceptions

In certain situations, we may use other pricing methods, such as billed charges or the pricing we would use if the healthcare services had been obtained within the Anthem Blue Cross Service Area, or a special negotiated price to determine the amount we will pay for services provided by non-participating providers. In these situations, you may be liable for the difference between the amount that the non-participating provider bills and the payment we make for the Covered Services as set forth in this paragraph.

F. Blue Cross Blue Shield Global Core® Program

If you plan to travel outside the United States, call the Member Services number on the back of the identification card 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 identification card with you.

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

If you need inpatient Hospital care, you or someone on your behalf, should contact Accolade for preauthorization. Keep in mind, if you need Emergency medical care, go to the nearest Hospital. There is no need to call before you receive care.

Please refer to the UTILIZATION REVIEW PROGRAM section in this booklet for further information. You can learn how to get pre-authorization when you need to be admitted to the Hospital for Emergency or non-Emergency care.

How Claims are Paid with Blue Cross Blue Shield Global Core

In most cases, when you arrange inpatient Hospital care with Blue Cross Blue Shield Global Core, claims will be filed for you. The only amounts that you may need to pay up front are any Copayment or Deductible amounts that may apply.

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

- Physician services;
- Inpatient Hospital care not arranged through Blue Cross Blue Shield Global Core; and
- Outpatient services.

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

When you need Blue Cross Blue Shield Global Core claim forms you can get international claims forms in the following ways:

- Call the Blue Cross Blue Shield Global Core Service Center at the numbers above; or
- Online at www.bcbsglobalcore.com.

You will find the address for mailing the claim on the form. Please also refer to the Notice of Claim section within this booklet for additional details.

Terms of Coverage

1. In order for you to be entitled to Benefits under the Plan, both the Plan and your coverage under the Plan must be in effect on the date the expense giving rise to a claim for Benefits is Incurred.
2. The Benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for Benefits is Incurred. An expense is Incurred on the date you receive the service or supply for which the charge is made.
3. The Plan is subject to amendment, modification or termination according to the provisions of the Plan without your consent or concurrence.

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

Protection of Coverage. UC does not have the right to cancel your coverage under this Plan while: (1) this Plan is in effect; (2) you are eligible; and (3) your required monthly contributions are paid according to the terms of the Plan.

Free Choice of Provider. This Plan in no way interferes with your right as a Member entitled to Hospital Benefits to select a Hospital. You may choose any Physician who holds a valid Physician and surgeon's certificate and who is a member of, or acceptable to, the attending staff and board of directors of the Hospital where services are received. You may also choose any other health care professional or Facility which provides care covered under this Plan, and is properly licensed according to appropriate state and local laws. However, your choice may affect the Benefits payable according to this Plan.

Provider Reimbursement. Physicians and other professional Providers are paid on a fee-for-service basis, according to an agreed schedule. A participating Physician may, after notice from Anthem, be subject to a

reduced negotiated rate in the event the participating Physician fails to make routine referrals to Anthem Prudent Buyer Providers, except as otherwise allowed (such as for Emergency Services). Hospitals and other health care facilities may be paid either a fixed fee or on a discounted fee-for-service basis.

Other forms of payment arrangement are Payment Innovation Programs. These programs may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner. The programs may vary in methodology and subject area of focus and may be modified by UC from time to time, but they will be generally designed to tie a certain portion of an Anthem Prudent Buyer Provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, Anthem Prudent Buyer Provider may be required to make payment to the Plan under the program as a consequence of failing to meet these pre-defined standards. The programs are not intended to affect the Member's access to health care. The program payments are not made as payment for specific Covered Services provided to the Member, but instead, are based on the Anthem Prudent Buyer Provider's achievement of these pre-defined standards. The Member is not responsible for any Copayment amounts related to payments made by the Plan or to the Plan under the programs and the Member does not share in any payments made by Anthem Prudent Buyer Providers to the Plan under the programs.

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

Medical Necessity. The Benefits of this Plan are provided only for services which Accolade determines to be Medically Necessary. The services must be ordered by the attending Physician for the direct care and treatment of a covered condition. They must be standard medical practice where received for the condition being treated and must be legal in the United States. The process used to authorize or deny health care services under this Plan is available to you upon request.

Expense in Excess of Benefits. We are not liable for any expense you incur in excess of the Benefits of this Plan.

Benefits Not Transferable. Only the Member is entitled to receive Benefits under this Plan. The right to Benefits cannot be transferred.

Notice of Claim. You must send Anthem properly and fully completed claim forms within 90 days of the date you receive the service or supply for which a claim is made. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed. UC is not liable for the Benefits of the Plan if you do not file claims within the required time period. UC will not be liable for Benefits if Anthem does not receive written proof of loss on time.

Services received and charges for the services must be itemized, and clearly and accurately described including the Tax ID and National Provider Identifier of the provider(s) who rendered each service. Claim forms must be used; canceled checks or receipts are not acceptable.

To obtain a claim form you or someone on your behalf may call the Member Services number on the back of the identification card or go to the website at www.anthem.com/ca and download and print one.

Payment to Providers. The Benefits of this Plan will be paid directly to contracting Hospitals, Anthem Prudent Buyer Providers and medical transportation providers. If you or one of your Dependents receives services from non-contracting Hospitals or Out-of-Network Providers, payment may be made directly to the Member and you will be responsible for payment to the provider. Any assignment of Benefits, even if assignment includes the provider's right to receive payment, is void unless an Authorized Referral has been approved by Anthem. The Plan will pay non-contracting Hospitals and other Providers of service directly when Emergency Services and care are provided to you or one of your Dependents. The Plan will continue such direct payment until the Emergency care results in stabilization. If you are a MediCal beneficiary and you assign Benefits in writing to the State Department of Health Services, the Benefits of this Plan will be paid to the State Department of Health Services. These payments will fulfill the Plan's obligation to you for those Covered Services.

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

Right of Recovery. Whenever payment has been made in error, Anthem will have the right to recover such payment from you or, if applicable, the provider, in accordance with applicable laws and regulations. In the event Anthem recovers a payment made in error from the provider, except in cases of fraud or misrepresentation on the part of the provider, Anthem will only recover such payment from the Provider within 365 days of the date the payment was made on a claim submitted by the provider. Anthem reserves the right to deduct or offset any amounts paid in error from any pending or future claim.

Under certain circumstances, if Anthem pays your healthcare Provider amounts that are your responsibility, such as Deductibles or Copayments Anthem may collect such amounts directly from you. You agree that Anthem has the right to recover such amounts from you.

Anthem has oversight responsibility for compliance with Provider and vendor and subcontractor contracts. Anthem may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a provider, vendor, or subcontractor resulting from these audits if the return of the overpayment is not feasible.

Anthem has established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses, and whether to settle or compromise recovery amounts. Anthem will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. Anthem may not provide you with notice of overpayments made by the Plan or you if the recovery method makes providing such notice administratively burdensome.

Plan Administrator - COBRA. In no event will Anthem be Plan Administrator for the purposes of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA). The term "Plan Administrator" refers to the University of California Executive Steering Committee on Health Benefits Programs or to a person or entity other than Anthem, engaged by to perform or assist in performing administrative tasks in connection with the Plan. In providing notices and otherwise performing under the CONTINUATION OF COVERAGE section of this Benefit Booklet, UC is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as your agent.

Workers' Compensation Insurance. The Plan does not affect any requirement for coverage by workers' compensation insurance. It also does not replace that insurance.

Prepayment Fees. UC may require that you contribute all or part of the costs of the required monthly contributions. Please consult UC for details.

Financial Arrangements with Providers. Anthem or an affiliate has contracts with certain health care providers and suppliers (hereafter referred to together as "Providers" in this section) for the provision of and payment for health care services rendered to its members and members entitled to health care benefits under individual certificates and group policies or contracts to which Anthem or an affiliate is a party, including all persons covered under the Plan.

Under the above-referenced contracts between Providers and Anthem or an affiliate, the negotiated rates paid for certain medical services provided to persons covered under the Plan may differ from the rates paid for persons covered by other types of products or programs offered by Anthem or an affiliate for the same medical services. In negotiating the terms of the Plan, UC was aware that Anthem or its affiliates offer several types of products and programs. The Members and UC are entitled to receive the Benefits of only those discounts, payments, settlements, incentives, adjustments and/or allowances specifically set forth in the Plan.

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

Transition Assistance for New Members: Transition Assistance is a process that allows for completion of Covered Services for new Members receiving services from an Out-of-Network Provider. If you are a new Member, you may request Transition Assistance if any one of the following conditions applies:

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

2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Anthem in consultation with you and the Out-of-Network Provider and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the time you enroll in this Plan.

3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Services shall be provided for the duration of the pregnancy.

4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of Covered Services shall be provided for the duration of the terminal illness.

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

6. Performance of a surgery or other procedure that Accolade 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 you enroll in this Plan.

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

You will be notified by telephone, and the Provider by telephone and fax, as to whether or not your request for Transition Assistance is approved. If approved, you will be financially responsible only for applicable Deductibles and Copayments under the Plan. Financial arrangements with Out-of-Network Providers are negotiated on a case-by-case basis. The Out-of-Network Provider will be asked to agree to accept reimbursement and contractual requirements that apply to Anthem Prudent Buyer Providers, including payment terms. If the Out-of-Network Provider does not agree to accept said reimbursement and contractual

requirements, the Out-of-Network Provider's services will not be continued. If you do not meet the criteria for Transition Assistance, you are afforded due process including having a Physician review the request.

Continuation of Care after Termination of Provider: Subject to the terms and conditions set forth below, Benefits will be provided at the Anthem Prudent Buyer Provider level for Covered Services (subject to applicable Copayments, Deductibles and other terms) received from a Provider at the time the provider's contract with Anthem terminates (unless the provider's contract terminates for reasons of medical disciplinary cause or reason, fraud, or other criminal activity). If your Physician leaves our network for any reason other than termination of cause, retirement or death, or if coverage under this *plan* ends because the Plan's Administrative Services Agreement, 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.

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

Benefits for the completion of Covered Services by a terminated Provider will be provided only for the following conditions:

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

2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Anthem in consultation with you and the terminated Provider and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the date the provider's contract terminates.

3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Services shall be provided for the duration of the pregnancy.

4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of Covered Services shall be provided for the duration of the terminal illness.

5. The care of a newborn child between birth and age thirty-six (36) months. Completion of Covered Services shall not exceed twelve (12) months from the date the provider's contract terminates.

6. Performance of a surgery or other procedure that Accolade has authorized as part of a documented course of treatment and that has been recommended and documented by the Provider to occur within 180 days of the date the provider's contract terminates.

Such Benefits will not apply to Providers who have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity.

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

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

Policies, Procedures, and Pilot Programs. We are able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the *plan* more orderly and efficient. *Members* must follow and accept any new policies, procedures, rules, and interpretations.

Under the terms of the *agreement*, we have the authority to introduce or terminate from time to time, pilot or test programs for disease management, care management, case management, clinical quality or wellness initiatives which may result in the payment of benefits not otherwise specified in this booklet. We reserve the right to discontinue a pilot or test program at any time.

Program Incentives. UC may offer incentives from time to time at its discretion in order to introduce you to new programs and services available under this Plan. UC may also offer the ability for you to participate in certain voluntary health or condition-focused digital applications or use other technology based interactive tool, or receive educational information in order to help you stay engaged and motivated, manage your health, and assist in your overall health and well-being. The purpose of these programs and incentives include, but are not limited to, making you aware of cost effective Benefit options or services, helping you achieve your best health, and encouraging you to update Member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards and health-related merchandise. Acceptance of these incentives is voluntary as long as the Plan offers the incentives program. Motivational rewards, awards or points for achieving certain milestones may be a feature of the program. UC may discontinue an incentive for a particular new service or program at any time. If you have any questions about whether receipt of an incentive or retailer coupon results in taxable income to you, please consult your tax advisor.

Plan Notice of Privacy Practices for Anthem*

Notice of Privacy Practices

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

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

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

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

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

- keep information about your premium and Deductible payments.
- may give information to a doctor's office to confirm your Benefits.
- may share explanation of benefits (EOB) with the Member of your Plan for payment purposes.
- may share PHI with your health care Provider so that the Provider may treat you.
- may use PHI to review the quality of care and services you get.
- may use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.
- may also use and share PHI directly or indirectly with or through health information exchanges for payment, health care operations and treatment. If you do not want your PHI to be shared for payment, health care operations, or treatment purposes in health information exchanges, please visit https://www.anthem.com/ca/privacy for more information.

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

You may obtain a full copy of the Notice of Privacy Practices at https://www.anthem.com/ca/privacy or you may contact the Member Services number on the back of the identification card.

***Business Associate to the UC Health Savings Plan**

Notice of Privacy Practice for Plan

A copy of the University of California Healthcare Plan Notice of Privacy Practices- Self-Funded Plans (Notice) that applies to your Plan can be found at ucal.us/hipaa or you may obtain a paper copy of the UC Notice by calling the UC Healthcare Plan Privacy Office at 800-888-8267, press 1.

BINDING ARBITRATION

A dispute regarding a claim for Benefits, including prescription drug benefits administered as a Covered Service, must proceed first through the claims process described in YOUR RIGHT TO APPEALS section before any further legal action can be taken with respect to that claim. Otherwise any dispute or claim, of whatever nature, including a claim for Benefits that has completed the internal appeals process, that arises out of, in connection with, or in relation to this Plan, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court.

Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

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

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

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

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

The arbitration is begun by the Member making written demand on UC. The arbitration will be conducted by Judicial Arbitration and Mediation Services (“JAMS”) according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the Member and UC, or by order of the court, if the Member and UC cannot agree that has completed the internal appeals process.

DEFINITIONS

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

Accidental Injury is physical harm or disability which is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental Injury does not include illness or infection, except infection of a cut or wound.

Ambulatory surgical center is a Facility licensed as an ambulatory surgery center as required by law that satisfies our accreditation requirements and is approved by us.

Anthem Prudent Buyer Provider is one of the following Providers or other licensed health care professionals who have a Prudent Buyer Plan Participating Provider Agreement in effect with Anthem or is participating in a Blue Cross and/or Blue Shield Plan at the time services are rendered:

- A Hospital
- A Physician
- An Ambulatory Surgical Center
- A Home Health Agency
- A Facility which provides diagnostic imaging services
- A durable medical equipment outlet
- A Skilled Nursing Facility
- A clinical laboratory
- A home infusion/home injection therapy provider
- An Urgent Care Center
- Centers for Medical Excellence (CME)
- Blue Distinction Centers for Specialty Care (BDCSC)
- A Retail Health Clinic
- A Hospice
- A licensed ambulance company
- A licensed qualified autism service provider

Anthem Prudent Buyer Providers agree to accept the Maximum Allowed Amount as payment for Covered Services. A directory of Anthem Prudent Buyer Provider is available upon request.

Authorized Referral occurs when you, because of your medical needs, require the services of a specialist who is an Out-of-Network Provider, or require special services or facilities not available at a contracting Hospital, but only when the referral has been authorized by Accolade before services are rendered and when the following conditions are met:

1. there is no Anthem Prudent Buyer Provider who practices in the appropriate specialty, or there is no contracting Hospital which provides the required services or has the necessary facilities;

2. that meets the adequacy and accessibility requirements of state or federal law.

3. the Member is referred to Hospital or Physician that does not have an agreement with Anthem for a Covered Service by an Anthem Prudent Buyer Provider.

Benefits for Medically Necessary and appropriate Authorized Referral services received from an Out-of-Network Provider will be payable as shown in the Medical Benefit Summary Notes.

You or your Physician must call the Member Services number on the back of the identification card prior to scheduling an admission to, or receiving the services of an Out-of-Network Provider.

Such Authorized Referrals are not available to bariatric surgical services. These services are only covered when performed at a designated bariatric BDCSC.

Balance Billed is when a Provider bills you for the difference between the amount they charge and the amount that the Plan will pay.

Bariatric BDCSC Coverage Area is the area within the 50-mile radius surrounding a designated bariatric BDCSC.

Benefit is a Benefit provided to eligible Members under the Plan consistent with any terms and conditions stated in the Plan.

Benefit Booklet is this written description of the Benefits provided under the Plan.

Blue Distinction Centers for Specialty Care (BDCSC) are health care providers designated by Anthem as a selected Facility for specified medical services. A Provider participating in a BDCSC network has an agreement in effect with Anthem at the time services are rendered or is available through their affiliate companies or our relationship with the Blue Cross and Blue Shield Association. BDCSC agree to accept the Maximum Allowed Amount as payment in full for Covered Services.

An Anthem Prudent Buyer Provider in the Prudent Buyer Plan network or the Blue Cross and/or Blue Shield Plan is not necessarily a BDCSC Facility.

Centers of Medical Excellence (CME) are health care providers designated by Anthem as a selected Facility for specified medical services. A Provider participating in a CME network has an agreement in effect with Anthem at the time services are rendered or is available through their affiliate companies or their relationship with the Blue Cross and Blue Shield Association. CME agree to accept the Maximum Allowed Amount as payment in full for Covered Services.

An Anthem Prudent Buyer Provider in the Prudent Buyer Plan network or the Blue Cross and/or Blue Shield Plan is not necessarily a CME Facility.

Chiropractic Services means Medically Necessary care by means of adjustment of the spine (to correct a subluxation) performed by a legally licensed chiropractor pursuant to the terms of their license. (Subluxation is a term used in the chiropractic field to describe what happens when one of the vertebrae in your spine moves out of position.)

Claims Administrator refers to Anthem Blue Cross Life and Health Insurance Company. On behalf of Anthem Blue Cross Life and Health Insurance Company, Anthem Blue Cross shall perform all administrative services in connection with the processing of claims under the Plan.

Consolidated Appropriations Act of 2021 is a federal law described in the “Consolidated Appropriations Act of 2021 Notice” at the end of this booklet for details.

Covered Service(s) are those Medically Necessary services and supplies associated with a Benefit under the Plan.

Copayment is the dollar amount or percentage of the Maximum Allowed Amount unless otherwise specified that a Member is required to pay for specific Covered Services after meeting any applicable Deductible. See page 32 under YOUR MEDICAL BENEFITS section.

Creditable Coverage is any individual or group plan that provides medical, Hospital and surgical coverage, including continuation coverage, coverage under Medicare or Medicaid, TRICARE, the Federal Employees Health Benefits Program, programs of the Indian Health Service or of a tribal organization, a state health benefits risk pool, coverage through the Peace Corps, the State Children's Health Insurance Program, or a public health plan established or maintained by a state, the United States government, or a foreign country. Creditable Coverage does not include accident only, credit, coverage for on-site medical clinics, disability income, coverage only for a specified disease or condition, hospital indemnity or other fixed indemnity insurance, Medicare supplement, long-term care insurance, dental, vision, workers' compensation insurance, automobile insurance, no-fault insurance, or any medical coverage designed to supplement other

private or governmental plans. Creditable Coverage is used to set up eligibility rules for children who cannot get a self-sustaining job due to a physical or mental condition. In addition, eligible children were covered under one of the above types of health coverage on his or her own and not as a Dependent child.

If your prior coverage was through an employer, you will receive credit for that coverage if it ended because your employment ended, the availability of medical coverage offered through employment or sponsored by the employer terminated, or the employer's contribution toward medical coverage terminated, and any lapse between the date that coverage ended and the date you become eligible under this Plan is no more than 180 days (not including any waiting period imposed under this Plan by the Employer).

If your prior coverage was not through an employer, you will receive credit for that coverage if any lapse between the date that coverage ended and the date you become eligible under this Plan is no more than 63 days (not including any waiting period imposed under this Plan by the Employer).

Custodial Care is care provided primarily to meet your personal needs. This includes help in walking, bathing or dressing. It also includes: preparing food or special diets; feeding by utensil, tube or gastrostomy; suctioning and administration of medicine which is usually self-administered or any other care which does not require continuing services of medical personnel.

If Medically Necessary, Benefits will be provided for feeding (by tube or gastrostomy) and suctioning.

Day Treatment Center is an outpatient psychiatric Facility which is licensed according to state and local laws to provide outpatient programs and treatment of Mental Health or substance use disorder under the supervision of Physicians.

Deductible is the Calendar Year amount which you must pay for specific Covered Services that are a Benefit of the Plan before you become entitled to receive Benefit payments from the Plan for those services. See page 32 under YOUR MEDICAL BENEFITS section.

Dependent as used in the “Family Member Eligibility Requirements” section of the University of California Group Insurance Regulations. A copy of this document is available in the HR Tools and Resources section of UCnet (ucnet.universityofcalifornia.edu). Additional resources are also available in the Compensation and Benefits section of UCnet to help you with your health and welfare plan decisions.

Designated Pharmacy Provider is an In-Network Pharmacy that has executed a Designated Pharmacy Provider Agreement with the Plan or an In-Network Provider that is designated to provide Prescription Drugs, including Specialty Drugs, to treat certain conditions.

Domestic Partner as defined in the “Family Member Eligibility Requirements” section of the University of California Group Insurance Regulations. A copy of this document is available in the HR Tools and Resources section of UCnet (ucnet.universityofcalifornia.edu). Additional resources are also available in the Compensation and Benefits section of UCnet to help you with your health and welfare plan decisions.

Effective Date is the date your coverage begins under this Plan.

Emergency is a sudden, serious, and unexpected acute illness, injury, or condition (including without limitation sudden and unexpected severe pain), or a Psychiatric Emergency Medical Condition, which the Member reasonably perceives, could permanently endanger health if medical treatment is not received immediately. Final determination as to whether services were rendered in connection with an Emergency will rest solely with Anthem.

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

Employee is an Individual who meets the eligibility requirements established by the Employer and accepted by Anthem.

Employer is the Regents of the University of California and its affiliate, UC College of the Law, San Francisco.

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

Facility is a facility including but not limited to, a hospital, freestanding ambulatory surgery center, chemical dependency treatment Facility, Residential Treatment Center, Skilled Nursing Facility, or Mental Health Facility, as defined in this booklet. The Facility must be licensed as required by law, satisfy our accreditation requirements, and be approved by us.

Family Member is the Member and all enrolled Dependents.

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

Home health agencies are providers, licensed when required by law and approved by us, that:

- Gives skilled nursing and other services on a visiting basis in your home; and
- Supervises the delivery of services under a plan prescribed and approved in writing by the attending physician.

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

Hospital is a facility licensed as a Hospital as required by law that 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

Incurred is a charge that will be considered Incurred on the date the particular services or supply which gives rise to it is provided or obtained.

Infertility is: a disease, condition, or status characterized by any of the following:

- The inability to achieve a successful pregnancy based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors.
- The need for medical intervention, including, but not limited to, the use of donor gametes or donor embryos in order to achieve a successful pregnancy either as an individual or with a partner.

- In patients having regular, unprotected intercourse and without any known etiology for either partner suggestive of impaired reproductive ability, evaluation should be initiated at 12 months when the female partner is under 35 years of age and at 6 months when the female partner is 35 years of age or older.

Nothing in this definition shall be used to deny or delay treatment to any individual, regardless of relationship status or sexual orientation.

Infusion Therapy Provider / Injectable Therapy Provider is a Provider licensed according to state and local laws as a pharmacy, and must be either certified as a home health care provider by Medicare, or accredited as a home pharmacy by the Joint Commission on Accreditation of Health Care Organizations.

In-Network Provider refers to a Provider who has contracted with Anthem to accept payment, plus any applicable Member Deductible, Copayment, or amounts in excess of specified Benefit maximums, as payment in full for Covered Services provided to Members.

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

Intensive Outpatient Program is a short-term behavioral health treatment that provides a combination of individual, group and family therapy.

Investigative or **Investigational** procedures, treatments, supplies, devices, equipment, facilities, or drugs (all services) that do not meet one (1) or more of the following criteria:

- have final approval from the appropriate government regulatory body; or
- have the credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community which permits reasonable conclusions concerning the effect of the procedure, treatment, supply, device, equipment, facility or drug (all services) on health outcomes; or
- be proven materially to improve the net health outcome; or
- be as beneficial as any established alternative; or
- show improvement outside the investigational settings.

Recommendations of national physician specialty societies, nationally recognized professional healthcare organizations and public health agencies, as well as information from the practicing community, may also be considered.

Maximum Allowed Amount is the maximum amount of reimbursement Anthem will allow for covered medical services and supplies under this Plan. See YOUR MEDICAL BENEFITS - Maximum Allowed Amount.

Medically Necessary procedures, supplies equipment or services are those Accolade determines to be:

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease
3. Provided for the diagnosis or direct care and treatment of the medical condition;
4. Within standards of good medical practice within the organized medical community;
5. Not primarily for your convenience, or for the convenience of your Physician or another provider;
6. Not more costly than an equivalent service or sequence of services that is medically appropriate and is likely to produce equivalent therapeutic or diagnostic results in regard to the diagnosis or treatment of the patient's illness, injury, or condition; and

7. The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:

    a. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and

    b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable.

For purposes of treatment of Mental Health and Substance Use Disorder, Medically Necessary means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following:

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

(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration, and

(iii) Not primarily for the economic benefit of the Claims Administrator and the Member or for the convenience of the patient, treating Physician, or other health care Provider.

Member/Individual is the eligible Employee, Spouse, Domestic Partner, or Dependent covered by the Plan.

Mental health and substance use disorder include conditions that are listed in the most current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders.

National Provider Identifier or NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA.

Other Health Care Provider is one of the following providers:

- A certified registered nurse anesthetist
- A blood bank

The Provider must be licensed according to state and local laws to provide covered medical services.

Out-of-Network Provider is one of the following Providers which does NOT have a Prudent Buyer Plan Participating Provider Agreement in effect with Anthem or is NOT participating in a Blue Cross and/or Blue Shield Plan at the time services are rendered:

- A Hospital
- A Physician
- An Ambulatory Surgical Center
- A Home Health Agency
- A Facility which provides diagnostic imaging services
- A durable medical equipment outlet
- A Skilled Nursing Facility
- A clinical laboratory
- An Infusion Therapy Provider/Injectable Therapy Provider
- An Urgent Care Center
- A Retail Health Clinic
- A Hospice

- A licensed ambulance company
- A licensed qualified autism service provider

These Providers are not Anthem Prudent Buyer Providers. Remember that the Maximum Allowed Amount may only represent a portion of the amount which an Out-of-Network Provider charges for services. See YOUR MEDICAL BENEFITS – Maximum Allowed Amount.

Out-of-Pocket Maximum is the highest Deductible and Copayment amount an Individual or family is required to for Covered Services each year as indicated in the SUMMARY OF BENEFITS. Charges for services that are not covered, charges in excess of the Maximum Allowed Amount do not accrue to the Calendar Year Out-of-Pocket Maximum.

Partial Hospitalization Program is a 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.

Physician means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or
2. One of the following providers, but only when the Provider is licensed to practice where the care is provided, is rendering a service within the scope of that license and such license is required to render that service, and is providing a service for which Benefits are specified in this booklet:
    - A dentist (D.D.S. or D.M.D.)
    - An optometrist (O.D.)
    - A dispensing optician
    - A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
    - A licensed clinical psychologist
    - A licensed educational psychologist or other Provider permitted by California law to provide behavioral health treatment services for the treatment of autism spectrum disorders only
    - A chiropractor (D.C.)
    - An acupuncturist (A.C.)
    - A licensed clinical social worker (L.C.S.W.)
    - A marriage and family therapist (M.F.T.)
    - A licensed professional clinical counselor (L.P.C.C.)*
    - A physical therapist (P.T. or R.P.T.)*
    - A speech pathologist*
    - An audiologist*
    - An occupational therapist (O.T.R.)*
    - A respiratory care practitioner (R.C.P.)*
    - A nurse midwife/doula **
    - A nurse practitioner
    - A Physician assistant
    - A Psychiatric Mental Health Nurse (R.N.)*
    - A registered dietitian (R.D.)* or another nutritional professional* with a master's or higher degree in a field covering clinical nutrition sciences, from a college or university accredited by a regional accreditation agency, who is deemed qualified to provide these services by the referring M.D. or D.O. A registered dietitian or other nutritional professional as described here are covered for the

provision of diabetic medical nutrition therapy and nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa only.

- A qualified autism service provider, qualified autism service professional, and a qualified autism service paraprofessional, as described under the BENEFITS FOR AUTISM SPECTRUM DISORDERS section.

***Note:** The Providers indicated by asterisks (*) are covered only by referral of a Physician as defined in 1 above.

**If there is no nurse midwife/doula who is a UC Select Provider or an Anthem Preferred Provider in your area, you may call the Member Services number on the back of the Identification card for help finding an OB/GYN.
Your UC Plan covers nurse midwives and doulas, **with some specifics**:

- If they are a licensed medical provider (or sanctioned to operate under another provider's license).
- They must bill medically appropriate services (no yoga or other items that would not be considered "covered" under the Plans) for claims to be allowed.
- Your Plan does not allow any "gap exceptions" for a midwife to be considered In-Network if their practice is not already in the UC Select or Anthem Prudent Buyer network.

Nurse Midwife: Nurse midwives are licensed medical providers with clinical training and can participate in and perform deliveries. Midwives that are not also nurses mainly practice in birthing centers and homes.

Doula: Doulas are not medical providers—doula training does not include clinical training. Doula providers are birth workers who provide health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum persons before, during, and after childbirth. (In order for doulas to be covered, they must be a licensed medical provider or must be sanctioned to operate under another provider's license.)

Plan is the UC Health Savings Plan (Medical and Behavioral Health Benefit Plan for eligible Employees and Non-Medicare Retirees of the Employer and their covered Dependents).

Plan Administrator is the University of California Executive Steering Committee on Health Benefits Programs, or its authorized delegate.

Plan Sponsor is The Regents of the University of California, a public corporation and agency of the State of California, and the constitutional trustee of the public trust known as the University of California.

Preventive Care Services include routine examinations, screenings, tests, education, and immunizations administered with the intent of preventing future disease, illness, or injury. Services are considered preventive if you have no current symptoms or prior history of a medical condition associated with that screening or service. These services shall meet requirements as determined by federal and state law. Sources for determining which services are recommended include the following:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF);

2. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

3. Preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

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

Please call the Member Services number on the back of the identification card for additional information about services that are covered by this Plan as preventive care services. You may also refer to the following websites that are maintained by the U.S. Department of Health & Human Services.

http://www.healthcare.gov/what-are-my-preventive-care-benefits

http://www.ahrq.gov

http://www.cdc.gov/vaccines/acip/index.html

Prior Plan is a Plan sponsored by us which was replaced by this Plan within 60 days. You are considered covered under the Prior Plan if you: (1) were covered under the Prior Plan on the date that plan terminated; (2) properly enrolled for coverage within 31 days of this Plan's Effective Date; and (3) had coverage terminate solely due to the Prior Plan's termination.

Prosthetic Devices are appliances which replace all or part of a function of a permanently inoperative, absent or malfunctioning body part. The term "Prosthetic Devices" includes orthotic devices, rigid or semi-supportive devices which restrict or eliminate motion of a weak or diseased part of the body.

Provider(s) is a professional or Facility licensed by law that gives health care services within the scope of that license and is approved by the Plan. Providers that deliver Covered Services are described throughout this Benefit Booklet. If you have a question about a Provider not described in this Plan, please call the Member Services number on the back of the identification card.

Psychiatric Emergency Medical Condition is a mental disorder that manifests itself by acute symptoms of sufficient severity that the patient is either (1) an immediate danger to himself or herself or to others, or (2) immediately unable to provide for or utilize food, shelter, or clothing due to the mental disorder.

Psychiatric Health Facility is an acute 24-hour Facility as defined in California Health and Safety Code 1250.2. It must be:

1. Licensed by the California Department of Health Services;
2. Qualified to provide short-term inpatient treatment according to the California Insurance Code;
3. Accredited by the Joint Commission on Accreditation of Health Care Organizations; and
4. Staffed by an organized medical or professional staff which includes a Physician as medical director.

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

Qualifying Payment Amount is the median Plan In-Network Provider 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 Provider 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 amount determined by a specified state law; the lesser of the Qualifying Payment Amount or the amount billed by the Out-of-Network Provider or Out-of-Network Provider Facility; or the amount approved under an applicable All-Payer Model Agreement under section 1115A of the Social Security Act.

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

Residential Treatment Center is a Provider licensed and operated as required by law, which includes:

- Room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24 hour availability;
- A staff with one or more doctors available at all times;

- Residential treatment that takes place in a structured facility-based setting;
- The resources and programming to adequately diagnose, care and treat a Mental Health or substance use disorder;
- Facilities that are designated for residential, sub-acute, or intermediate care and that may occur in care systems that provide multiple levels of care; and
- Accreditation by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

The term Residential Treatment Center/Facility does not include a Provider, or that part of a Provider, used mainly for:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial Care
- Educational care

Retail Health Clinic is a facility that provides limited basic medical care services to Members on a "walk-in" basis. These clinics normally operate in major pharmacies or retail stores.

Skilled nursing facility is an Inpatient Facility that provides multidisciplinary treatment for convalescent and rehabilitative care. It must be licensed as a skilled nursing facility in the state in which it is located that 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 Care Units are special areas of a Hospital which have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

Spouse as defined in the "Family Member Eligibility Requirements" section of the University of California Group Insurance Regulations. A copy of this document is available in the HR Tools and Resources section of UCnet (ucnet.universityofcalifornia.edu). Additional resources are also available in the Compensation and Benefits section of UCnet to help you with your health and welfare plan decisions.

Stay is inpatient confinement which begins when you are admitted to a facility and ends when you are discharged from that Facility.

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

Urgent care are the services necessary to prevent serious deterioration of your health or, in the case of pregnancy, the health of the unborn child, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed. Urgent care services are for conditions which require prompt attention as required by state law and are not Emergency Services.

Urgent Care Center is a Physician's office or a similar facility which meets established ambulatory care criteria and provides medical care outside of a Hospital Emergency department, usually on an unscheduled, walk-in basis. Urgent Care Centers are staffed by medical doctors, nurse practitioners and Physician assistants primarily for the purpose of treating patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room.

To find an Urgent Care Center, please call the Member Services number on the back of the identification card. Please call the Urgent Care Center directly for hours of operation and to verify that the center can help with the specific care that is needed.

We (us, our) refers to Anthem.

Year or **Calendar Year** is a 12 month period starting January 1 at 12:01 a.m. Pacific Standard Time.

You (your) refers to the Member and Dependents who are enrolled for Benefits under this Plan.

YOUR RIGHT TO APPEALS

For purposes of these Appeal provisions, “claim for benefits” means a request for benefits under the plan. The term includes both pre-service and post-service claims.

- A pre-service claim is a claim for benefits under the Plan for which you have not received the benefit or for which you may need to obtain approval of Medical Necessity in advance.
- A post-service claim is any other claim for benefits under the Plan for which you have received the service.

PRE-SERVICE CLAIMS

If your pre-service claim is denied or if your coverage is rescinded:

• you will be provided with a written notice of the denial or rescission; and
• you are entitled to a full and fair review of the pre-service claim denial

The procedure Accolade will follow will satisfy following the minimum requirements for a full and fair review under applicable federal regulations.

Notice of Adverse Pre-Service Claim Determination

If your pre-service claim is denied, Accolade’s notice of the adverse pre-service claim determination (denial) will include:

• information sufficient to identify the pre-service claim involved;
• the specific reason(s) for the denial;
• an explanation of why the additional material or information is needed;
• a description of the plan’s review procedures and the time limits that apply to them if your appeal and the pre-service claim denial is upheld;
• information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision; and
• information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the pre-service claim denial decision; and

Appeals

You have the right to appeal an adverse benefit determination (pre-service claim denial). You, your Provider, or your authorized representative must file your appeal within 180 calendar days after you are notified of the pre-service claim denial. You will have the opportunity to submit written comments, documents, records, and other information supporting your pre-service claim. Accolade’s review of your pre-service claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

Accolade offer two levels of pre-service claim appeal. The time frame allowed for Accolade to complete its review is dependent upon the type of review requested – either standard review or expedited/urgent review

To file an appeal for a pre-service claim, you, your Provider or your authorized representative must submit the request in writing and provide at least the following information:

• the identity of the claimant;
• the date (s) of the medical service;

• the specific medical condition or symptom;
• the Provider's name;
• the service or supply for which approval of Benefits was sought; and
• any reasons why the appeal should be processed on a more expedited basis.

You or your authorized representative must submit the written pre-service claim to:

Accolade UM Appeals Department
7400 West Campus Road
Suite F-510
New Albany, OH 43054

You must include the pre-service claim Reference Number (included on the pre-service denial letter), and Your Member Identification Number when submitting an appeal.

How Your Appeal will be Decided

When Accolade reviews your pre-service claim appeal, Accolade will not rely upon the initial benefit determination or, for second-level pre-service claim 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. Any second-level pre-service claim reviews 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 pre-service claim 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 pre-service claim and it was an expedited/urgent review, Accolade will notify you of the outcome of the pre-service claim appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

If you appeal a pre-service claim and it is a standard appeal, either first-level or second-level, Accolade will notify you of the outcome of the both the first-level and second-level appeal within 15 days after receipt of your request for appeal.

Pre-Service Claim Appeal Denial

• If your pre-service claim appeal is denied, that denial will be considered an adverse benefit determination. The notification from Accolade will include all of the information set forth in the above subsection entitled "Notice of Adverse Pre-Service Claim Determination".

Pre-Service Second Level Claim Appeals

If you are dissatisfied with Accolade's first-level appeal decision, a second level appeal is available. If you would like to initiate a voluntary second level appeal, please write to the address listed above.

Voluntary second-level pre-service claim appeals must be submitted within 60 calendar days of the denial of the first level appeal.

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 recission of coverage, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to Anthem within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless Anthem determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

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

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

All other requests for External Review should be submitted in writing unless Anthem determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

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

You must include Your Member Identification Number when submitting a request for External Review.

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent External Review.

Requirement to file an Appeal before taking further legal action

No legal action of any kind related to a benefit decision may be filed by you in any other forum, unless it is commenced within three years of the Plan's final decision on the claim or other request for benefits. If the plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust Accolade's first-level and second-level Appeals, and External Review, but not including any voluntary level of appeal, before taking other legal action of any kind against the plan.

POST-SERVICE CLAIMS

If your claim is denied or if your coverage is rescinded:

- you will be provided with a written notice of the denial or rescission; and
- you are entitled to a full and fair review of the denial or rescission.

Appeals Related to Medical Judgment

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, you or your authorized representative must submit the written appeal to:

Accolade UM Appeals Department
7400 West Campus Road
Suite F-510
New Albany, OH 43054

Notice of Adverse Benefit Determination

The procedure Anthem will follow will satisfy following the minimum requirements for a full and fair review under applicable federal regulations.

If your claim is denied, Anthem's notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific plan provision(s) on which Anthem's determination is based;
- a description of any additional material or information needed to perfect your claim;
- an explanation of why the additional material or information is needed;
- a description of the plan's review procedures and the time limits that apply to them if you appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision; and
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you.

Appeals

You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. Anthem's review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

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

All other requests for appeals should be submitted in writing by the Member or the Member's authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the appeal (e.g. Urgent Care). You or your authorized representative must submit a request for review to:

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

You must include Your Member Identification Number when submitting an appeal.

Upon request, Anthem will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly-situated claimants; or
- is a statement of the plan's policy or guidance about the treatment or benefit relative to your diagnosis.

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

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

How Your Appeal will be Decided

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

Notification of the Outcome of the Appeal

If you appeal a post-service claim, the reviewer 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 reviewer will include all of the information set forth in the above subsection entitled "Notice of Adverse Benefit Determination".

Voluntary Second Level Appeals

If you are dissatisfied with the plan's mandatory first level appeal decision, a voluntary second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.

External Review

If the outcome of the mandatory first level appeal is adverse to you and it was based on medical judgment, or if it pertained to a rescission of coverage, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to Anthem within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless Anthem determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

All other requests for External Review should be submitted in writing unless Anthem determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

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

You must include Your Member Identification Number when submitting an appeal.

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent External Review.

Requirement to file an Appeal before taking further legal action

No legal action of any kind related to a benefit decision may be filed by you in any other forum, unless it is commenced within three years of the plan's final decision on the claim or other request for benefits. If the plan decides an appeal is untimely, the plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the plan's internal Appeals Procedure but not including any voluntary level of appeal, before taking other legal action of any kind against the plan.

The policies, procedures and timeframes in this section may be modified upon further clarification from Department of Health and Human Services and Department of Labor.

FOR YOUR INFORMATION

ANTHEM BLUE CROSS WEB SITE

Anthem Blue Cross Life and Health is an affiliate of Anthem Blue Cross. You may use Anthem Blue Cross's web site to access Benefit information, claims payment status, Benefit maximum status, In-Network Providers or to order an identification card. Simply log on to www.anthem.com/ca, select "Log In", and click the "Register now" link on your first visit to establish a User ID and Password to access the personalized and secure MemberAccess Web site. Once registered, simply click the "Log In" button and enter your User ID and Password to access the MemberAccess Web site.

LANGUAGE ASSISTANCE PROGRAM

Requesting a written or oral translation is easy. Just contact Member Services by calling the phone number on your identification card to update your language preference to receive future translated documents or to request interpretation assistance.

STATEMENT OF RIGHTS UNDER THE NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any Hospital length of Stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However the plan or issuer may pay for a shorter Stay if the attending Physician (e.g., your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) Stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the Stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or Other Health Care Provider obtain authorization for prescribing a length of Stay of up to 48 hours (or 96 hours). However, to use certain Providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, please call the Member Services number on the back of the identification card.

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

This Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). If you have any questions about this coverage, please call the Member Services number on the back of the identification card.

Language Assistance Services for Self-Funded PPO Plans

English: Language assistance services, free of charge, are available to you. Call the Member Services number on the back of the identification card. TTY Users Call 711.

Arabic: 711 تي اتصل ب 1182-406-866-1 اتصل بالرقم. خدمات المساعدة اللغوية متاحة لك مجانا.

Armenian: Լեզվի օգնության ծառայությունները մատչելի են ձեզ համար անվճար: Զանգահարեք 1-866-406-1182 TTY Users զանգահարեք 711:

Farsi: 1182-406-866-1 با شماره تلفن. خدمات کمک به زبان برای شما رایگان است TTY 711 تماس بگیرید.

Hindi: भाषा सहायता सेवाएं आपके लिए नि: शुल्क उपलब्ध हैं कॉल 1-866-406-1182 टीटीआई उपयोगकर्ता कॉल 711

Hmong: Cov kev pabcuam hauv kev txhais lus muaj rau koj dawb xwb. Hu rau 1-866-406-1182 TTY Cov Neeg Siv Hu Xov tooj 711.

Japanese: 言語支援サービスは無料でご利用いただけます。電話1-866-406-1182 TTYユーザーは711に電話をかける。

Khmer: សេវាកម្មជំនួយភាសាអាចរកបានសម្រាប់អ្នកដោយមិនគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-866-406-1182 អ្នកប្រើ TTY ហៅលេខ 711 ។

Korean: 언어 지원 서비스는 무료로 이용하실 수 있습니다. 전화 1-866-406-1182 TTY 사용자는 711에 전화하십시오.

Punjabi: ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹਨ. ਕਾਲ ਕਰੋ 1-866-406-1182 TTY ਉਪਭੋਗਤਾ ਕਾਲ 711.

Russian: Языковые услуги предоставляются вам бесплатно. Вызов 1-866-406-1182 Пользователи TTY Вызов 711.

Spanish: Los servicios de asistencia lingüística están disponibles gratuitamente. Llame al 1-866-406-1182 Usuarios de TTY Llame al 711.

Tagalog: Ang mga serbisyo ng tulong sa wika ay libre sa iyo. Tumawag sa 1-866-406-1182 Mga gumagamit ng TTY Tumawag sa 711.

Thai: มีบริการช่วยเหลือด้านภาษาโดยไม่เสียค่าใช้จ่าย โทร 1-866-406-1182 ผู้ใช้ TTY โทร. 711

Chinese: 免费提供语言援助服务。致电1-866-406-1182 TTY用户致电711。

Vietnamese: Các dịch vụ hỗ trợ ngôn ngữ có sẵn cho bạn miễn phí. Gọi số 1-866-406-1182 Người sử dụng TTY Gọi số 711.

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements

Discrimination is Against the Law. UC's Self-Funded Plans comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. The UC Self-Funded Plans do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

UC's Self-Funded Plans:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact the Member Services number on the back of the identification card (TTY 711).

If you believe that UC's Self-Funded Plans have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: UC's Lead Discrimination Affirmative Action Title IX Officer, 1111 Franklin St., 5th Floor, Oakland, CA 94607, Phone Number: (510) 987-0477, Fax Number: (510) 217-9114, Email: John.Sims@ucop.edu. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, UC's Lead Discrimination, Affirmative Action Title IX Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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; and
- 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; (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; or
2. If the notice and consent is given on the date of the service, if you make an appointment within 72 hours of the services being delivered.

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 Surprises Act, you have the right to appeal that claim. If your appeal of a Surprise Billing Claim is denied, then you have a right to appeal the adverse decision to an Independent Review Organization as set out in the "YOUR RIGHT TO APPEALS" section of this Benefit Book.

Provider Directories

The Claims Administrator is required to confirm the list of In-Network Providers in its Provider Directory every 90 days. If you can show that you received inaccurate information from The Claims Administrator that a Provider was In-Network on a particular claim, then you will only be liable for In-Network cost shares (i.e., Copayments, Deductibles, and/or Coinsurance) for that claim. Your In-Network 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); and
- 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; and
- Historical Out-of-Network rates.

Claims Administered by:

ANTHEM BLUE CROSS

on behalf of

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

By authority of the Regents, University of California Human Resources, located in Oakland, administers all benefit plans in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations for Faculty and Staff, group insurance contracts, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by the Regents. Source documents are available for inspection upon request (800-888-8267). What is written here does not constitute a guarantee of plan coverage or benefits—particular rules and eligibility requirements must be met before benefits can be received. The University of California intends to continue the benefits described here indefinitely; however, the benefits of all employees, retirees, and plan beneficiaries are subject to change or termination at the time of contract renewal or at any other time by the University or other governing authorities. The University also reserves the right to determine new premiums, employer contributions and monthly costs at any time. Health and welfare benefits are not accrued or vested benefit entitlements. UC's contribution toward the monthly cost of the coverage is determined by UC and may change or stop altogether, and may be affected by the state of California's annual budget appropriation. If you belong to an exclusively represented bargaining unit, some of your benefits may differ from the ones described here. For more information, employees should contact their Human Resources Office and retirees should call the Retirement Administration Service Center (800-888-8267).

In conformance with applicable law and University policy, the University is an affirmative action/equal opportunity employer. Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to Systemwide AA/EEO Policy Coordinator, University of California, Office of the President, 1111 Franklin Street, 5th Floor, Oakland, CA 94607, and for faculty to the Office of Academic Personnel and Programs, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.