AMY'S KITCHEN, LLC.
MEDICAL PLAN

Custom Anthem Classic PPO 1500/100/0

PLAN DOCUMENT
AND
SUMMARY PLAN DESCRIPTION

Component Plan of ERISA Plan Name:
Amy's Kitchen, LLC. Employee Benefit Health Plan

Effective Date: 1/1/2025

Benefit Booklet

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

Amy's Kitchen, LLC.

01-01-2025

Custom Anthem Classic PPO 1500/10/0

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 services; (D) radiology; (E)

neonatology; (F) diagnostic services; (G) assistant surgeons; (H) Hospitalists; (I) Intensivists; and (J) any services set out by the U.S. Department of Health & Human Services.

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

1. By obtaining your written consent not later than 72 hours prior to the delivery of services; 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 Surprise Billing Act, you have the right to appeal that claim. If your appeal of a Surprise Billing Claim is denied, then you have a right to appeal the adverse decision to an Independent Review Organization as set out in the "Your Right to Appeals" section of this Benefit Book.

Provider Directories

The Claims Administrator is required to confirm the list of In-Network Providers in its Provider Directory every 90 days. If you can show that you received inaccurate information from The Claims Administrator that a Provider was In-Network on a particular claim, then you will only be liable for In-Network cost shares (i.e., Copayments, Deductibles, and/or Coinsurance) for that claim. Your In-Network cost shares will be calculated based upon the Maximum Allowed Amount.

Transparency Requirements

The Claims Administrator provides the following information on its website:

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

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

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

Federal Notices

Choice of Primary Care Physician

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

Access to Obstetrical and Gynecological (ObGyn) Care

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

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

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

Mental Health Parity and Addiction Equity Act

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

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

Also, the Plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on Mental Health and Substance Use Disorder benefits that are more restrictive than Deductibles, Copayment, Coinsurance, and out of pocket expenses applicable to other medical and surgical benefits in the same classification. Medical Necessity criteria and other plan documents showing comparative criteria, as well as the processes, strategies, evidentiary standards, and substantially all factors used to apply an NQTL are available upon request.

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

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

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

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

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

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

Special Enrollment Notice

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

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

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

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

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

To request special enrollment or obtain more information, call the Member Services telephone number on your Identification Card, or contact your Employer.

Statement of ERISA Rights

Please note: This section applies to employer sponsored plans **other than** Church employer groups and government groups. If you have questions about whether this Plan is governed by ERISA, please contact the Plan Administrator (the Employer).

The Employee Retirement Income Security Act of 1974 (ERISA) entitles you, as a Member of the Employer under the Plan, to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by this plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions;
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies; and
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for you and other Employees, ERISA imposes duties on the people responsible for the operation of your Employee benefit plan. The people who operate your plan are called plan fiduciaries. They must handle your plan prudently and in the best interest of you and other plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your right under ERISA. If your claim for welfare benefits is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claims reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide you the materials and pay you up to $110 a day until you receive the materials, unless the materials are not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. If plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. It may order you to pay these expenses, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

COMPLAINT NOTICE

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

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

Claims Administered by:

ANTHEM BLUE CROSS

on behalf of

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

Introduction

This Benefit Booklet gives you a description of your benefits while you are enrolled under the health care plan (the "Plan") offered by your Employer. You should read this Benefit Booklet carefully to get to know the Plan's main provisions and keep it handy for reference. A thorough understanding of your coverage will allow you to use your benefits wisely. If you have any questions about the benefits shown in this Benefit Booklet, please call your Employer's Health Plan Administrator or the Member Services number on the back of your Identification Card.

The Plan benefits described in this Benefit Booklet are for eligible Members only. The health care services are subject to the limitations and Exclusions, Copayments, Deductible, and Coinsurance rules given in this Benefit Booklet. Any group plan or certificate which you received before will be replaced by this Benefit Booklet.

Your Group has agreed to be subject to the terms and conditions of the Administrator's Provider agreements which may include Pre-service Review and utilization management requirements, coordination of benefits, timely filing limits, and other requirements to administer the benefits under this Plan.

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

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

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

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

How to Get Language Assistance

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

GENERAL INFORMATION

Name of Component Plan:	Amy's Kitchen, Inc. Medical Plan
Component Plan under ERISA PlanNumber:	502
ERISA Plan Name:	Amy's Kitchen, Inc. Employee Benefit Health Plan
Name, Address and Phone Numberof Employer/Plan Sponsor:	Amy's Kitchen, Inc. 1650 Corporate Circle Ste. 200 Petaluma, California 94954 (707) 787-1597
Employer Identification Number:	68-0154899
Type of Plan:	Welfare Benefit Plan: Medical, Prescription Drug Benefits
Name, Address and Phone Number of Plan Administrator and Fiduciary	Amy's Kitchen, Inc. 1650 Corporate Circle Ste. 200 Petaluma, California 94954 707-781-7796
Agent for Service of Legal Process:	Amy's Kitchen, Inc. ATTN: Plan Administrator 1650 Corporate Circle Ste. 200 Petaluma, California 94954 707-781-7796 And Amy's Kitchen, Inc. ATTN: Office of General Counsel1650 Corporate Circle Ste. 200 Petaluma, California 94954 707-781-7796
	Amy's Kitchen, Inc. shall perform its duties as the Plan Administrator and in its sole discretion shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established andmaintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all Plan Documents and make all interpretive and factual determinations as to whether any individuals isentitled to receive any benefit under the terms of this Plan. Any construction of terms of any Plan Documents and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties.
Source of Plan Contributions:	Amy's Kitchen, Inc. and Employees covered by the Plan contribute to the cost of the Plan. Employee contributions are the Employee's share of costs as determined by the Plan Administrator.

Funding Method:	The Employer pays Plan benefits and administration expenses directly from general assets. Contributions received from Members are used to cover Plan costs and are expended immediately. Plan contributions are made by the Employer and covered Employee. All benefits under the Plan are paid from general assets. Employee required contributions are the Employee's share of costs as determined by the Plan Administrator. From time to time the Plan Administrator will determine the required Employee contributions and will notify Employee in writing. Payments of Plan benefits will be based on the provisions of the Plan.
Initial Effective Date:	January 1, 2022
Benefit Year:	January 1 through December 31
Plan Renewal Date:	January 1
Effective Date of Coverage andWaiting Period:	First day of the month coincident with or following forty-five (45) days of continuous employment.
Termination Date of Coverage:	The last day of the month in which the Member ceases to meet the eligibility requirements or for which required premium was paid.
Type of Administration of the Plan:	The self-funded Plan is administered directly by the Plan Administrator. The Plan Administrator has appointed a Claims Administrator to handle the day-to-day operation of the Plan. The Claims Administrator does not serve as an insurer, but only as a Claims Administrator. The Claims Administrator processes claims, then requests and receives funds from the Plan Administrator for the amount of the claims, and processes payment on the claims to Hospitals and other providers.
Claims Administrator:	Anthem, Inc. PO Box 60007 Los Angeles, CA 90060-0007 (800) 227-3771
Pharmacy Claims Administrator:	Caremark Claims Department P.O. Box 52136 Phoenix, AZ 85072-2136
Right to Amend or Terminate thePlan:	The Plan Administrator reserves the right to amend or terminate this Plan at any time. You will be properly notified of any and all changes subject to the Plan's provisions.
Statement of ERISA rights:	The Plan Administrator holds the position that ERISA governs the Plan. The Plan Administrator is guided by ERISA provisions as applicable to its Plan. Accordingly, interpretations of the Plan, including words and phrases, shall be guided by ERISA as applicable to the Plan.

Table of Contents

Schedule of Benefits

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

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

IMPORTANT NOTE: Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. **Except for Surprise Billing Claims, when you use an Out-of-Network Provider you may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please read the "Claims Payment" section for more details.**

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

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

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

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

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

- **Ambulatory patient services,**
- **Emergency services,**
- **Hospitalization,**
- **Maternity and newborn care,**
- **Mental Health and Substance Use Disorder services, including behavioral health treatment,**
- **Prescription drugs,**
- **Rehabilitative and habilitative services and devices,**
- **Laboratory services,**
- **Preventive and wellness services, and**

- **Chronic disease management and pediatric services, including oral and vision care.**

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

Benefit Period	Calendar Year
Dependent Age Limit	To the end of the month in which the child attains age 26. Please see the "Eligibility and Enrollment – Adding Members" section for further details.

Deductible	**In-Network**	**Out-of-Network**
Per Member	$1,500	$1,500
Per Family – All other Members combined	$3,000	$3,000

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

The In-Network and Out-of-Network Deductibles are combined. Amounts you pay toward the In-Network Deductible will apply toward the Out-of-Network Deductible and amounts you pay toward the Out-of-Network Deductible will apply toward the In-Network Deductible.

When the Deductible applies, you must pay it before benefits begin. See the sections below to find out when the Deductible applies.

Copayments and Coinsurance are separate from and do not apply to the Deductible.

Coinsurance	**In-Network**	**Out-of-Network**
Plan Pays	100%	70%
Member Pays	0%	30%

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

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

Out-of-Pocket Limit	In-Network	Out-of-Network
Per Member	$2,500	$2,500
Per Family– All other Members combined	$5,000	$5,000

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

The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments you pay during a Benefit Period unless otherwise indicated below. It does not include charges over the Maximum Allowed Amount or amounts you pay for non-Covered Services

The In-Network and Out-of-Network Out-of-Pocket Limit does not include amounts you pay for the following and is always your responsibility:

- Expense which is in excess of the Maximum Allowed Amount for medical and Prescription Drug services.

No one person will pay more than their individual Out-of-Pocket Limit. Once the Out-of- Pocket Limit is satisfied, you will not have to pay any additional Deductibles, Coinsurance, or Copayments for the rest of the Benefit Period, except for the services listed above.

The In-Network and Out-of-Network Out-of-Pockets are combined. Amounts you pay toward the In-Network Out-of-Pocket will apply toward the Out-of-Network Out-of-Pocket and amounts you pay toward the Out-of-Network Out-of-Pocket will apply toward the In-Network Out-of-Pocket.

Important Notice about Your Cost Shares

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

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

Benefits	In-Network	Out-of-Network
Acupuncture	Benefits are based on the setting in which Covered Services are received.	

Benefits	In-Network	Out-of-Network
Allergy Services	Benefits are based on the setting in which Covered Services are received.	
Ambulance Services (Ground, Air and Water) for Emergency Services Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount.	0% Coinsurance after Deductible*	
Ambulance Services (Ground and Water) for non-Emergency Services **Important Notes:** • All scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through precertification. Please see "Getting Approval for Benefits" for details. • Out-of-Network Providers (both inside and outside California) may bill you for any charges over the Plan's Reasonable and Customary Value or Maximum Allowed Amount, respectively.]	0% Coinsurance after Deductible*	30% Coinsurance after Deductible*
Ambulance Services (Air only) for non-Emergency Services • When using an air ambulance for non-Emergency transportation, we reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider we select no benefits will be available. • Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through precertification. Please see "Getting Approval for Benefits" for details. • Out-of-Network air ambulance Providers (both inside and outside California) may not bill you for any charges over the Plan's Reasonable and Customary Value or Maximum Allowed Amount.	0% Coinsurance after Deductible*	30% Coinsurance after Deductible*
Autism Spectrum Disorders	Mental Health and Substance Use Disorder Services are covered as required by state and federal law. Please see the rest of this Schedule for the cost shares that apply in each setting.	
Bariatric Surgery **Bariatric surgery is covered only when performed at a designated Blue Distinction Centers for Specialty Care (BDCSC) facility**		

Benefits	In-Network	Out-of-Network
• Inpatient Services (designated BDCSC facility)	0% Coinsurance after Deductible	Not covered
• Outpatient Facility Services (designated BDCSC facility)	0% Coinsurance after Deductible	Not covered
• Travel expense For an approved, specified bariatric surgery, performed at a designated BDCSC facility that is fifty (50) miles or more from the Member's place of residence, the following travel expenses incurred by the Member and/or one companion are covered: ▪ Transportation for the Member and/or one companion to and from the designated BDCSC facility. ▪ Lodging, limited to one room, double occupancy. ▪ Other reasonable expenses. Meals, tobacco, alcohol and drug expenses are excluded from coverage.	Covered up to $2,500 per surgery.	Not covered
Behavioral Health Services	Mental Health and Substance Use Disorder Services are covered as required by state and federal law. Please see the rest of this Schedule for the cost shares that apply in each setting.	
Clinical Trials	Benefits are based on the setting in which Covered Services are received.	
Dental Services (All Members / All Ages)	Benefits are based on the setting in which Covered Services are received.	
Diabetes Equipment, Education, and Supplies Screenings for gestational diabetes are covered under "Preventive Care."	Benefits for diabetic education are based on the setting in which Covered Services are received. Please see those settings to determine your cost share.	
Diabetes education services are covered at no cost to the Member. Benefits for other Covered Services and supplies for the treatment of diabetes are provided on the same basis, at the same Cost Shares, as any other medical condition. Benefits are based on the setting in which Covered Services are received.		
Diagnostic Services		
• Reference Labs	0% Coinsurance no Deductible	0% Coinsurance no Deductible
• All Other Diagnostic Services	0% Coinsurance no Deductible	0% Coinsurance no Deductible

Benefits	In-Network	Out-of-Network
All Diagnostic Services are based on the setting in which Covered Services are received.		
Durable Medical Equipment (DME), Medical Devices and Supplies		
• Durable Medical Equipment	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Orthotics	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Prosthetics	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Prosthetics Limbs	0% Coinsurance after Deductible	30% Coinsurance after Deductible
The cost shares listed above apply when your Provider submits separate bills for the equipment or supplies.		
• Hearing Aids	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Hearing Aids Benefit Maximum	$4,000 every 4 Benefit Periods $30,000 lifetime maximum for Cochlear Implants.	
The Plan's reimbursement for durable medical equipment, orthotics, prosthetics, devices and supplies, and wigs will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary to meet your needs. If you choose to purchase an item with features that exceed what is Medically Necessary, benefits will be limited to the Maximum Allowed Amount for the standard		
Emergency Room Services		
Emergency Room		
• Emergency Room Facility Charge	$100 Copayment per visit after Deductible* Copayment waived if admitted	
• Emergency Room Doctor Charge (ER Physician, Radiologist, Anesthesiologist, Surgeon, etc.)	0% Coinsurance after Deductible*	
• Emergency Room Doctor Charge (Mental Health and Substance Use Disorder)	0% Coinsurance after Deductible*	
• Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)	0% Coinsurance after Deductible*	
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	0% Coinsurance after Deductible*	

Benefits	In-Network	Out-of-Network
For Emergency room services from an Out-of-Network Provider you do not need to pay any more than would have paid for services from an In-Network Provider. Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount. As described in the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet, for Emergency Services, Out-of-Network Providers may only bill you for any applicable Copayments, Deductible and Coinsurance and may not bill you for any charges over the Plan's Maximum Allowed Amount until the treating Out-of-Network Provider has determined you are stable and followed the notice and consent process. Please refer to the Notice at the beginning of this Booklet for more details.		
Gender Affirming Services Precertification required	Benefits are based on the setting in which Covered Services are received.	
• Travel expense	No Copayment, Deductible, or Coinsurance	30% Coinsurance
For an approved gender affirming surgery, the following travel expenses incurred by the Member and/or one companion are covered: – Ground transportation for the Member and/or one companion to and from the Hospital when it is 50 miles or more from the Member's place of residence. – Coach airfare to and from the Hospital when it is 300 miles or more from the Member's place of residence. – Lodging, limited to one room, double occupancy. – Other reasonable expenses. Meals, tobacco, alcohol and drug expenses are excluded from coverage.	Covered up to $10,000 per surgery or series of surgeries	Covered up to $10,000 per surgery or series of surgeries
Habilitative Services		
• Outpatient Facility Services	Benefits are based on the setting in which Covered Services are received. See "Office Visits" and "Outpatient Facility Services" for details on Benefit Maximums.	Benefits are based on the setting in which Covered Services are received. See "Office Visits" and "Outpatient Facility Services" for details on Benefit Maximums.
Home Health Care		

Benefits	In-Network	Out-of-Network
• Home Care Visits from a Home Health Care Agency – (Including intermittent skilled nursing services)	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Home Infusion Therapy / Chemotherapy	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Other Home Health Care Services / Supplies	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Private Duty Nursing (Including continuous complex skilled nursing services)	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Home Care Benefit Maximum	Benefit maximum of 180 visit per Benefit Period, up to 4 hours each visit, In- and Out-of-Network combined. The limit does not apply to Home Infusion Therapy. The limit includes Therapy Services (e.g., physical, speech, occupational, cardiac and pulmonary rehabilitation given as part of the Home Care benefit.	
Home Infusion Therapy	See “Home Health Care”.	
Hospice Care		
• Home Hospice Care	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Bereavement	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Inpatient Hospice	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Inpatient Hospice maximum of 180 days per Benefit Period.		
• Outpatient Hospice	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Respite Care	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Respite Care Benefit Maximum	Up to 5 days per admission	
Out-of-Network Providers may also bill you for any charges over the Plan’s Maximum Allowed Amount.		
This Plan’s Hospice benefit will meet or exceed Medicare’s Hospice benefit.		

Benefits	In-Network	Out-of-Network
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services	Please see the separate summary later in this section	
Precertification required	Important Note on Kidney Transplants: If you choose to receive a kidney transplant from an In-Network Transplant Provider, benefits will be paid under the "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services" section later in this Schedule. If you choose to receive a kidney transplant from any other Provider, benefits will be paid as any other surgery.	
Transportation and Lodging Limit	Covered, as approved by us, up to $25,000 per transplant. In-Network only. Benefits are not available Out-of-Network.	Not covered
Donor Search Limit	Covered, as approved by us, up to $30,000 per transplant. In-Network only. Benefits are not available Out-of-Network.	Not covered
Donor Health Service Limit	Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	Not covered
Inpatient Services		
Facility Room & Board Charge:		
• Hospital / Acute Care Facility	0% Coinsurance after Deductible	30% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
• Skilled Nursing Facility	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Rehabilitation	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Skilled Nursing Facility / Rehabilitation Services (Includes Services in an Outpatient Day Rehabilitation Program) Benefit Maximum	(Benefit maximum of 180 visits per Benefit Period, In- and Out-of-Network combined, and office and outpatient visits combined)	
Ancillary Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Note: The maximum does not apply to Emergency Medical Conditions.		
In addition to the Copayments / Coinsurances shown above for a Hospital / Acute Care Facility, Rehabilitation or Ancillary Services, you will be required to pay a penalty of $500 if you do not obtain Precertification before the admission. This penalty will not apply if you are admitted to the Hospital from the Emergency Room, services provided by an In-Network Provider, or to medically necessary inpatient facility services from a BlueCard provider. Please see "Getting Approval for Benefits" for more details.		
Doctor Services when billed separately from the Facility for:		
• General Medical Care / Evaluation and Management (E&M)	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Surgery	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Maternity	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Mental Health and Substance Use Disorder Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Maternity and Reproductive Health Services		
• Maternity Visits (Global fee for the ObGyn's postnatal and delivery services)	Benefits are based on the setting in which Covered Services are received. Please see those settings to determine your Cost Share.	
• Prenatal Office Visits	$0 Copayment per visit	30% Coinsurance no Deductible
• Postpartum Office Visits	$0 Copayment per visit	30% Coinsurance no Deductible
If you obtain services other than Prenatal or Postpartum Office Visits (e.g., postnatal office visits), please see that setting for your cost share.		
Inpatient Services (Delivery)	See "Inpatient Services."	
Newborn / Maternity Stays: If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission.		

Benefits	In-Network	Out-of-Network
• **Infertility**	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Infertility Benefit Maximum	$5,000 per Member In- and Out-of-Network combined per benefit year	
Important Note: Certain Infertility services including in-vitro fertilization, GIFT (gamete intrafallopian transfer),ZIFT (zygote intra-fallopian transfer), supplies, appliances, and Drugs administered in a Physician's office, are limited to a maximum of $5,000 per Member per benefit year. Please see Maternity and Reproductive Health Services in "What's Covered" for a list of those services.		
Mental Health and Substance Use Disorder Services (includes behavioral health treatment for autism spectrum disorders)	Mental Health and Substance Use Disorder Services are covered as required by state and federal law. Please see the rest of this Schedule for the cost shares that apply in each setting.	
Office and Home* Visits *Home visits are not the same as Home Health Care. For Home Health Care benefits please see the "Home Health Care" section. Important Note on Office Visits at an Outpatient Facility: If you have an office visit with your PCP or SCP at an Outpatient Facility (e.g., Hospital or Ambulatory Surgery Center), benefits for Covered Services will be paid under the "Outpatient Facility Services" section later in this Schedule. Please refer to that section for details on the cost shares (e.g., Deductibles, Copayments, Coinsurance) that will apply.		
• Primary Care Physician / Provider (PCP) (Includes Ob/Gyn) (Including In-Person and/or Virtual Visits)	$10 Copayment per visit	30% Coinsurance no Deductible
• Additional Telehealth / Telemedicine Services from a Primary Care Provider (PCP) (as required by law)	$10 Copayment per visit	
• Mental Health and Substance Use Disorder Services Provider (Including In-Person and/or Virtual Visits)	$10 Copayment per visit	30% Coinsurance no Deductible
• Specialty Care Physician / Provider (SCP) (Including In-Person and/or Virtual Visits)	$10 Copayment per visit	30% Coinsurance no Deductible
• Additional Telehealth / Telemedicine Services from a Specialty Care Provider (SCP) (as required by law)	$10 Copayment per visit	
Additional Services in an Office Setting In addition to the applicable Office Visit Copayment listed above, if you receive any services listed below that have a Coinsurance cost share, the cost share for those services will also apply.		
• Counseling – Includes Family Planning and Nutritional Counseling (Other Than Eating Disorders) "Counseling related to the provision or use of contraception is covered under "Preventive Care".	0% Coinsurance no Deductible	30% Coinsurance no Deductible
• Nutritional Counseling for Eating Disorders	$10 Copayment per visit	30% Coinsurance no Deductible

Benefits	In-Network	Out-of-Network
• Allergy Testing	0% Coinsurance no Deductible	30% Coinsurance no Deductible
• Shots / Injections (other than allergy serum)	$10 Copayment per visit	30% Coinsurance no Deductible
• Allergy Shots / Injections (including allergy serum)	$10 Copayment per visit	30% Coinsurance no Deductible
• Diagnostic Lab (other than reference labs)	0% Coinsurance no Deductible	0% Coinsurance no Deductible
• Diagnostic X-ray	0% Coinsurance no Deductible	0% Coinsurance no Deductible
• Other Diagnostic Tests (including hearing and EKG)	0% Coinsurance no Deductible	0% Coinsurance no Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Office Surgery (including anesthesia)	No Copayment, Deductible, or Coinsurance	30% Coinsurance after Deductible
• Therapy Services:		
– Chiropractic / Osteopathic / Manipulative Therapy	$10 Copayment per visit	30% Coinsurance no Deductible
– Chiropractic / Osteopathic / Manipulative Therapy Benefit Maximum	Benefit maximum of 24 visits per Benefit Period, In- and Out-of-Network combined, and office and outpatient facility visits combined	
– Physical Therapy	0% Coinsurance after Deductible	30% Coinsurance after Deductible
– Speech Therapy	0% Coinsurance after Deductible	30% Coinsurance after Deductible
– Occupational Therapy	0% Coinsurance after Deductible	30% Coinsurance after Deductible
– Radiation / Chemotherapy / Respiratory Therapy	0% Coinsurance after Deductible	30% Coinsurance after Deductible
– Cardiac Rehabilitation	0% Coinsurance after Deductible	30% Coinsurance after Deductible
– Pulmonary Therapy	0% Coinsurance after Deductible	30% Coinsurance after Deductible
– Biofeedback Therapy	0% Coinsurance no Deductible	30% Coinsurance no Deductible
– Biofeedback Therapy Benefit Maximum	Benefit maximum of 24 visits per Benefit Period, In- and Out-of-Network combined.	

Benefits	In-Network	Out-of-Network
– Naturopathy	0% Coinsurance no Deductible	30% Coinsurance no Deductible
– Naturopathy Benefit Maximum	Benefit maximum of 24 visits per Benefit Period, In- and Out-of-Network combined.	
– Acupuncture	$10 Copayment per visit	30% Coinsurance no Deductible
– Acupuncture Benefit Maximum	Benefit maximum of 24 visits per Benefit Period, In- and Out-of-Network combined, and office and outpatient facility visits combined	
Please note: A 180 visits per Benefit Period maximum is combined for the following therapy services: • Physical Therapy • Occupational Therapy • Respiratory Therapy • Pulmonary Therapy • Speech Therapy • Cardiac Rehabilitation		
Benefit maximum of 180 visits per Benefit Period, In- and Out-of-Network combined, and combined with office, inpatient and outpatient facility visits.		
• Prescription Drugs Administered in the Office (other than allergy serum)	0% Coinsurance after Deductible up to a maximum of Copayment of $250	30% Coinsurance after Deductible up to a maximum of Copayment of $250
Orthotics	See “Durable Medical Equipment (DME), Medical Devices and Supplies”	
Other Eligible Providers	Not applicable	0% Coinsurance after Deductible plus all charges in excess of the Maximum Allowed Amount
Nurse anesthetists and blood banks do not enter into participating agreements with us, and these Providers must be licensed according to state and local laws to provide covered medical services.		
Outpatient Facility Services		
• Facility Surgery Charge	0% Coinsurance after Deductible	30% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
• Facility Surgery Lab	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Facility Surgery X-ray	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Ancillary Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Doctor Surgery Charges	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant)	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Other Facility Charges (for procedure rooms)	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Mental Health / Substance Use Disorder Outpatient Facility Services (Partial Hospitalization Program / Intensive Outpatient Program)	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Mental Health / Substance Use Disorder Outpatient Facility Provider Services (e.g., Doctor and other professional Providers in a Partial Hospitalization Program / Intensive Outpatient Program)	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Note: The maximum does not apply to Emergency Medical Conditions.		
• Shots / Injections (other than allergy serum)	10 Copayment per visit	30% Coinsurance no Deductible
• Allergy Shots / Injections (including allergy serum)	$10 Copayment per visit	30% Coinsurance no Deductible
• Diagnostic Lab (non-preventive)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
• Diagnostic X-ray (non-preventive)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
• Other Diagnostic Tests (EKG, EEG, etc.)	0% Coinsurance after Deductible	0% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Therapy Services:		
– Chiropractic / Osteopathic / Manipulative Therapy	$10 Copayment per visit	30% Coinsurance no Deductible
– Chiropractic / Osteopathic / Manipulative Therapy Benefit Maximum	Benefit maximum of 24 visits per Benefit Period, In- and Out-of-Network combined, and office and outpatient facility visits combined	

Benefits	In-Network	Out-of-Network
– Physical Therapy	0% Coinsurance after Deductible	30% Coinsurance after Deductible
– Speech Therapy	0% Coinsurance after Deductible	30% Coinsurance after Deductible
– Occupational Therapy	0% Coinsurance after Deductible	30% Coinsurance after Deductible
– Radiation / Chemotherapy / Respiratory Therapy	0% Coinsurance after Deductible	30% Coinsurance after Deductible
– Cardiac Rehabilitation	0% Coinsurance after Deductible	30% Coinsurance after Deductible
– Pulmonary Therapy	0% Coinsurance after Deductible	30% Coinsurance after Deductible
– Biofeedback Therapy	$10 Copayment per visit	30% Coinsurance no Deductible
– Biofeedback Therapy Benefit Maximum	Benefit maximum of 24 visits per Benefit Period, In- and Out-of-Network combined. and office and outpatient facility visits combined	
– Acupuncture	$10 Copayment per visit	30% Coinsurance no Deductible
– Acupuncture Benefit Maximum	Benefit maximum of 24 visits per Benefit Period, In- and Out-of-Network combined. and office and outpatient facility visits combined	
Please note: A 180 visits per Benefit Period maximum is combined for the following therapy services: • Physical Therapy • Occupational Therapy • Respiratory Therapy • Pulmonary Therapy • Speech Therapy • Cardiac Rehabilitation Benefit maximum of 180 visits per Benefit Period, In- and Out-of-Network combined, and combined with office, inpatient and outpatient facility visits.		
• Prescription Drugs Administered in an Outpatient Facility (other than allergy serum)	0% Coinsurance after Deductible up to a maximum of Copayment of $250	30% Coinsurance after Deductible up to a maximum of Copayment of $250
Preventive Care	No Copayment, Deductible, or Coinsurance	30% Coinsurance no Deductible

Benefits	In-Network	Out-of-Network
Preventive Care for Chronic Conditions (per IRS guidelines)		
Prescription Drugs	Please refer to the "Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits" section.	Please refer to the "Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits" section.
Medical items, equipment and screenings	No Copayment, Deductible, or Coinsurance	30% Coinsurance no Deductible
Please see the "What's Covered" section for additional detail on IRS guidelines.		
Prosthetics	See "Prosthetics" under "Durable Medical Equipment (DME), Medical Devices and Supplies."	
Rehabilitative Services		
• Outpatient Facility Services	Benefits are based on the setting in which Covered Services are received. See "Office Visits" and "Outpatient Facility Services" for details on Benefit Maximums.	
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Travel Benefit		
• Transportation and Lodging Limit	Covered up to $4,000 per Benefit Period In- and Out-of-Network combined**.**	
Unless as prohibited by law, the Plan will cover reasonable and necessary travel costs when you are required to travel to another state to obtain Covered Services that are not available within your state. Our help with travel costs includes transportation to and from the Facility, and lodging for the patient and one companion. You must send itemized receipts for transportation and lodging costs in a form satisfactory to us when claims are filed within 12 months of services. For lodging and ground transportation benefits, the Plan will cover costs up to the current limits set forth in the Internal Revenue Code. Call us for complete information or refer to IRS Publication 502.		

Benefits	In-Network	Out-of-Network
Urgent Care Services (Office & Home* Visits)		
*Home visits are not the same as Home Health Care. For Home Health Care benefits please see the "Home Health Care" section.		
• Urgent Care Office Visit Charge	$10 Copayment per visit	30% Coinsurance no Deductible
• Allergy Testing	0% Coinsurance no Deductible	30% Coinsurance no Deductible
• Shots / Injections (other than allergy serum)	$10 Copayment per visit	30% Coinsurance no Deductible
• Allergy Shots / Injections (including allergy serum)	$10 Copayment per visit	30% Coinsurance no Deductible
• Diagnostic Lab (other than reference labs)	0% Coinsurance no Deductible	0% Coinsurance no Deductible
• Diagnostic X-ray	0% Coinsurance no Deductible	0% Coinsurance no Deductible
• Other Diagnostic Tests (including hearing and EKG)	0% Coinsurance no Deductible	0% Coinsurance no Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	0% Coinsurance after Deductible	30% Coinsurance after Deductible
• Office Surgery (including anesthesia)	No Copayment, Deductible, or Coinsurance	30% Coinsurance after Deductible
• Prescription Drugs Administered in the Office (other than allergy serum)	0% Coinsurance after Deductible up to a maximum of Copayment of $250	30% Coinsurance after Deductible up to a maximum of Copayment of $250
If you get Urgent Care at a Hospital or other outpatient Facility, please refer to “Outpatient Facility Services” for details on what you will pay.		
Virtual Visits (from Virtual Care-Only Providers**)**		
Virtual Visits from our Online Provider (Medical Services)	$10 Copayment per visit	
Virtual Visits from our Online Provider (Mental Health and Substance Use Disorder Services)	$10 Copayment per visit	
Virtual Visits from our Online Provider (Specialty Care Services)	$10 Copayment per visit	
If Preventive Care is provided during a Virtual Visit, it will be covered under the “Preventive Care” benefit, as required by law. Please refer to that section for details.		

Benefits	In-Network	Out-of-Network
Vision Services (for medical and surgical treatment of injuries and/or diseases of the eye). Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.	Benefits are based on the setting in which Covered Services are received	
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services **Please call our Transplant Department as soon as you think you may need a transplant to talk about your benefit options. You must do this *before* you have an evaluation and/or work-up for a transplant. To get the most benefits under your Plan, you must get certain human organ and tissue transplant services from an In-Network Transplant Provider that we have chosen as a Centers of Medical Excellence for Transplant Provider and/or a Provider designated as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association.** Even if a Hospital is an In-Network Provider for other services, it may not be an In-Network Transplant Provider for certain transplant services. Please call us to find out which Hospitals are In-Network Transplant Providers. (When calling Member Services, ask for the Transplant Case Manager for further details.) **Centers of Excellence (COE) Transplant Providers** **Blue Distinction Center Facility**: Blue Distinction facilities have met or exceeded national quality standards for care delivery. **Centers of Medical Excellence (CME)**: Centers of Medical Excellence facilities have met or exceeded quality standards for care delivery. **In-Network Transplant Provider**: Providers who have achieved designation as a Centers of Medical Excellence for Transplant and/or Blue Distinction Centers + or Blue Distinction Centers for Transplant. **Out of Network (PAR) Transplant Provider**: Providers participating in the Plan's networks but not designated as a Centers of Medical Excellence for Transplant or Blue Distinction Center + or Blue Distinction Center for Transplant. **The requirements described below do not apply to the following:** • Cornea transplants, which are covered as any other surgery; and • Any Covered Services related to a Covered Transplant Procedure that you get before or after the Transplant Benefit Period. Please note that the initial evaluation, any added tests to determine your eligibility as a candidate for a transplant by your Provider, and the collection and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service. Benefits for Covered Services that are not part of the Human Organ and Tissue Transplant benefit will be based on the setting in which Covered Services are received. Please see the "What's Covered" section for additional details. **Important Note on Kidney Transplants:** If you choose to receive a kidney transplant from an In-Network Transplant Provider, benefits will be paid under the "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services". If you choose to receive a kidney transplant from any other Provider, benefits will be paid as any other surgery.		

Benefits	In-Network	Out-of-Network
	In-Network Transplant Provider	**Out-of-Network Transplant Provider**
Transplant Benefit Period	Starts one day before a Covered solid organ Transplant Procedure and one day before high dose chemotherapy or preparative regimen for a covered bone marrow/stem cell transplant and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider information for services received at or coordinated by an In-Network Transplant Provider Facility.	Starts the day of a Covered Transplant Procedure and continues to the date of discharge at an Out-of- Network Transplant Provider Facility.
Inpatient Facility Services		
• **Precertification required**	During the Transplant Benefit Period, you will pay 0% Coinsurance after Deductible Before and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.	Not covered
Inpatient Professional and Ancillary (non-Hospital) Services	0% Coinsurance after Deductible	Not covered
Outpatient Facility Services	0% Coinsurance after Deductible	Not covered

Benefits	In-Network	Out-of-Network
Outpatient Facility Professional and Ancillary (non-Hospital) Services	0% Coinsurance after Deductible	Not covered
Transportation and Lodging	0% Coinsurance after Deductible	Not covered
• **Transportation and Lodging Limit**	Covered, as approved by us, up to $25,000 per transplant In-Network only. Benefits are not available Out-of-Network.	
Unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants for a Covered Transplant Procedure	0% Coinsurance after Deductible	Not covered
• **Donor Search Limit**	Covered, as approved by us, up to $30,000 per transplant In-Network only. Benefits are not available Out-of-Network.	
Live Donor Health Services	0% Coinsurance after Deductible	Not covered
• **Donor Health Service Limit**	Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	

How Your Plan Works

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, you will pay less in out-of-pocket costs, such as Copayments, Deductibles, and Coinsurance. If you use an Out-of-Network Provider, you will have to pay more out-of-pocket costs. (**Note:** If you receive services from an In-Network Facility at which, or as a result of which, you receive non-Emergency Covered Services provided by an Out-of-Network Provider, you will pay the Out-of-Network Provider no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider. Please see "Member Cost Share" in the "Claims Payment" section for more information.) Cost sharing for services with Copayments is the lesser of the Copayment amount or the Maximum Allowed Amount.

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

In-Network Services

When you use an In-Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the In-Network level. Regardless of Medical Necessity, benefits will not be provided for care that is not a Covered Service. The Claims Administrator has final authority to determine the Medical Necessity of the service.

To maximize your benefits, be sure to confirm that the Provider you wish to see is an In-Network Provider with your Plan. Do not assume that a Provider is participating in the network of Providers participating on your Plan. Claims paid for Out-of-Network Provider services may mean a higher financial responsibility for you. However, if you receive services from an In-Network Facility at which, or as a result of which, you receive non-Emergency Covered Services provided by Out-of-Network Providers, you will pay no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider. Please see "Member Cost Share" in the "Claims Payment" section for more information.

When you use an In-Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the In-Network level.

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

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

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

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

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

your network panel of Providers, will be paid as Out-of-Network Provider services, even if you have been referred by another participating Provider. However, if you receive services from an In-Network Facility at which, or as a result of which, you receive non-Emergency Covered Services provided by an Out-of-Network Provider, you will pay the Out-of-Network Provider no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider. Please see "Member Cost Share" in the "Claims Payment" section for more information.

To see a Doctor, call their office:

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

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

In-Network Provider Services

For services from In-Network Providers:

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

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

After Hours Care

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

Out-of-Network Services

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

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

- The Out-of-Network Provider can charge you the difference between their bill and the Plan's Maximum Allowed Amount plus any Deductible and/or Coinsurance/Copayments, except for Emergency Care, and certain non-Emergency Covered Services that you receive from an Out-of-Network Provider while you are receiving services from an In-Network Facility, as described under "Member Cost Share" in the "Claims Payment" section, unless your claim involves a Surprise Billing Claim;
- You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments), unless your claim involves a Surprise Billing Claim;
- You will have to pay for services that are not Medically Necessary;
- You will have to pay non-Covered Services;
- You may have to file claims; and

- You must make sure any necessary Precertification is done. (Please see the "Getting Approval for Benefits" section for further details.)
- After Coinsurance is applied, certain Out-of-Network benefits, such as inpatient and outpatient Facilities, are payable based on a maximum payment. If your Out-of-Network Deductible has not been satisfied and you submit a claim for services which have a maximum payment (e.g., per day, visit or admission), the Plan will apply only up to the applicable maximum payment, not the Maximum Allowed Amount, toward your Out-of-Network Deductible. For all other Out-of-Network benefits that are **not** payable based on a maximum payment, the Plan will apply only up to the Maximum Allowed Amount toward your Out-of-Network Deductible.

Surprise Billing Claims

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

Connect with Us Using Our Mobile App

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

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

How to Find a Provider in the Network

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

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

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

Second Opinions

If you have a question about your condition or about a plan of treatment which your Physician has recommended, you may receive a second medical opinion from another Physician. This second opinion visit would be provided according to the benefits, limitations and Exclusions of this Booklet. If you wish to receive a second medical opinion, remember that greater benefits are provided when you choose an In-Network Provider. You may also ask your Physician to refer you to an In-Network Provider to receive a second opinion.

Triage or Screening Services

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

Continuity of Care

Transition Assistance for New Members

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

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services shall be provided for the duration of the acute condition.
2. A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by the Claims Administrator in consultation with the Member and the Out-of-Network Provider and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the time the Member enrolls with the Plan.
3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Services shall be provided for the duration of the pregnancy. For purposes of an individual who presents written documentation of being diagnosed with a Maternal Mental Health Condition from the individual's treating health care provider, completion of covered services for the Maternal Mental Health Condition shall not exceed twelve (12) months from the diagnosis or from the end of pregnancy, whichever occurs later. A Maternal Mental Health Condition is a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.
4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of Covered Services shall be provided for the duration of the terminal illness.
5. The care of a newborn child between birth and age thirty-six (36) months. Completion of Covered Services shall not exceed twelve (12) months from the time the Member enrolls with the Plan.
6. Performance of a surgery or other procedure that the Claims Administrator has authorized as part of a documented course of treatment and that has been recommended and documented by the Provider to occur within 180 days of the time the Member enrolls.

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

You will be notified by telephone, and the Provider by telephone and fax, as to whether or not your request for Transition Assistance is approved. If approved, the Member will be financially responsible only for applicable Deductibles, Coinsurance and/or Copayments under this Plan. Financial arrangements with Out-of-Network Providers are negotiated on a case-by-case basis. The Claims Administrator will request that the Out-of-

Network Provider agree to negotiate reimbursement and/or contractual requirements that apply to In-Network Providers, including payment terms. If the Out-of-Network Provider does not agree to negotiate said reimbursement and/or contractual requirements, the Claims Administrator is not required to continue that Provider's services. If the Member does not meet the criteria for Transition Assistance, the Member is afforded due process including having a Physician review the request.

Continuation of Care after Termination of Provider

Subject to the terms and conditions set forth below, the Plan will pay benefits to a Member at the In-Network Provider level for Covered Services (subject to applicable Copayments, Coinsurance, Deductibles and other terms) rendered by a Provider whose participation in the Claims Administrator's Provider network has terminated. If your In-Network Provider leaves our network for any reason other than termination of cause, retirement or death, or if coverage under this Plan ends because the Plan's Administrative Services Agreement ends, or because your Group changes plans**,** and you are in active treatment, you may be able to continue seeing that Provider for a limited period of time and still get the In-Network benefits.

1. The Member must be under the care of the In-Network Provider at the time of the termination of the Provider's participation. The terminated Provider must agree in writing to provide services to the Member in accordance with the terms and conditions of his/her agreement with the Claims Administrator prior to termination. The Provider must also agree in writing to accept the terms and reimbursement rates under his/her agreement with the Claims Administrator prior to the termination. If the Provider does not agree with these contractual terms and conditions, the Claims Administrator is not required to continue the Provider's services beyond the contract termination date.
2. The Plan will furnish such benefits for the continuation of services by a terminated Provider only for any of the following conditions:
    a. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services shall be provided for the duration of the acute condition.
    b. A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by the Claims Administrator in consultation with the Member and the terminated Provider and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the Provider's contract termination date.
    c. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Services shall be provided for the duration of the pregnancy. For purposes of an individual who presents written documentation of being diagnosed with a Maternal Mental Health Condition from the individual's treating health care provider, completion of covered services for the Maternal Mental Health Condition shall not exceed twelve (12) months from the diagnosis or from the end of pregnancy, whichever occurs later. A Maternal Mental Health Condition is a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.
    d. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of Covered Services shall be provided for the duration of the terminal illness.
    e. The care of a newborn child between birth and age thirty-six (36) months. Completion of Covered Services shall not exceed twelve (12) months from the Provider's contract termination date.

f. Performance of a surgery or other procedure that the Claims Administrator has authorized as part of a documented course of treatment and that has been recommended and documented by the Provider to occur within 180 days of the Provider's contract termination date.

3. Such benefits will not apply to Providers who have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity.
4. Please contact Member Services at the telephone number on the back of your Identification Card to request continuation of care or to obtain a copy of the written policy. Eligibility is based on the Member's clinical condition; it is not determined by diagnostic classifications. Continuation of care does not provide coverage for services not otherwise covered under the Agreement.

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

Your Cost-Shares

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

Crediting Prior Plan Coverage

If you were covered by the Employer's prior carrier / plan immediately before the Employer signs up with us, with no break in coverage, then you will get credit for any accrued Deductible and, if applicable and approved by us, Out of Pocket amounts under that other plan. This does not apply to people who were not covered by the prior carrier or plan on the day before the Employer's coverage with us began, or to people who join the Employer later.

If your Employer moves from one of our plans to another, (for example, changes its coverage from HMO to PPO), and you were covered by the other product immediately before enrolling in this product with no break in coverage, then you may get credit for any accrued Deductible and, Out of Pocket amounts, if applicable and approved by us. Any maximums, when applicable, will be carried over and charged against the maximums under this Plan.

If your Employer offers more than one of our products, and you change from one product to another with no break in coverage, you will get credit for any accrued Deductible and, if applicable, Out of Pocket amounts and any maximums will be carried over and charged against maximums under this Plan.

If your Employer offers coverage through other products or carriers in addition to ours, and you change products or carriers to enroll in this product with no break in coverage, you will get credit for any accrued Deductible, Out of Pocket amounts, and any maximums under this Plan.

This Section Does Not Apply To You If:

- Your Employer moves to this Plan at the beginning of a Benefit Period;
- You change from one of our individual policies to a group plan;

- You change employers; or
- You are a new Member of the Group who joins the Group after the Employer's initial enrollment with us.

The BlueCard Program

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

Identification Card

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

UTILIZATION REVIEW

Utilization Review is the process of evaluating if services, supplies or treatment are Medically Necessary, appropriate to help ensure cost-effective care. Utilization Review can eliminate unnecessary services, hospitalizations, and shorten Confinements while improving quality of care and reducing costs to the Member and the Plan.
Pre-certification establishes the Medical Necessity of certain care and services covered under the Plan. It ensures that the pre-certified care and services will not be denied on the basis of Medical Necessity (as defined by this Plan). The Precertification process will also establish the reference prices for requested services. However, pre-certification does not guarantee the payment of benefits. Coverage and benefits are always subject to other requirements and provisions of the Plan, such as, Plan limitations, exclusions, and eligibility at the time care and services are provided.

PRE-CERTIFICATION

Pre-certification, also known as prior authorization, is the process of getting approval from your health Plan before you have any health procedures performed.

Pre-certification is the determination that selected medical services meet Medical Necessity criteria under the Member's benefits contract. For the Member to receive maximum benefits, the health Plan must authorize or “pre-certify” these Covered Benefits prior to being rendered. Pre-certification includes a review of both the service and the setting. Care will be covered according to the Member's benefits for the services and/or number of days pre-certified unless our Concurrent Review determines that additional services and/or days do not qualify for coverage. A copy of the approval will be provided to you, the Physician and the Hospital or Facility. For benefits to be paid the Member must be eligible for benefits and the service must be a Covered Benefit under the contract at the time the services are rendered.

To make sure we have enough time to review the request, for in-network services, and depending on the type of service, your doctor should generally contact us at least 14 business days in advance of the date on which you are expected to have the procedure. This typically allows us enough time to review the request and ask for additional information, if it is needed.

Pre-certification requirements are listed on the Schedule of Benefits indicating services that require pre-certification from the Claim Administrator Utilization Review Department in order for the services to be covered under the Plan.

Emergency Hospital admissions are to be reported to the Utilization Review Department within forty-eight (48) hours following admission, or on the next business day after admission that occurs on a weekend or holiday.

When reviewing a pre-certification request, the Utilization Review Department is reviewing whether or not the requested service is medically appropriate and SHOULD NOT be considered a guarantee that the requested service is a Covered Benefit under this Plan. We also check the cost-effectiveness of the service and we may communicate with your doctor if necessary. It is your responsibility to make sure the service is pre-certified, so be sure to talk to your doctor about it. Failure to obtain pre-certification may result in additional costs to you beyond the "Reasonable and Allowed Amounts" in addition to your Copayment, Deductible and Coinsurance amounts.

After admission to the Hospital, the Utilization Review Department will continue to evaluate the Member's progress through concurrent telephonic review to monitor the length of Confinement and Medical Necessity of treatment of any admission. If the Utilization Review Department disagrees with the length of Confinement recommended by the Physician, the Member and the Physician will be advised. If the Utilization Review Department determines that continued Confinement is no longer necessary, additional days will not be certified. Benefits payable for days not certified as Medically Necessary by the Utilization Review Department shall be denied. In the event certification of Medical Necessity is denied by the Utilization Review Department, the Member may appeal the decision. The Member may call the Utilization Review Department for more information concerning the appeal process. Additional information is listed in the Appeals Section of this document.

TIMING OF NOTIFICATION

The Member shall be notified of the Plan's benefit determination on review as follows:
We will make a pre-certification decision within a reasonable time period considering the medical circumstances, but not later than fifteen (15) business days from receipt of the pre-certification request. If we require more time to make a pre-certification decision, we may extend the time by an additional forty-five (45) days by notifying you, within the initial fifteen (15) day period of need for an extension, the expected decision date, and any additional information needed for the decision. Based on that plan, we may pre-certify a certain number of visits or services over a certain period of time.

Urgent: If the Physician classifies the pre-certification request as urgent and is approved by the Plan, the Plan must recognize the request as urgent. Members must be notified of decisions as soon as possible, but no more than seventy-two (72) hours after receipt of the pre-certification request. (Urgent requests are based on the Member's condition and generally not for scheduling reasons.)
Retrospective: The Plan will make a benefit determination no later than thirty (30) days from the received date. If the Retrospective Review (a review completed after the event) determines that the hospitalization or surgery did not exceed that which would have been approved had the pre-certification been completed, no adverse action will be taken by the Plan and the amount of any Deductible and/or Coinsurance will count towards the satisfaction of the Member's maximum Out-of-Pocket expense. However, should a portion of the hospitalization or surgery be determined to be in excess of what would have been approved had the pre-certification been completed, the Plan may deny that portion of the services as not Covered Expenses.
In the event that a pre-certification request is denied by the Utilization Review Department, the Member may appeal the decision. The Member may call the Customer Service Department for more information concerning the appeal process. Additional information is listed in the Appeals Section of this document.

CASE MANAGEMENT/ALTERNATE TREATMENT

In cases where the Member's condition is expected to be or is of a serious nature, the Plan Administrator may arrange for review and/or Case Management services from a professional qualified to perform such services. The Plan Administrator shall have the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost-effective result without a sacrifice to the quality of care.
The Utilization Review Department ***may*** recommend (or change) alternative methods of medical care or treatment, equipment or supplies that are not Covered Benefits under this Plan; or are Covered Benefits under this Plan but on a basis that differs from the alternative recommended by the Utilization Review Department. The Plan will recognize such alternative services as Covered Benefits. The use of Case Management or alternate treatment is a voluntary program to the Member; however, the Plan will generally provide a greater benefit to the Member by participating in the program.
If the Plan should determine that an alternate, less expensive, course of treatment is appropriate, and if the attending Physician agrees to the alternate course of treatment, all Medically Necessary expenses stated in the treatment plan will be eligible for payment under the Plan, even if these expenses normally would not be eligible for payment under the Plan. In the event the Member and the attending Physician select a more expensive course of treatment, coverage under the Plan will be based upon the charge allowed for the alternate, less expensive, course of treatment.
Alternative treatment will be determined on the merits of each individual case, and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that Member or any other Member.

Pre-certification is required for the following services:

- **Acute Care;**
- **Advanced Radiology (MRI, PET, CT, MRA. EBCT);**
- **Bariatric Surgery;**
- **Birthing Center Services;**
- **Chemotherapy;**
- **Clinical Trials for Cancer;**
- **Colonoscopy (if diagnostic and if in hospital setting);**
- **Concurrent Review;**
- **Inpatient Dialysis and Supplies;**
- **Discharge Planning;**
- **Durable Medical Equipment – Based on clinical guidelines;**
- **Endoscopic Procedures;**
- **Enteral Nutrition Therapy;**
- **Epidural/Facet & Trigger Point Injections;**
- **High Risk Maternity Care Services;**
- **Home Health Services;**
- **Hospice/Respite Care Services;**
- **Infertility Services;**
- **Infusion Services – Based on clinical guidelines;**
- **Injectable Medications – Based on clinical guidelines;**
- **Inpatient Hospitalizations;**
- **Inpatient Maternity Stay in excess of Federal Mandate**
- **Inpatient Mental/Behavioral Health Services;**
- **Inpatient Substance Abuse Services and Chemical Dependency (including Detox);**
- **Inpatient Rehabilitation;**
- **Non-emergent Ambulance Services;**
- **Observation Stay**
- **Organ Transplant Services;**
- **Orthotics & Prosthetics;**
- **Outpatient Services at Day Treatment Centers;**
- **Outpatient Surgery Services;**
- **Retrospective Review;**
- **Skilled Nursing Facility;**
- **Specialty Drugs;**
- **Spinal Procedures;**
- **Surgical Sterilization Procedures;**
- **Surgical Treatment of Obesity; and**
- **Temporomandibular Joint Dysfunction (TMJ) Treatment.**

What's Covered

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

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

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

Acupuncture

Please see "Therapy Services" later in this section.

Allergy Services

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

Ambulance Services

Medically Necessary ambulance services are a Covered Service when:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.

And one or more of the following criteria are met:

- For ground ambulance, you are taken:
  - From your home, scene of accident or medical Emergency to a Hospital;
  - Between Hospitals, including when the Claims Administrator requires you to move from an Out-of-Network Hospital to an In-Network Hospital;
  - Between a Hospital and Skilled Nursing Facility; or
  - Between a Hospital or Skilled Nursing Facility or other approved Facility.
- For air or water ambulance, you are taken:
  - From the scene of an accident or medical Emergency to a Hospital;
  - Between Hospitals, including when the Claims Administrator requires you to move from an Out-of-Network Hospital to an In-Network Hospital; or
  - Between a Hospital and an approved Facility.

Ambulance services are subject to Medical Necessity reviews. Emergency ground ambulance services do not require precertification and are allowed regardless of whether the Provider is an In-Network or Out-of-Network Provider. For Emergency ambulance services performed by an Out-of-Network Provider you do not need to pay any more than would have been paid for services from an In-Network Provider.

Non-Emergency ambulance services are subject to Medical Necessity reviews by us. When using an air ambulance for non-Emergency transportation, we reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider we select, the Out-of-Network Provider may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

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

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

Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or Doctor are not a Covered Service.

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

a) A Doctor's office or clinic;

b) A morgue or funeral home.

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

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

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

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

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

Hospital to Hospital Transport

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

Autism Spectrum Disorders Services

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

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

Behavioral Health Treatment

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

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

- The treatment must be provided under a treatment plan prescribed by a Qualified Autism Service Provider and administered by one of the following: (a) Qualified Autism Service Provider, (b) Qualified Autism Service Professional supervised by the Qualified Autism Service Provider, or (c) Qualified Autism Service Paraprofessional supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional, 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 Providers is limited to licensed Qualified Autism Service Providers who contract with the Claims Administrator and who may supervise and employ Qualified Autism Service Professionals or Paraprofessionals who provide and administer behavioral health treatment.

For purposes of this section, the following definitions apply:

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

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

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

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

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

Behavioral Health Services

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

Cardiac Rehabilitation

Please see “Therapy Services” later in this section.

Chemotherapy

Please see “Therapy Services” later in this section.

Chiropractic Services

Please see “Therapy Services” later in this section.

Clinical Trials

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

Benefits are limited to the following trials:

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

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

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 this Plan.

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

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

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

Dental Services

Preparing the Mouth for Medical Treatments

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

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

Treatment of Accidental Injury

Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident within 12 months of the injury. An injury that results from chewing or biting is not considered an Accidental Injury under this Plan, unless the chewing or biting results from a medical or mental condition.

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

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

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

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

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

Diabetes Equipment, Education, and Supplies

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

- The following Diabetes Equipment and Supplies:
  - Glucose monitors, including monitors designed to assist the visually impaired.
  - Blood glucose testing strips.

- Insulin pumps and related necessary supplies.
- Pen delivery systems for Insulin administration.
- Podiatric devices, such as therapeutic shoes and shoe inserts, to prevent and treat diabetes-related complications. These devices are covered under your Plan's benefits for Orthotics.
- Visual aids (but not eyeglasses) to help the visually impaired to properly dose Insulin.

These equipment and supplies are covered under your Plan's benefits for medical equipment (please see "Durable Medical Equipment (DME), Medical Devices and Supplies" later in this section).

- The Diabetes Outpatient Self-Management Training Program, which:
  - is designed to teach a Member who is a patient, and covered Members of the patient's family, about the disease process and the daily management of diabetic therapy;
  - includes self-management training, education, and medical nutrition therapy to enable the Member to properly use the equipment, supplies, and medications necessary to manage the disease; and
  - is supervised by a Doctor.

  Diabetes education services are covered under the Plan benefits for professional services by Doctors.

- Screenings for gestational diabetes are covered under "Preventive Care" in this section.

Diagnostic Services

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

Diagnostic Laboratory and Pathology Services

- Laboratory and pathology tests, such as blood tests.

Diagnostic Imaging Services and Electronic Diagnostic Tests

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

Advanced Imaging Services

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

- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Spectroscopy (MRS)
- Nuclear Cardiology

- PET scans
- PET/CT Fusion scans
- QCT Bone Densitometry
- Diagnostic CT Colonography

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

Dialysis

See “Therapy Services” later in this section.

Durable Medical Equipment (DME), Medical Devices and Supplies

Durable Medical Equipment and Medical Devices

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

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

Covered Services include but are not limited to:

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

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

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

Oxygen and equipment for its administration are also Covered Services.

Hearing Aids Services

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

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

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

Orthotics

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

Prosthetics

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

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

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

Medical and Surgical Supplies

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

Covered supplies include syringes, needles, surgical dressings, compression burn garments, lymphedema wraps and garments, splints, enteral formula required for tube feeding in accordance with Medicare guidelines, and other similar items that serve only a medical purpose.
Covered Services do not include items often stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Ostomy and Urological Supplies

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

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

Blood and Blood Products

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

Diabetes Equipment and Supplies

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

Asthma Treatment Equipment and Supplies

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

Infusion Therapy Supplies

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

Emergency Care Services

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

Emergency Services

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

Emergency (Emergency Medical Condition)

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

Emergency Care

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

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

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

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

Treatment you get after your condition has stabilized is not Emergency Care. Please refer to the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet for more details on how this will impact your benefits. (**Note**: If you receive services from an In-Network Facility at which, or as a result of which, you receive non-Emergency Covered Services provided by an Out-of-Network Provider, you will pay the Out-of-Network Provider no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider. Please see "Member Cost Share" in the "Claims Payment" section for more information.)

Gender Affirming Services

Gender Affirming Medical Benefits are based on the Standards of Care published by the World Professional Association for Gender Affirming Health (WPATH). All Gender Affirming services that meet the prior approval requirements are subject to the most current Standards of Care published by WPATH.

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

Coverage includes, but is not limited to, Medically Necessary services related to Gender Transition such as gender affirming surgery, hormone therapy, psychotherapy, and vocal training. Coverage is provided for specific services according to benefits under this Booklet that apply to that type of service generally, if the Plan includes coverage for the service in question. 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 this Booklet's Prescription Drug benefits.

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

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

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

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

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

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

Habilitative Services

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

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

Home Health Care Services

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

Covered Services include but are not limited to:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the home health care Provider. Other organizations may give services only when approved by the Claims Administrator, and their duties must be assigned and supervised by a

professional nurse on the staff of the home health care Provider or other Provider as approved by the Claims Administrator.

- Therapy Services
- Medical supplies
- Durable medical equipment
- Private duty nursing services

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

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

Home Infusion Therapy

See “Therapy Services” later in this section.

Hospice Care

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

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

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Nursing care services on a continuous basis or short-term Inpatient Hospital care when needed in periods of crisis.
- Short-term respite care for the Member only when necessary to relieve the family members or other persons caring for the Member.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Medical social services under the direction of a Physician.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes or hyperalimentation.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member’s death. Bereavement services are available to the patient and those individuals who are closely linked to the patient, including the immediate family, the primary or designated care giver and individuals with significant personal ties, for one year after the Member’s death.
- Volunteer services provided by trained Hospice volunteers under the direction of a Hospice staff member.
- Medical direction, with the medical director being also responsible for meeting the general medical needs of the Member to the extent that these needs are not met by an attending Physician.

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

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

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services

Your Plan includes coverage for Medically Necessary human organ and tissue transplants. Certain transplants (e.g., cornea) are covered like any other surgery, under the regular inpatient and outpatient benefits described elsewhere in this Booklet.

Please call our Transplant Department as soon as you think you may need a transplant to talk about your benefit options. You must do this *before* you have an evaluation and/or work-up for a transplant. To get the most benefits under your Plan, you must get certain human organ and tissue transplant services from an In-Network Transplant Provider that we have chosen as a Centers of Medical Excellence for Transplant Provider and/or a Provider designated as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association. Even if a Hospital is an In-Network Provider for other services, it may not be an In-Network Transplant Provider for certain transplant services. Please call us to find out which Hospitals are In-Network Transplant Providers. (When calling Member Services, ask for the Transplant Case Manager for further details.)

In this section, you will see the term Covered Transplant Procedure, which is defined below:

Covered Transplant Procedure

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

Centers of Excellence (COE) Transplant Providers

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

Prior Approval and Precertification

To maximize your benefits, you should call the Claims Administrator's Transplant Department as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation and/or work-up for a transplant. They 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 or Exclusions apply.

Call the Member Services phone number on the back of your Identification Card and ask for the transplant coordinator. Even if you are given a prior approval for the Covered Transplant Procedure, you or your Provider must call the Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Precertification is required before the Plan will cover benefits for a transplant. Your Physician must certify, and the Claims Administrator must agree, that the transplant is Medically Necessary. Your Physician should send a written request for Precertification to the Claims Administrator as soon as possible to start this process. Not getting Precertification will result in a denial of benefits.

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

Donor Benefits

Benefits for an organ donor are as follows:

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

Transportation and Lodging

The Plan will cover the cost of reasonable and necessary travel costs when you get prior approval and need to travel more than 100 miles from your permanent home to reach the Facility where the Covered Transplant Procedure will be performed. Help with travel costs includes transportation to and from the Facility, and lodging for the patient and one companion. If the Member receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions. You must send itemized receipts for transportation and lodging costs in a form satisfactory to the Claims Administrator when claims are filed. Call the Claims Administrator for complete information.

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

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

1. Child care,
2. Mileage within the medical transplant Facility city,
3. Rental cars, buses, taxis, or shuttle service, except as specifically approved by the Claims Administrator,
4. Frequent Flyer miles,
5. Coupons, Vouchers, or Travel tickets,
6. Prepayments or deposits,
7. Services for a condition that is not directly related, or a direct result, of the transplant,
8. Phone calls,
9. Laundry,
10. Postage,
11. Entertainment,
12. Travel costs for donor companion/caregiver,
13. Return visits for the donor for a treatment of an illness found during the evaluation, and
14. Meals.

Certain Human Organ and Tissue Transplant Services may be limited. See the Schedule of Benefits.

Infertility Services

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

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting.

Benefits for room, board, and nursing services include:

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

Benefits for ancillary services include:

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

Skilled Nursing Facility

Covered Services include:

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

Inpatient Professional Services

Covered Services include:

1. Medical care visits.

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

Maternity and Reproductive Health Services

Maternity Services

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

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed nurse midwife;
- Routine nursery care for the newborn during the mother's normal Hospital stay to include circumcision of a covered male Dependent;
- Prenatal, postnatal, and postpartum services;
- Medically Necessary fetal screenings, which are genetic or chromosomal status of the fetus, as allowed; and

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

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

Contraceptive Benefits

Benefits include prescription oral contraceptive drugs, injectable contraceptive drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.

Sterilization Services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Sterilizations for women are covered under the "Preventive Care" benefit. Surgical tubal ligation reversal coverage is limited to one reversal per lifetime, which is subject to the plan coinsurance after the calendar year deductible and combined with the infertility maximum of $5,000 per member per benefit year.

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. Covered services are not subject to the Deductible, if applicable, Copayment, and/or Coinsurance.

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

Infertility Services

Covered Services include diagnostic tests to find the cause of Infertility, such as diagnostic laparoscopy, endometrial biopsy, semen analysis and services to treat the underlying medical conditions that cause Infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency).

Benefits do include assisted reproductive technologies (ART) or the diagnostic tests and Drugs to support it. Examples of ART include artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT).

Family Planning Services

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

Covered Services for all Members include:

- All FDA approved contraceptive Drugs, devices, and other products, including all FDA-approved contraceptive Drugs, devices, and products available over-the-counter. Generic FDA-approved contraceptive Drugs, devices, and other products at $0 cost share when obtained from an In-Network Provider, unless there is no Generic equivalent, the Generic is unavailable or the Generic would be medically inappropriate as determined by your Provider at which time the brand name would be covered with no Deductible, Copayment or Coinsurance when obtained from an In-Network Provider. Some categories and classes of contraceptives do not have Generics available and, in each of these categories, at least one brand name is available at a $0 cost share when you receive it from an In-Network Provider. If your Provider determines that a brand name with an available Generic therapeutic equivalent is necessary because a Generic therapeutic equivalent drug is not appropriate for you, you may obtain coverage of the brand name Drug with a $0 cost share when obtained from an In-Network Provider. If there is one or more therapeutic equivalent of a contraceptive Drug, device or product, the Plan will cover at least one, if available, at a $0 cost share when obtained from an In-Network Provider. Certain contraceptives are covered under the “Preventive Care Services” benefits. Please see that section for more details.
    - A Prescription will not be required for over-the-counter FDA-approved contraceptive Drugs, devices, and products and
    - Over-the-counter FDA-approved contraceptive Drugs, devices, and products will be provided at no cost when obtained from In-Network Pharmacies. The Plan will not impose any medical management restrictions and prior authorization is not required.
- Voluntary tubal ligation and other similar sterilization procedures.
- Vasectomies and related services. Covered Services are available with no Deductible, Copayment, and/or Coinsurance. Benefits include services to reverse a non-elective sterilization that resulted from an illness or injury. Reversal of elective sterilization is not covered.
- Clinical services related to the provision or use of contraception, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referrals, and counseling.
- Follow-up services related to FDA-approved contraceptive Drugs, devices, products, and procedures, including, but not limited to, management of side effects, counseling for continued adherence, and device removal.

Mental Health and Substance Use Disorder Services

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

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

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that the Plan must cover per state law. Inpatient benefits include the following:
  - Inpatient psychiatric hospitalization, including room and board, drugs, and services of physicians and other providers who are licensed health care professionals acting within the scope of their license,
  - Psychiatric observation for an acute psychiatric crisis,
  - Detoxification — medical management of withdrawal symptoms, including room and board, physician services, drugs, dependency recovery services, education and counseling,
  - Residential treatment which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:
    - Treatment in a crisis residential program:
      - Observation and assessment by a psychiatrist weekly or more often,
      - Rehabilitation and therapy.
  - Transitional residential recovery services for substance use disorder (chemical dependency).
  - Reconstructive surgery for Gender Dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which the Member identifies, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested.
- **Outpatient Office Visits** including the following:
  - Individual and group mental health evaluation and treatment,
  - Individual, Family and group substance use and mental health counseling,
  - Outpatient services to monitor drug therapy and medication management,
  - Narcotic (opioid) treatment programs and methadone maintenance treatment,
  - Outpatient Prescription Drugs prescribed for Mental Health and Substance Use Disorder pharmacotherapy, including office-based opioid treatment. For more information on covered Prescription Drugs, please refer to the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section,
  - Intensive In-Home Behavioral Health Services,
  - Intensive community-based treatment, including assertive community treatment and intensive case management,
  - Behavioral health treatment for autism spectrum disorders delivered in an office setting,
  - Urgent Care services rendered inside and outside Anthem's Service Area.
- **Virtual Visits** as described under the "Virtual Visits (Telemedicine / Telehealth Visits)" section.
- **Other Outpatient Services** including the following:
  - Partial Hospitalization Programs and Intensive Outpatient Programs,
  - Outpatient psychological and neuropsychological testing,
  - Outpatient day treatment programs,
  - Multidisciplinary treatment in an intensive outpatient psychiatric treatment program,

- Electroconvulsive therapy,
- Behavioral health treatment for autism spectrum disorders delivered at home,
- Ambulatory care services, including but not limited to physical therapy, occupational therapy, speech therapy and infusion therapy,
- Ambulatory withdrawal management with or without extended on-site monitoring,
- Diagnostic laboratory services, diagnostic and therapeutic radiologic services, and other diagnostic and therapeutic services,
- Drug testing,
- Preventive health care services,
- Transcranial magnetic stimulation.

- **Other Services** including the following:
  - Home health care service including but not limited to physical therapy, occupational therapy, and speech therapy,
  - Intensive home-based treatment,
  - Coordinated specialty care for the treatment of first episode psychosis,
  - School site services for a Mental Health and Substance Use Disorder that are delivered to an enrollee at a school site pursuant to state law,
  - For Gender Dysphoria, all health care benefits identified in the most recent edition of the Standards of Care developed by the World Professional Association for Transgender Health,
  - Hospice care,
  - Polysomnography.
- **Behavioral health treatment for autism spectrum disorders**. Inpatient services, office visits, and other outpatient items and services are covered under this section. See "Autism Spectrum Disorders" later in this section for a description of additional services that are covered.

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

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

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

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

- Qualified Autism Service Providers, Qualified Autism Service Professionals, and Qualified Autism Service Paraprofessionals. See the definitions of these in the "Autism Spectrum Disorders" section below,
- Registered psychological assistant, as described in the CA Business and Professions Code,
- Psychology trainee or person supervised as set forth in the CA Business and Professions Code,
- Associate clinical social worker functioning pursuant to the CA Business and Professions Code,
- Associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to the CA Business and Professions Code,
- Associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to the CA Business and Professions Code.

Occupational Therapy

Please see "Therapy Services" later in this section.

Office and Home Visits

Covered Services include:

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

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

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

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

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

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

Prescription Drugs Administered in the Office

Orthotics

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

Outpatient Facility Services

Your Plan includes Covered Services in an:

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

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

- Surgical rooms and equipment,
- Prescribed Drugs including Specialty Drugs,

- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility,
- Medical and surgical dressings and supplies, casts, and splints,
- Diagnostic services, and
- Therapy services.

Phenylketonuria (PKU)

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

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

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

1. Prescribed by a Physician or nurse practitioner for the treatment of PKU, and
2. Consistent with the recommendations and best practices of qualified health professionals with expertise in the treatment and care of PKU, and
3. 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

Please see “Therapy Services” later in this section.

Pregnancy

Covered Expenses for Pregnancy or Complications of Pregnancy shall be provided for a covered female Employee, a covered female spouse/domestic partner of a covered Employee, and dependent female children.

In the event of early discharge from a Hospital or Birthing Center following delivery, the Plan will cover two (2) Registered Nurse home visits.

The Plan shall cover home births for low-risk, healthy pregnancies with the participation of Certified Nurse Midwives (CNM). Services of a midwife are a Covered Expense provided that the midwife is a licensed Certified Nurse Midwife (CNM) practicing within the scope of practice as designated by his/her State’s Board of Nursing. CNMs must have a supervising Physician or Facility (where the Physician has admitting privileges) designated in the event of an Emergency. The American Congress of Obstetrics & Gynecologists (ACOG) contraindicates home births in the following situations: prior cesarean section, vaginal birth after cesarean, post-term (greater than 42 weeks gestation), carrying twins or a breach presentation.

Note: Although the risk is low, planned home births are associated with a 2 to 3-fold increase risk of neonatal death when compared with a planned Hospital or Birthing Center birth.

The Plan shall cover services, supplies and treatments for elective abortions for a covered female Employee, covered female spouse/domestic partner of a covered Employee or covered dependent female child of an Employee. Complications from an abortion shall also be a Covered Expense.

Medical services Incurred by the newborn of a Dependent covered under this Plan shall not be considered Covered Expenses.

Preventive Care

Preventive care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA) and applicable state law. This means many preventive care services are covered with no Deductible, Copayments or Coinsurance.

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

Covered Services fall under the following broad groups:

- Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples include screenings for:
  - Breast cancer,
  - Cervical cancer,
  - Colorectal cancer,
  - High blood pressure,
  - Type 2 Diabetes Mellitus,
  - Cholesterol,
  - Child and adult obesity,
  - Preexposure prophylaxis (PrEP) for prevention of HIV infection.
- Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration;
- Preventive care and screening as listed in the guidelines supported by the Health Resources and Services Administration, including:
  - All FDA-approved contraceptive Drugs, devices, and other products, including over-the-counter FDA-approved contraceptive Drugs, devices, and other products. This includes contraceptive Drugs as well as other contraceptive medications such as injectable contraceptives 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 the Physician, the prescribed FDA-approved form of contraception will be covered as Preventive Care under this section.

    Some categories and classes of contraceptives do not have Generics commercially available in the market and, in each of these categories, at least one Brand Drug is available at $0 cost sharing when you receive it from an In-Network Provider. If your Provider determines that a Brand Drug with an available Generic therapeutic equivalent commercially available in the market is Medically Necessary because a Generic equivalent drug is not appropriate for you, you may obtain coverage of the Brand Drug with $0 Cost Sharing if your Provider submits an exception request. Your Doctor must complete a contraceptive exception form and return it to us. You or your Doctor can find the form online [at https://file.anthem.com/Anthem_ABC_BrandContraceptiveCopayWaiverForm.pdf] or by calling the number listed on the back of your ID Card. If Medical Necessity has been determined by your Provider, an exception will be granted and coverage of the Drug will be provided at $0 Cost Sharing. Otherwise, Brand

Drugs will be covered as a Preventive Care benefit when Medically Necessary according to your attending Provider, otherwise they will be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy."

In order to be covered as Preventive Care, contraceptive Prescription Drugs must be Generic oral contraceptives. Brand Drugs will be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy."

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

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

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

- Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.
- Gestational diabetes screening.
- Preventive prenatal care.

- Preventive care services for smoking cessation and tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including counseling.

- Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider including:

  - Aspirin
  - Folic acid supplement
  - Bowel preparations

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

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

Examples of preventive care Covered Services are provided below.

Well Baby and Well Child Preventive Care

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

Adult Preventive Care

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

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

Preventive Care for Chronic Conditions (per IRS guidelines)

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

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

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

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

Prosthetics

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

Pulmonary Therapy

Please see “Therapy Services” later in this section.

Radiation Therapy

Please see “Therapy Services” later in this section.

Rehabilitation Services

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

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

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

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

Respiratory Therapy

Please see “Therapy Services” later in this section.

Skilled Nursing Facility

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

Smoking Cessation

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

Speech Therapy

Please see “Therapy Services” later in this section.

Surgery

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

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

Bariatric Surgery

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

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

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

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

Bariatric Travel Expense. Certain travel expenses incurred in connection with an approved, specified bariatric surgery, performed at a designated BDCSC facility that is fifty (50) miles or more from the Member’s place of residence, are covered, provided the expenses are authorized by the Claims Administrator in advance. The fifty

(50) mile radius around the BDCSC will be determined by the Bariatric BDCSC Coverage Area. Our maximum payment will not exceed $2,500 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 designated BDCSC facility.
- Lodging, limited to one room, double occupancy.
- Other reasonable expenses. Meals, tobacco, alcohol and drug expenses are excluded from coverage.

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

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

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

Oral Surgery

Important Note: Although this Plan provides coverage for certain oral surgeries, many types of oral surgery procedures are not covered by this medical Plan.

Benefits are also limited to certain oral surgeries including:

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

Reconstructive Surgery

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

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

Mastectomy Notice

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

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

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

Note: Reconstructive breast reduction is not limited to only post mastectomy.

Temporomandibular Joint Disorder (TMJ) and Craniomandibular Joint Services

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

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

Therapy Services

Physical Medicine Therapy Services

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

- **Physical therapy** – The treatment by physical means to ease pain, restore function, and to avoid disability after an illness, injury, or loss of an arm or leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech language and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.
- **Post-cochlear implant aural therapy** – Services to help a person understand the new sounds they hear after getting a cochlear implant.
- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities daily living such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- **Chiropractic / Manipulation therapy** –Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments.

Massage therapy provided prior to and in conjunction with an adjustment by a chiropractor on the same day shall be a covered expense.

- **Acupuncture –** Treatment of neuromusculoskeletal pain by an acupuncturist who acts within the scope of their license. Treatment consists of inserting needles along specific nerve pathways to ease pain.

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation –** Medical evaluation, training, supervised exercise and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance services.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Dialysis** – Services for acute renal failure and chronic (end-stage) renal disease, which are rendered in a Hospital ("Inpatient Dialysis"). Services for acute renal failure and chronic (end-stage) renal disease which are not rendered in a Hospital ("Outpatient Dialysis") are covered under the Outpatient Dialysis Health Reimbursement Arrangement Plan of Amy's Kitchen, Inc. Dialysis services not covered by the Outpatient Dialysis plan will be covered by this plan.
- **Infusion Therapy** – Nursing, durable medical equipment and Prescription Drug that are delivered and administered to you through an I.V. in your home. Also includes: Total Parenteral Nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore your health after an illness or injury.
- **Cognitive rehabilitation therapy** –Medically Necessary cognitive rehabilitation, including therapy following a post-traumatic brain injury or cerebral vascular accident.
- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies used in therapy, and treatment planning.
- **Respiratory Therapy** – Includes the use of dry or moist gases into the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Prescription Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Transplant Services

Please see "Human Organ and Tissue Transplant" earlier in this section.

Urgent Care Services

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

- X-ray services;
- Care for broken bones;
- Tests such as flu, urinalysis, pregnancy test, rapid strep;
- Lab services;

- Stitches for simple cuts; and
- Draining an abscess.

Virtual Visits (Telehealth / Telemedicine Visits)

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

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

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

Benefits do not include the use of texting or non-secure instant messaging. Benefits also do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to Providers outside our network, benefit precertification, or Provider to Provider discussions except as approved under "Office and Home Visits."

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

Vision Services (All Members / All Ages)

Benefits include medical and surgical treatment of injuries and illnesses of the eye. Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.

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

- **Eye Exercises** Orthoptics and vision therapy.

Prescription Drugs Administered by a Medical Provider

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

Prescription Drugs you get from a Retail or Mail Order Pharmacy are not covered by this Plan.

Important Requirements for Prescription Drug Coverage

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

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

- Quantity, dose, and frequency of administration,
- Specific clinical criteria including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease,
- Specific Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies),
- Step therapy requiring one Drug, Drug regimen, or treatment be used prior to use of another Drug, Drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated,
- Use of a Prescription Drug List (a formulary developed by the Claims Administrator) which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

Covered Prescription Drugs

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

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

Precertification and Step Therapy Exceptions

Precertification may be required for certain Prescription Drugs to help make sure proper use and guidelines for Prescription Drug coverage are followed. A step therapy exception means a decision to override a generally applicable step therapy protocol in favor of covering the Prescription Drug prescribed by your Provider. The Claims Administrator will give the results of the decision to both you and your Provider.

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

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

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

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

Designated Pharmacy Provider

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

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

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

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

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

Therapeutic Equivalents

Therapeutic equivalents is a program that tells you and your Doctor about alternatives to certain prescribed Drugs. We may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic equivalent is right for you. For questions or issues about therapeutic Drug equivalents call Member Services at the phone number on the back of your Identification Card.

What's Not Covered

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

- **Administrative Charges**
  - Charges for the completion of claim forms,
  - Charges to get medical records or reports,
  - Membership, administrative, or access fees charged by Physicians or other Providers. Examples include, but are not limited to, fees charged for educational brochures or calling you to give you the test results.
- **Alternative / Complementary Medicine** Services or supplies related to alternative or complementary medicine. This includes, but is not limited to:
  - Acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body,
  - Holistic medicine,
  - Homeopathic medicine,
  - Hypnosis,
  - Aroma therapy,
  - Massage and massage therapy other than what is covered under Chiropractic / Manipulation therapy,
  - Reiki therapy,
  - Herbal, vitamin or dietary products or therapies,
  - Thermography,
  - Orthomolecular therapy,
  - Contact reflex analysis,
  - Bioenergetic synchronization technique (BEST),
  - Iridology-study of the iris,
  - Auditory integration therapy (AIT),
  - Colonic irrigation,
  - Magnetic innervation therapy,
  - Electromagnetic therapy,
- **Autopsies** Autopsies and post-mortem testing.
- **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.
- **Certain Providers** Services you get from Providers that are not licensed by law to provide Covered Services, as defined in this Booklet. Examples include, but are not limited to, masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers.
- **Charges over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services. except for Surprise Billing Claims as outlined in the "Consolidated Appropriations Act of 2021 Notice" in the front of this Booklet.
- **Charges Not Supported by Medical Records** Charges for services not described in your medical records.
- **Chats or Texts.** Chats and texting are not a Covered Service unless appropriately provided via a secure and compliant application, according to applicable legal requirements.

- **Clinical Trial Non-Covered Services** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.
- **Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. "Clinically equivalent" means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit the CVS Pharmacy website.
- If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with the Claims Administrator. The other Prescription Drug will be covered only if it's agreed that it is Medically Necessary and appropriate over the clinically equivalent Drug. Benefits for the Prescription Drug will be reviewed from time to time to make sure the Drug is still Medically Necessary.
- **Complications of/or Services Related to Non-Covered Services** Services, supplies, or treatment related to, or for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service. This Exclusion does not apply to problems resulting from pregnancy.
- **Compound Ingredients** Compound ingredients that are not FDA-approved or do not require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
- **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for Cosmetic Services. Cosmetic Services are meant to preserve, change**,** or improve how you look. This exclusion does not apply to services mandated by federal law, or listed as covered under "What's Covered," "Prescription Drugs Administered by a Medical Provider," and/or "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy."
- **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.
- **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.
- **Delivery Charges** Charges for delivery of Prescription Drugs.
- **Dental Devices for Snoring** Oral appliances for snoring.
- **Dental Treatment** Excluded dental treatment includes but is not limited to preventive care and fluoride treatments; dental X-rays, supplies, appliances and all associated expenses; and diagnosis and treatment for the teeth, jaw or gums such as;
  - removing, restoration, and replacement of teeth;
  - medical care or surgery for dental problems (unless listed as a Covered Service in this Booklet); or
  - services to help dental clinical outcomes.

  This exclusion does not apply to the services that must be covered by law.
- **Drugs Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan or the Claims Administrator.
- **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations, and/or certifications, as determined by the Claims Administrator.
- **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin or other Drugs provided in the Preventive Care paragraph of the "What's Covered" section.

- **Educational Services** Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.
- **Experimental / Investigative Services** Services or supplies that are found to be Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.

  The fact that a service or supply is the only available treatment for a condition will not make it eligible for coverage if the Claims Administrator deems it to be Experimental / Investigative.
- **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy
- **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight. This exclusion does not apply to lenses needed after a covered eye surgery.
- **Family Members** Services prescribed, ordered, referred by or given by a member of your family, including your spouse, child, brother, sister, parent, in-law, or self.
- **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removal of corns and calluses; trimming nails; hygienic and preventive foot care, including but not limited to:
  - Cleaning and soaking the feet.
  - Applying skin creams to care for skin tone.
  - Other services that are given when there is not an illness, injury or symptom involving the foot.
- **Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items except as specifically covered under Durable Medical Equipment (DME), Medical Devices and Supplies.
- **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratosis.
- **Fraud, Waste, Abuse, and Other Inappropriate Billing** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.
- **Free Care** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services received during a jail or prison sentence, services you get from Workers Compensation benefits, and services from free clinics.

  If Worker's Compensation benefits are not available to you, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.
- **Gene Therapy Services**
- **Genetic testing** except for the BRCA risk assessment, genetic counseling/testing requirement of the women's preventive care mandate of the ACA, and homozygousproprotein or compound heterozygous variants in proopiomelanocortin (POMC), proprotein convertasesubtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiencies genes, if such testing is to determine the appropriateness of IMCIVREE (setmelanotide) treatment.
- **Growth Hormone Treatment** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
- **Health Club Memberships and Fitness Services** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Physician. This Exclusion also applies to health spas.
- **Home Health Care**
  - Services given by registered nurses and other health workers who are not employees or under approved arrangements with a home health care Provider.
  - Food, housing, homemaker services and home delivered meals.

- **Hospital Services Billed Separately** Services rendered by Hospital resident Doctors or interns that are billed separately. This includes separately billed charges for services rendered by employees of Hospitals, labs or other institutions, and charges included in other duplicate billings.
- **Hyperhidrosis Treatment** Medical and surgical treatment of excessive sweating (hyperhidrosis).
- **Incarceration** For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.
- **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 us.
- **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
- **Maintenance Therapy** Rehabilitative treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better. This Exclusion does not apply to "Habilitative Services" as described in the "What's Covered" section.
- **Medical Equipment, Devices and Supplies**
  - Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
  - Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
  - Non-Medically Necessary enhancements to standard equipment and devices.
  - Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense, including items you purchase with features exceed what is Medically Necessary, will be limited to the Maximum Allowable Amount for the standard item, and the additional costs will be your responsibility.
  - Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the "What's Covered" section.
- **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.
- **Non-Approved Drugs** Drugs not approved by the FDA.
- **Non-Approved Facility** Services from a Provider that does not meet the definition of Facility.
- **Non-Medically Necessary Services** Services the Claims Administrator concludes are not Medically Necessary This includes services that do not meet medical policy, clinical coverage, or benefit policy guidelines.
- **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Benefit Booklet or that must be covered by law. This Exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written prescription or from a licensed pharmacist.
- **Off Label Use.** Off label use, unless the Plan must cover it by law or if the Plan approve it.
- **Oral Surgery** Extraction of teeth, surgery for impacted teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Benefit Booklet.
- **Outpatient Dialysis.** For Outpatient Dialysis coverage, see the Outpatient Dialysis Health Reimbursement Arrangement Plan of Amy's Kitchen, Inc.
- **Personal Care and Convenience**
  - Items for personal comfort, convenience, protective, or cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,

- First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),
- Home workout or therapy equipment, including treadmills and home gyms,
- Pools, whirlpools, spas, or hydrotherapy equipment,
- Hypo-allergenic pillows, mattresses, or waterbeds, or
- Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).

- **Prescription Drugs** Prescription Drugs received from a Retail or Home Delivery (Mail Order) Pharmacy. This Exclusion does not apply to Prescription Drugs used to treat diabetes.
- **Private Duty Nursing** Private duty nursing services given in a Hospital or Skilled Nursing Facility. Private duty nursing services are a Covered Service only when given as part of the "Home Health Care Services" benefit.
- **Prosthetics** Prosthetics for sports or cosmetic purposes. This includes wigs and scalp hair prosthetics. This exclusion does not apply when baldness is the result of burns, chemotherapy, radiation therapy, or surgery. Under these conditions, purchase of a wig or artificial hair piece is limited to two (2) while covered by this Plan
- **Residential accommodations** Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center. This Exclusion includes procedures, equipment, services, supplies or charges for the following:
  - Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
  - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
  - Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.
  - Services or care billed by a program or facility that principally or primarily provides services for individuals with a medical or mental health or substance use disorder diagnosis or condition in an outdoor environment, including wilderness, adventure, outdoor programs or camps, unless Medically Necessary.
- **Routine Physicals and Immunizations** Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the "Preventive Care" benefit.
- **Services Not Appropriate for Virtual Telemedicine / Telehealth Visits** Services that the Claims Administrator determines require in-person contact and/or equipment that cannot be provided remotely.
- **Services Received Outside of the United States** Services rendered by Providers located outside the United States, unless the services are for Emergency Care, and Emergency Ambulance.
- **Sexual Dysfunction** Services or supplies for male or female sexual problems.
- **Special Footwear** Footwear that is needed by persons who suffer from foot disfigurement.
- **Stand-By Charges** Stand-by charges of a Physician or other Provider.
- **Surrogacy Arrangements** Services, supplies, Prescription Drugs, or other care or treatment arising out of a Surrogacy Arrangement even those that would otherwise be Covered Services , unless you comply with the terms of the Plan's "Reimbursement Due to Surrogacy Agreement" provision.
- **Surrogate Mother Services** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
- **Temporomandibular Joint Treatment** Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).
- **Travel Costs** Mileage, lodging, meals and other Member-related travel costs except as described in this Plan.
- **Unlisted Services** Services not specifically listed in this Plan as Covered Services.

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

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

  This exclusion does not apply to weight management programs required under federal law as part of the "Preventive Care" benefit.

Claims Payment

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

Maximum Allowed Amount

General

This section describes the term "Maximum Allowed Amount*"* as used in this Booklet, and what the term means to you when obtaining Covered Services under this Plan. The Maximum Allowed Amount is the total reimbursement payable under your Plan for Covered Services you receive from In-Network and Out-of-Network Providers. It is our payment towards the services billed by your Provider combined with any Deductible, Coinsurance or Copayment owed by you. In some cases, you may be required to pay the entire Maximum Allowed Amount. For instance, if you have not met your Deductible under this Plan, then you could be responsible for paying the entire Maximum Allowed Amount for Covered Services. Except for Surprise Billing Claims*, when you receive services from an Out-of-Network Provider you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. In many situations, this difference could be significant. If you receive services from an In-Network Facility at which, or as a result of which, you receive non-Emergency Covered Services provided by an Out-of-Network Provider, you will pay the Out-of-Network Provider no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider. Please see "Member Cost Share" below for more information.

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

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

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

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

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

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

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

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

When you receive Covered Services, The Plan will, to the extent applicable, apply claim processing rules to the claim submitted. We use these rules to evaluate the claim information and determine the accuracy and

appropriateness of the procedure and diagnosis codes included in the submitted claim. Applying these rules may affect the Maximum Allowed Amount if The Plan determine 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 In-Network Provider or an Out-of-Network Provider.

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

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

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

Unlike In-Network Providers, Out-of-Network Providers and Other Eligible Providers may send you a bill and collect for the amount of the Out-of-Network Provider’s or Other Eligible Provider’s charge that exceeds the Maximum Allowed Amount under this Plan or the Reasonable and Customary Value. This amount can be significant. (**Note**: If you receive services from an In-Network Facility at which, or as a result of which, you receive non-Emergency Covered Services from Out-of-Network Providers, you will pay no more than the same cost sharing that you would pay for those same non-Emergency Covered Services received from an In-Network Provider, and you will not have to pay the Out-of-Network Provider more than the In-Network cost sharing for such non-Emergency Covered Services. Please see “Member Cost Share” below for more information.) Choosing an In-Network Provider will likely result in lower out-of-pocket costs to you. Please call the Member Services telephone number on the back of your Identification Card for help in finding an In-Network Provider or visit our website at www.anthem.com. Member Services is also available to assist you in determining your Plan’s Maximum Allowed Amount for a particular Covered Service from an Out-of-Network Provider or Other Eligible Provider. Please see “Inter-Plan Arrangements” later in this section for additional details.

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

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

Member Cost Share

For certain Covered Services, and depending on your Plan design, you may be required to pay all or a part of the Maximum Allowed Amount as your cost share amount (Deductible, Copayment, and/or Coinsurance). Your cost share amount and Out-of-Pocket Limits may be different depending on whether you received Covered Services from an In-Network Provider, Out-of-Network Provider or Other Eligible Provider. Specifically, you may be required to pay higher cost-sharing amounts or may have limits on your benefits when using Out-of-Network Providers or Other Eligible Providers. However, if you receive services from an In-Network Facility at which, or as a result of which, you receive non-Emergency Covered Services from Out-of-Network Providers, you will pay no more than the same cost sharing that you would pay for those same non-Emergency Covered Services received from an In-Network Provider, and you will not have to pay the Out-of-Network Provider more than the In-Network cost sharing for such non-Emergency Covered Services. Please see Your "Schedule of Benefits" in this Booklet for your cost share responsibilities and limitations, or call Member Services at the telephone number on the back of your Identification Card to learn how this Plan's benefits or cost share amounts may vary by the type of Provider you use.

The Claims Administrator will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network Provider, Out-of-Network Provider or Other Eligible Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Plan and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/ visit limits.

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

- At least 24 hours in advance of care, you consent in writing to receive services from the identified Out-of-Network Provider;

- The consent was obtained by the Out-of-Network Provider in a document that is separate from the document used to obtain the consent for any other part of the care or procedure. The consent was not obtained by the Facility or any representative of the Facility at the time of admission or at any time when you were being prepared for surgery or any other procedure;

- At the time of consent, the Out-of-Network Provider gave you a written estimate of your total Out-of-Pocket cost of care, based on the Provider's billed charges for the services to be provided. The Out-of-Network Provider shall not attempt to collect more than the estimated amount without receiving a separate written consent from you or your authorized representative, unless the Provider was required to make changes to the estimate due to circumstances during the delivery of services that were unforeseeable at the time the estimate was given;

- The consent advises that you may elect to seek care from an In-Network Provider or that you may make arrangements with your Plan to receive services from an In-Network Provider for lower Out-of-Pocket costs;

- The consent advises you that any costs incurred as a result of your use of the Out-of-Network benefits are in addition to the In-Network cost-sharing amounts and may not count toward the annual In-Network Out-of-Pocket Limit or In-Network Deductible.

Authorized Referrals

In some circumstances, The Plan may authorize In-Network Provider cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In

such circumstance, you or your Physician must contact us in advance of obtaining the Covered Service. It is your responsibility to ensure that The Plan has been contacted. If The Plan authorizes an In-Network Provider cost share amount to apply to a Covered Service received from an Out-of-Network Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. 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 contact Member Services at the telephone number on the back of your Identification Card for Authorized Referrals information or to request authorization.

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

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

If you receive services from an In-Network Facility at which, or as a result of which, you receive non-Emergency Covered Services provided by an Out-of-Network Provider, you will pay the Out-of-Network Provider no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider. Please see "Member Cost Share" above for more information.

Federal/State Taxes/Surcharges/Fees

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

Claims Review

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

Notice of Claim & Proof of Loss

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

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

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

    - Name of patient.
    - Patient's relationship with the Subscriber.
    - Identification number.

- Date, type, and place of service.
- Your signature and the Provider's signature.

Out-of-Network claims must be submitted within 365 days after the date of service. In certain cases, state or federal law may allow additional time to file a claim, if you could not reasonably file within the 365-day period. The claim must have the information The Plan needs to determine benefits. If the claim does not include enough information, the Claims Administrator will ask you for more details and inform you of the time by which The Plan needs to receive that information. Once the Claims Administrator receives the required information, the Claims Administrator will process the claim according to the terms of your Plan.

Claims submitted by a public (government operated) Hospital or clinic will be paid by the Claims Administrator directly, as long as you have not already received benefit under that claim. The Claims Administrator will pay all claims within 30 days after receiving proof of loss. If you are dissatisfied with the Claims Administrator's denial or amount of payment, you may request that the Claims Administrator review the claim a second time, and you may submit any additional relevant information.

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

Claim Forms

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

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

Member's Cooperation

You will be expected to complete and submit to the Claims Administrator all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. If you fail to cooperate, you will be responsible for any charge for services.

Payment of Benefits

You authorize the Claims Administrator, in its own discretion and on behalf of the Employer, to make payments directly to Providers for Covered Services. In no event, however, shall the Plan's right to make payments directly to a Provider be deemed to suggest that any Provider is a beneficiary with independent claims and appeal rights under the Plan. The Claims Administrator also reserves the right, in its own discretion, to make payments directly to you as opposed to any Provider for Covered Services, except for claims for Emergency Care or Surprise Billing Claims for ground or air ambulance services or non-Emergency services performed by Out-of-Network Providers at certain In-Network Facilities, which will be paid directly to Providers and Facilities. In the event that payment is made directly to you, you have the responsibility to apply this payment to the claim from the Out-of-Network Provider. Payments and notice regarding the receipt and/or adjudication of claims may also be sent to an Alternate Recipient (which is defined herein as any child of a Subscriber who is recognized under a "Qualified Medical Child Support Order" as having a right to enrollment under the Group's Plan), or that person's custodial parent or designated representative. Any payments made by the Claims Administrator (whether to any Provider for Covered Service or You) will discharge the Plan's obligation to pay for Covered Services. You cannot assign your right to

receive payment to anyone, except as required by a "Qualified Medical Child Support Order" as defined by, and if subject to, ERISA or any applicable Federal law.

Once a Provider performs a Covered Service, the Claims Administrator will not honor a request to withhold payment of the claims submitted.

The coverage, rights, and benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above. This prohibition against assignment includes rights to receive payment, claim benefits under the Plan and/or law, sue or otherwise begin legal action, or request Plan documents or any other information that a Participant or beneficiary may request under ERISA. Any assignment made without written consent from the Plan will be void and unenforceable.

Inter-Plan Arrangements

Out-of-Area Services

Overview

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

When you receive care outside of the Anthem Service Area, you will receive it from one of two kinds of Providers. Most Providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("nonparticipating providers") don't contract with the Host Blue. Explained below is how both kinds of Providers are paid.

Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. 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, Anthem will still fulfill their contractual obligations. But, the Host Blue is responsible for: (a) contracting with its Provider; and (b) handling its interactions with those Providers.

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

- The billed charges for Covered Services; 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 Anthem uses for your claim because they will not be applied after a claim has already been paid.

B. Negotiated (non-BlueCard Program) Arrangements

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

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

C. Special Cases: Value-Based Programs

BlueCard® Program

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

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

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

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

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

E. Nonparticipating Providers Outside The Service Area

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

F. Blue Cross Blue Shield Global Core® Program

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

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

If you need inpatient hospital care, you or someone on your behalf, should contact us for 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.

How Claims are Paid with Blue Cross Blue Shield Global Core®

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

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

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

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

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

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

DEFINITIONS

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

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

The following are not Allowable Expense:

1. Use of a private hospital room is not an Allowable Expense unless the patient's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage for hospital private rooms.
2. If you are covered by two plans that calculate benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method, any amount in excess of the higher of the reasonable and customary amounts.
3. If a person is covered by two plans that provide benefits or services on the basis of negotiated rates or fees, an amount in excess of the lower of the negotiated rates.
4. If a person is covered by one plan that calculates its benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method and another plan provides its benefits or services on the basis of negotiated rates or fees, any amount in excess of the negotiated rate.
5. The amount of any benefit reduction by the Principal Plan because you did not comply with the plan's provisions is not an Allowable Expense. Examples of these types of provisions include second surgical opinions, utilization review requirements, and network provider arrangements.
6. If you advise the Claims Administrator that all plans covering you are high deductible health plans as defined by Section 223 of the Internal Revenue Code, and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code, any amount that is subject to the primary high deductible health plan's deductible.

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage;
2. Group service plan contract, group practice, group individual practice and other group prepayment coverages;
3. Group coverage under labor-management trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.
4. Medicare. This does not include Medicare when, by law, its benefits are secondary to those of any private insurance program or other non-governmental program, including a self-insured program.

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

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

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

EFFECT ON BENEFITS

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

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

ORDER OF BENEFITS DETERMINATION

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy, or personal injury protection policy regardless of any election made by anyone to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies. This provision applies notwithstanding any coordination of benefits term to the contrary.

The first of the following rules which 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 Subscriber pays before a plan which covers you as a dependent. But, if you are retired and eligible for Medicare, Medicare pays (a) after the plan which covers you as a dependent of an active employee, but (b) before the plan which covers you as a retired employee.

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

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

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

Plan do not agree under these circumstances with the order of benefit determination provisions of This Plan, this rule will not apply.

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

THE CLAIMS ADMINISTRATOR'S RIGHTS UNDER THIS PROVISION

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

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

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

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

COORDINATION WITH MEDICARE

Individuals who have earned the required number of quarters for Social Security benefits within the specified time frame are eligible for Medicare Part A at no cost. Participation in Medicare Part B is available to all individuals who make application and pay the full cost of the coverage.

1. When an Employee becomes entitled to Medicare coverage and is still actively at work, the Employee may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.
2. When a Dependent becomes entitled to Medicare coverage and the Employee is still actively at work, the Dependent may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.
3. If the Employee and/or Dependent is also enrolled in Medicare, this Plan shall pay as the primary plan. Medicare will pay as secondary plan.
4. If the Employee and/or Dependent elect to discontinue health coverage under this Plan and enroll under the Medicare program, no benefits will be paid under this Plan. Medicare will be the only payor.
5. A Member that is an active Employee and his or her spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan at open enrollment or some other specified special enrollment period. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.
   Amy's Kitchen, Inc. Medical Plan 80
6. To the extent required by Federal regulations, this Plan will pay Covered Expenses at the "Reasonable and Allowed Amount" before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor (as described under the Article entitled "Coordination of Benefits"). The Member will be assumed to have full Medicare coverage (that is, both Parts A & B) whether or not the Member has enrolled for the full coverage. If the Provider accepts assignment with Medicare, Covered Expenses will not exceed the Medicare approved expenses.
7. If any Member is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of Medicare entitlement, unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

This section is subject to the standard terms of the Medicare Secondary Payor laws and regulations, including but not limited to, determination of first and second payor for a person with End Stage Renal Disease, or a person eligible for Medicare due to disability. Any changes in these related laws and regulations will apply to the provisions of this section.

LIMITATIONS ON PAYMENTS

In no event shall the Member recover under this Plan and all Other Plan(s) combined more than the total Allowable Expenses offered by this Plan and the Other Plan(s). Nothing contained in this section shall entitle the Member to benefits in excess of the total Maximum Allowable Payment of this Plan during the claim determination period. The Member shall refund to the Plan Administrator any excess it may have paid.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of determining the applicability of and implementing the terms of this Coordination of Benefits provision, the Plan may, without the consent of or notice to any person, release to or obtain from any insurance company or any other organization any information with respect to any Member. Any person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement the Coordination of Benefits provision.

FACILITY OF BENEFIT PAYMENT

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any Other Plan, the Plan Administrator shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, the Plan Administrator shall be fully discharged from liability.

THIRD PARTY RECOVERY, SUBROGATION, AND REIMBURSEMENT

PAYMENT CONDITION

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness, or Disease or Disability is caused in whole or in part by, or results from the acts or omissions of Members, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as “Member(s)”) or a third party, where any party besides the Planmay be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively “Coverage”).

Member(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance ofthe Plan’s conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan’s conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan’s assignee. By accepting benefits, the Member(s) agrees the Plan shall have anequitable lien on any funds received by the Member(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan fully expects to be reimbursed any amounts paid on behalf of the Member(s) for medical care from the amount(s) received in settlementfrom the third party and expects such award amounts to remain segregated until such time that the Plan has been repaid. The Member(s) agrees to include the Plan’s name as a co-payee on any and all settlement drafts.

In the event a Member(s) settles, recovers, or is reimbursed by any Coverage, the Member(s) agrees to reimburse thePlan for all benefits paid or that will be paid by the Plan on behalf of the Member(s). If the Member(s) fails to reimburse the Plan out of any judgment or settlement received, the Member(s) will be responsible for any and all expenses (feesand costs) associated with the Plan’s attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by thePlan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Member(s) is/are only one ora few, that unallocated settlement fund is considered designated as an “identifiable” fund from which the Plan may seek reimbursement.

SUBROGATION

As a condition to participating in and receiving benefits under this Plan, the Member(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Member(s) is entitled, regardless of how classified or characterized, at the Plan's discretion.

If a Member(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Member(s) may have against any Coverage and/or party causing the Injury, Illness, or Disease to the extent of such conditional payment by the Plan plus reasonable costs of collection.

The Plan may, at its discretion, in its own name or in the name of the Member(s) commence a proceeding or pursue aclaim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefitsor conditional payments advanced by the Plan.

If the Member(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of that party;
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage,uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Workers' compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

Then the Member(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Member(s)'and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Member(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

RIGHT OF REIMBURSEMENT

The Plan shall be entitled to recover one hundred percent (100%) of the benefits paid, without deduction for attorneys'fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Member(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibitingassignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Member(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted fromthe Plan's recovery without the prior, expressed written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Member(s), whether under the doctrines of causation, comparative fault or contributory negligence, orother similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce asubrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Member(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Injury, Illness,or Disease or Disability.

MEMBER IS A TRUSTEE OVER PLAN ASSETS

Any Member who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury or Accident. By virtue of this status, the Member understands that he or she is required to:

1. Notify the Plan or its Authorized Representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
2. Instruct his or her attorney to ensure that the Plan and/or its Authorized Representative is included as a payee on all settlement drafts.
3. In circumstances where the Member is not represented by an attorney, instruct the insurance company or any third party from whom the Member obtains a settlement, judgment or other source of coverage to include the Plan or its Authorized Representative as a payee on the settlement draft.
4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Member disputes this obligation to the Plan under this section, the Member or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is lessthan the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Member, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

RELEASE OF LIABILITY

The Plan's right to reimbursement extends to any incident related care that is received by the Member(s) (Incurred) prior to the liable party being released from liability. The Member's/Members' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Member has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release ofany liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care Incurredprior to the proposed date of settlement and/or release, which is not listed but has been or will be Incurred, and for which the Plan will be asked to pay.

EXCESS INSURANCE

If at the time of Injury, Illness, or disease or disability there is available, or potentially available any other source of coverage (including but not limited to coverage resulting from a judgment of law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to, whenever possible, any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party;
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage,uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Workers' compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

SEPARATION OF FUNDS

Benefits paid by the Plan, funds recovered by the Member(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Member(s), such that the death of the Member(s), or filing of bankruptcy by the Member(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

WRONGFUL DEATH

In the event that the Member(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is assertedagainst a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entitypursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Member(s) and all others that benefit from such payment.

OBLIGATIONS

It is the Member(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery,attending depositions, and/or cooperating in trial to preserve the Plan's rights;
2. To provide the Plan with pertinent information regarding the Injury, Illness, disease or disability, includingaccident reports, settlement information and any other requested additional information;
3. To take such action and execute such documents as the Plan may require facilitating enforcement of itssubrogation and reimbursement rights;
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment isreceived;
6. To notify the Plan or its Authorized Representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf ofthe Plan.
7. To notify the Plan or its Authorized Representative of any settlement prior to finalization of the settlement;
8. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Member may have against any responsible party or Coverage;
9. To instruct his or her attorney to ensure that the Plan and/or its Authorized Representative is included as a payee on any settlement draft;
10. In circumstances where the Member is not represented by an attorney, instruct the insurance company or any third party from whom the Member obtains a settlement to include the Plan or its Authorized Representativeas a payee on the settlement draft; and
11. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Member over settlement funds is resolved.

If the Member(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury, Illness, or disease or condition, out of any proceeds, judgment or settlement received, the Member(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such moneyfrom the Member(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Member(s)' cooperation oradherence to these terms.

OFFSET

If timely repayment is not made, or the Member and/or his or her attorney fails to comply with any of the requirementsof the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Member's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and anyfunds or payments due under this Plan on behalf of the Member(s) in an amount equivalent to any outstanding amounts owed by the Member to the Plan. This provision applies even if the Member has disbursed settlement funds.

MINOR STATUS

In the event the Member(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointedguardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minorand his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advancepayment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

LANGUAGE INTERPRETATION

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of thisprovision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

SEVERABILITY

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shallbe construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

Your Right To Appeals

For purposes of these Appeal provisions, “claim for benefits” means a request for benefits under the Plan. The term includes both pre-service and post-service claims.

- A pre-service claim is a claim for benefits under the Plan for which you have not received the benefit or for which you may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the Plan for which you have received the service.

If your claim is denied or if your coverage is rescinded:

- You will be provided with a written notice of the denial or rescission; and
- You are entitled to a full and fair review of the denial or rescission.

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

Notice of Adverse Benefit Determination

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

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific Plan provision(s) on which the Claims Administrator’s determination is based;
- a description of any additional material or information needed to perfect your claim;
- an explanation of why the additional material or information is needed;
- a description of the Plan’s review procedures and the time limits that apply to them, including a statement of your right to bring a civil action under ERISA (if applicable)within one year of the grievance or appeal decision, if you submit a grievance or 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;
- information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision; and
- information regarding your potential right to an External Appeal pursuant to federal law.

For claims involving urgent/concurrent care:

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

Appeals

You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. The Claims Administrator’s review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

The Claims Administrator shall offer a single mandatory level of appeal and an additional mandatory second level of appeal which may be a panel review, independent review, or other process consistent with the entity reviewing

the appeal. The time frame allowed for the Claims Administrator to complete its review is dependent upon the type of review involved (e.g. pre-service, concurrent, post-service, urgent, etc.).

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

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

All other requests for appeals should be submitted in writing by the Member or the Member's authorized representative, except where the acceptance of oral *Appeals* is otherwise required by the nature of the appeal (e.g. urgent care). You or your authorized representative must submit a request for review to:

Anthem Blue Cross Life and Health Insurance Company
ATTN: Appeals
P.O. Box 4310, Woodland Hills, CA 91365-4310

You must include your Member Identification Number when submitting an appeal.

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

- was relied on in making the benefit determination; 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.

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

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

How Your Appeal will be Decided

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

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not Medically Necessary, the reviewer will consult with a health care professional who has the

appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal

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

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

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

Appeal Denial

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

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

Mandatory Second Level Appeals

If you are dissatisfied with the Plan's mandatory first level appeal decision, a mandatory second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed in the first level appeal decision letter that you received. Mandatory appeals must be submitted within 60 calendar days of the denial of the first level appeal. You are required to complete a mandatory second level appeal prior to submitting a request for an independent External Review.

Anthem will handle all levels of appeal for clinical appeals. For benefit administration appeals Anthem will handle the first level of appeal and Amy’s Kitchen will handle second Level of Appeal. Second level benefit administration appeals should be mailed to:

1650 Corporate Circle, Suite 200
Petaluma, CA 94954
Attention: Came Lewis

External Review

If the outcome of the mandatory second level appeal is adverse to you and it was based on medical judgment, or if it pertained to a rescission of your coverage, you may be eligible for an independent External Review pursuant to federal law. You must submit your request for External Review to the Claims Administrator within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless the Claims Administrator 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 the Claims Administrator's internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact the Claims Administrator at the phone number listed on your ID card and provide at least the following information:

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;
- the provider's name;
- the service or supply for which approval of benefits was sought; 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 the Claims Administrator 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

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

Legal Action

Requirement to file an Appeal before filing a lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within one year of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's 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, not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan.

If your health benefit Plan is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA after the expiration of one (1) year from the exhaustion of the administrative process.

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

You may not take legal action against the Claims Administrator to receive benefits:

- Earlier than 60 days after the Claims Administrator receives the claim; or
- Later than one year after the date the claim is required to be furnished to the Claims Administrator.

ELIGIBILITY

This section identifies the Plan's requirements for a person to be eligible to enroll. Refer to Enrollment and Effective Date of Coverage for more information.

EMPLOYEE ELIGIBILITY

All Employees regularly scheduled to work at least twenty-four (24) hours per work week in any forty-five (45) day period shall be eligible to enroll for coverage under this Plan. Coverage shall be effective on the first of the month following or coincident with forty-five (45) days of employment. Part-time Employees (less than 24 hours), temporary Employees, Interns and seasonal Employees are excluded unless mandated by law unless noted below.

Temporary Employees and Interns working at least thirty (30) hours per week shall be eligible to enroll for coverageunder this Plan on the ninety first (91st) day of employment.

Rehired Employees who return to Amy's Kitchen, Inc. within six (6) months of their separation date can elect to havetheir benefits reinstated on the first of the month following their rehire date. Coverage shall be effective first of the month coincident with or following the date of rehire or return to work.

Employees who have a change in eligibility status by moving from a non-benefits-eligible position into a benefits-eligible position are subject to the new hire benefits waiting period of forty-five (45) days.

Variable Hour (Part-time) Employee – Amy's Kitchen, Inc. uses a twelve-month measurement period, during which time Employees will be ineligible for benefits. Following this period, Amy's Kitchen, Inc. will use an administrativeperiod to calculate whether the Employee worked, on average, 30 or more hours per week. If it is established that theEmployee satisfies the above criteria, the Employee will then become eligible for enrollment in the company benefits offering, effective the first day of the month following the administrative period.

DEPENDENT ELIGIBILITY

The following describes Dependent eligibility requirements. The Plan Administrator will require proof of Dependent status.

1. **Spouse.** The term "spouse" means the spouse of the Employee under a legally valid existing marriage, unlesscourt ordered separation exists; or

2. **Domestic Partner.** The term "Domestic Partner" means a person of the opposite sex or same sex with whomthe Employee has established a Domestic Partnership. All of the following requirements apply to both persons:
    a. They must be at least 18 years of age and competent to enter into a contract;
    b. They must not be currently married to, or a Domestic Partner of, another person under eitherstatutory or common law;
    c. They must not be legally separated from another person;
    d. They must not be related by blood or a degree of closeness that would prohibit marriage in the lawof the state in which they reside;
    e. They must have allowed at least six (6) months to pass since the termination of any previous domestic partnership (this does not apply if the previous domestic partnership ended due to the domestic partner's death); and
    f. They must share a permanent residence.

Employees enrolling a Domestic Partner must provide an Affidavit of Domestic Partnership. Employees terminating a Domestic Partner must provide an Affidavit of Domestic Partnership Termination. Employeesshould contact the Employer for the required documentation.

3. **Child/Children.** The term "Child/Children" means the Employee's or the Employee's covered spouse's/domestic partner's natural child, stepchild, legally adopted child, foster child, and a child for whom the Employee or covered spouse has been appointed legal guardian or power of attorney for medical expenses, provided the child has not reached the end of the month of his or her twenty-sixth (26th) year of age.

4. **Qualified Medical Child Support Order (QMCSO)**. An eligible child shall also include any other child ofan Employee or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order asbeing entitled to enrollment for coverage under this Plan, even if the child is not residing in the Employee's household. Such child shall be referred to as an Alternate Recipient. An application for enrollment must be submitted to the Plan Administrator for coverage under this Plan. The Plan Administrator shall establish written procedures for determining whether a medical child support order is a QMCSO or NMSN and for administering the provision of benefits under the Plan pursuant to a valid QMCSO or NMSN. Within a reasonable period after receipt of a medical child support order, the Plan Administrator shall determine whether such order is a Qualified Medical Child Support Order or a National Medical Support Notice (NMSN) as defined in Section 401 of the Child Support Performance and Incentive Act of 1998.

The Plan Administrator reserves the right, at its discretion, to seek clarification with respect to the order from the court or administrative agency which issued the order, up to and including the right to seek a hearing before the court or agency.

5. **Developmentally or Physically Disabled Child.** A child who is unmarried, incapable of self-sustaining employment, and dependent upon the Employee for support due to a mental and/or physical disability, and who was covered under the Plan prior to reaching the maximum age limit or other loss of Dependent's eligibility, will remain eligible for coverage under this Plan beyond the date coverage would otherwise be lost.

   Proof of incapacitation must be provided within thirty (30) days of the child's loss of eligibility and thereafteras requested by the Plan Administrator or Claims Administrator, but not more than once every two (2) years.

   Eligibility may not be continued beyond the earliest of the following:

   a. Cessation of the mental and/or physical disability;
   b. Failure to furnish any required proof of mental and/or physical disability or to submit to any requiredexamination;

6. **Newborn Child**. Newborn Children will be considered a Dependent under this Plan for thirty-one (31) daysimmediately following birth. For coverage under the Plan for the newborn beyond that date, the Employee must submit an application for enrollment within thirty (30) days of birth.

   These persons are excluded as Dependents:

   - A spouse who is legally separated or divorced from the Employee;
   - Children of a Dependent son or daughter;
   - Children who are, or become, a full-time member of the armed forces of any country;
   - Any person who is covered as a Dependent of another Employee under this Plan;
   - Any person who is eligible as an Employee under the Plan; and
   - The spouse of a Dependent child.

ENROLLMENT

The benefits of this Plan are based on a Benefit Year. If an Employee or Dependent enrolls for coverage at any time during the Benefit Year, the benefits shall be calculated on a Benefit Year

APPLICATION FOR ENROLLMENT

An Employee must file a written application (or electronic, if applicable) with the Plan Administrator for coverage hereunder for himself and/or his eligible Dependents within thirty (30) days of becoming eligible for coverage. The Employee shall have the responsibility of timely forwarding to the Plan Administrator all applications for enrollment hereunder. Once a properly completed application for enrollment has been submitted to the Plan Administrator and coverage has become effective, as defined in the section titled, Effective Date of Coverage, the Employee's enrollmentoptions shall remain in effect. The only opportunity to change the enrollment option shall be at the annual open enrollment period, or upon a special enrollment option as defined below.

The Plan Administrator must be notified of any change in eligibility of Dependents within thirty (30) days of the change, including the birth of a child that is to be covered and adding or deleting any other Dependents.

Failure to complete the application for enrollment within thirty (30) days shall result in the Late Enrollment provision applying to the individual. An Alternate Recipient can be enrolled in the Plan at any time and shall not be subject to theLate Enrollment provision.

Dual Eligibility

Every eligible Employee may enroll eligible Dependents. If the Employee, spouse, domestic partner or child(ren) are Employees, each individual will be covered as an Employee. An Employee cannot be covered as an Employee and a Dependent. Eligible children may be enrolled as Dependents of one spouse/domestic partner, but not both.

Transfer of Coverage

If an Employee and spouse or domestic partner are both Employees and are covered as Employees under this Plan andone of them terminates, the terminating spouse and any of the eligible enrolled children will be permitted to immediately enroll under the remaining Employee's coverage. Such new enrollment will be deemed a continuation of prior coverage and will not operate to reduce or increase any coverage to which the person was entitled while enrolled as the Employee or the Dependent of the terminated Employee.

SPECIAL ENROLLMENT PERIOD: LOSS OF ELIGIBILITY FOR OTHER COVERAGE

An Employee or Dependent who did not enroll for coverage under this Plan because he was covered under other groupcoverage or had health insurance coverage at the time he was initially eligible for coverage under this Plan, may request a special enrollment period if he is no longer eligible for the other coverage. The Plan Administrator may require proof of the special enrollment event noted below. Special enrollment periods will be granted if the individual's loss of eligibility is due to:

1. Termination of the other coverage (including exhaustion of COBRA benefits)
2. Cessation of employer contributions toward the other coverage
3. Legal separation or divorce
4. Termination of other employment or reduction in number of hours of other employment
5. Death of spouse who had the coverage under the other plan.
6. Cessation of other coverage because employee or dependent no longer resides or works in the service areaand no other benefit package is available to the individual.

The end of any extended benefits period which has been provided due to any of the above will also be considered a loss of eligibility.

However, loss of eligibility does not include a loss due to failure of the individual to pay premiums or contributions on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other coverage).

The Employee or Dependent must request the special enrollment and enroll no later than thirty (30) days from the dateof loss of other coverage.

The Effective Date of coverage as the result of a special enrollment shall be the first day of the first calendar month following the special enrollment event.

SPECIAL ENROLLMENT PERIOD: DEPENDENT ACQUISITION

An Employee who is currently covered or not covered under the Plan, but who acquires a new Dependent may request a special enrollment period for himself, if applicable, his newly acquired Dependent and his Spouse/Domestic Partner, if not already covered under the Plan and otherwise eligible for coverage. For the purposes of this provision, the acquisition of a new Dependent includes:

1. Marriage or domestic partnership;
2. Birth of a Dependent child;
3. Adoption or placement for adoption of a Dependent child;
4. Obtaining Legal Guardianship or power of attorney of a Dependent child; or
5. A foster child being placed with an Employee.

The Employee must request the special enrollment within thirty (30) days of the acquisition of the

Dependent.The Effective Date of coverage as the result of a special enrollment shall be:

1. In the case of marriage or domestic partnership, the first day of the calendar month following the marriageor domestic partnership.
2. In the case of a Dependent's birth, the date of such birth.
3. In the case of adoption or placement for adoption, the first of the month following the date of such adoption or placement for adoption.
4. In the case of legal guardianship or power of attorney, the first of the month following obtainment of such legal guardianship or power of attorney.
5. In the case of a court order mandating coverage under the Plan, the earlier of the first of the month following receipt of the court order, or the date specified in the court order.
6. In the case of a foster child being placed with the Employee, on the date on which such child is placed with the Employee by an authorized placement agency or by judgement, decree or other order of a court competentjurisdiction.

SPECIAL ENROLLMENT PERIOD: MEDICAID AND CHIP ELIGIBILITY

An eligible Employee, or an Employee's eligible Dependent, who is currently covered or not covered under the Planmay request a special enrollment period for himself, if applicable, and his dependent. Special enrollment periods willbe granted if:

1. Termination of Medicaid or CHIP Coverage: If the Employee or Dependent is covered under a State Medicaid plan under Title XIX of the Social Security Act, or under a State Child Health Plan under Title XXI of the Social Security Act, and coverage of the Employee or Dependent under such coverage is terminated as a result of loss of eligibility for such coverage
2. Eligibility for Premium Assistance Under Medicaid or CHIP: If the Employee or Dependent becomes eligible for premium assistance, with respect to coverage under the Plan, under a Medicaid plan or State Child HealthPlan.

The Employee or Dependent must submit a complete application for enrollment to the Plan Administrator within sixty

(60) days of either: (1) termination of coverage under such other coverage, or (2) the date the Employee or Dependentis determined to be eligible for premium assistance. Failure to submit the completed application for enrollment withinthe designated time shall result in the Employee's or Dependent's forfeiture of this enrollment right and shall be subject to enrolling upon the next open enrollment period sponsored by the Plan Administrator.

OPEN ENROLLMENT

Open enrollment is the period designated by the Plan Administrator during which the Employee may elect coverage for himself and any eligible Dependents if he is not covered under the Plan and does not qualify for a Special Enrollment as described herein. Enrolled Employees may add or drop coverage for Dependents during this open enrollment period.

During this open enrollment period, an employee and his dependents that are not covered under this Plan must complete and submit an enrollment form for coverage. Coverage shall be effective on the following January 1.

LATE ENROLLMENT

With the exception of the provisions identified in Special Enrollment above, applications for Employee or Dependent coverage which are not filed with the Plan Administrator within thirty (30) days of meeting the eligibility requirements of the Plan shall be subject to this late enrollment provision.

Late enrollment applicants shall be eligible to enroll for coverage during the Plan's annual open enrollment period. Coverage shall be effective January 1 provided a properly completed application for enrollment has been received by the Plan Administrator. This late enrollment provision shall not apply to an Alternate Recipient.

EFFECTIVE DATE OF COVERAGE

EMPLOYEE EFFECTIVE DATE

Eligible Employees, as described in Eligibility, are effective under the Plan the first of the month coincident with or following forty-five (45) days of continuous Full-Time employment; provided a properly completed enrollment formwas submitted to the Plan Administrator. Temporary Employees and Interns are effective under the Plan on the ninety- first (91st) day of employment.

In the event a part-time Employee changes employment status to Full-Time, coverage will be effective on the date theEmployee meets the Plan's eligibility requirements, provided the Employee worked in a part-time capacity for the Employer for at least the period of time equal to the Plan's waiting period.

If the Employee does not enroll for coverage within thirty (30) days of meeting the Plan's eligibility requirements, theEffective Date of coverage will be delayed. Refer to Enrollment.

DEPENDENT EFFECTIVE DATE

Eligible Dependents, as described in Eligibility, will become covered under the Plan as specified under the section titled, Special Enrollment Period: Dependent Acquisition, provided the Employee has enrolled them in the Plan within thirty

(30) days of meeting the Plan's eligibility requirements. If the Employee does not enroll eligible Dependents within thirty

(30) days of meeting the Plan's eligibility requirements, the Dependents' Effective Date of coverage will be delayed.Refer to Enrollment.

TERMINATION OF COVERAGE

Except as provided in the Plan's Continuation of Coverage (COBRA) provision, coverage under this Plan will terminate on the earliest of the following dates:

EMPLOYEE TERMINATION DATE

1. The date the Plan is terminated.
2. The last day of the month in which the Employee ceases to meet the eligibility requirements of the Plan.
3. The last day of the month in which employment terminates.
4. The date the Employee becomes a full-time, active member of the armed forces of any country.
5. Midnight on the first day after the date any required contribution is due but not paid, unless the Member hasreceived confirmation in writing from a representative of the Plan that coverage will not be terminated.
6. The last day of the month the Employee fails to return from an approved Leave of Absence.
7. At any time, coverage may be rescinded, or retroactively terminated, effective the date the Employee commitsor has committed an intentional act of fraud or material misrepresentation with respect to the Plan, with 30 days' written notice from the Plan.

DEPENDENT TERMINATION DATE

1. The date the Plan is terminated.
2. The date the Employee's coverage terminates.
3. The last day of the month such person ceases to meet the eligibility requirements of the Plan.
4. Midnight on the first day after the date any required contribution is due but not paid, unless the Member hasreceived confirmation in writing from a representative of the Plan that coverage will not be terminated.
5. The date the Dependent becomes a full-time, active member of the armed forces of any country.
6. The date the Plan discontinues Dependent coverage for any and all dependents.
7. The last day of the month in which the Plan Administrator receives a cancellation of a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN).
8. At any time, coverage may be rescinded, or retroactively terminated, effective the date the Employee commitsor has committed an intentional act of fraud or material misrepresentation with respect to the Plan, with 30 days' written notice from the Plan.

LEAVE OF ABSENCE

Coverage may be continued for a limited time, but not to exceed eighteen (18) months, contingent upon payment of any required contributions for Employees and/or Dependents, when the Employee is on an authorized Leave of Absence from the Employer. For additional information on Amy's Kitchen, Inc.'s leave policy contact the HR Department.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

Eligible Leave

An Employee who is eligible for unpaid leave and benefits under the terms of the Family and Medical Leave Act of 1993, as amended, has the right to continue coverage under this Plan for up to twelve (12) weeks during any twelve (12) month period.

Contributions

During this leave, the Employer will continue to pay the same portion of the Employee's contribution for the Plan. The Employee shall be responsible to continue payment for eligible Dependent's coverage and any remaining Employee contributions. For further information regarding continued contributions while on leave contact the Plan Administrator.

Reinstatement

If coverage under the Plan was terminated during an approved FMLA leave, and the Employee returns to active workimmediately upon completion of that leave, Plan coverage will be reinstated on the date the Employee returns to active work as if coverage had not terminated, provided the Employee makes any necessary contributions and enrolls for coverage within thirty (30) days of his return to active work.

Repayment Requirement

The Employer may require Employees who fail to return from a leave under FMLA to repay any contributions paid by the Employer on the Employee's behalf during an unpaid leave. Contact the Plan Administrator for further information.

EMPLOYEE REINSTATEMENT

Employees and eligible Dependents that lost coverage due to an approved Leave of Absence, Layoff, or termination of employment with the Employer are eligible for reinstatement of coverage as follows:

1. Reinstatement of coverage is available to Employees and Dependents that were previously covered under the Plan.
2. Rehire or return to work must occur within six (6) months of last day worked.
3. The Employee must submit the completed application for enrollment to the Plan Administrator within thirty (30) days of rehire or return to work.
4. Coverage shall be effective from the first of the month coincident with or following the date of rehire or return to work. Prior benefits and limitations, such as Deductible and Maximum Benefit Amount shall be applied with no break in coverage if the Employee returns within the same Benefit Year.

If the provisions of (1) through (3) above are not met, the Plan's provisions for eligibility and application for enrollment shall apply.

An Employee who returns to work after six (6) months of an approved Leave of Absence, Layoff, or separation of employment will be considered a new Employee for purposes of eligibility and will be subject to all eligibility requirements.

SITE CLOSURE/LAYOFF

Coverage may continue for a limited time, but not to exceed sixty (60) days, when employees are terminated as a result of a site closure or layoff.

CONTINUATION OF COVERAGE

This section pertains to Employers that are eligible and have elected COBRA coverage. If you have any questions, please contact your Human Resources Department.

In order to comply with federal regulations, this Plan includes a continuation of coverage option for certain individuals whose coverage would otherwise terminate. The following is intended to comply with the Public Health Services Act. This continuation of coverage may be commonly referred to as "COBRA coverage."

The coverage which may be continued under this provision consists of health coverage. It does not include life insurance benefits, accidental death and dismemberment benefits, or income replacement benefits. Health coverage includes medical, prescription drug, and vision benefits as provided under the Plan.

QUALIFYING EVENTS

Qualifying events are any one of the following events that would cause a Member to lose coverage under this Plan, even if such coverage is not lost immediately, and allow such person to continue coverage beyond the date described in Termination of Coverage:

1. Death of the Employee.
2. The Employee's termination of employment or reduction in work hours to less than the minimum required for coverage under the Plan.
3. Divorce, legal separation or termination of Domestic Partnership from the Employee.
4. The Employee's entitlement to Medicare benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this Plan.
5. A dependent child no longer meets the eligibility requirements of the Plan.
6. The last day of leave under the Family Medical Leave Act of 1993.
7. The call-up of an Employee reservist to active duty.

NOTIFICATION REQUIREMENTS

1. When eligibility for continuation of coverage results from a spouse being divorced or legally separated from a covered Employee, or a child's loss of Dependent status, the Employee or Dependent must notify the Plan Administrator of that event within sixty (60) days of the event. The Employee or Dependent must advise thedate and nature of the qualifying event and the name, address and Social Security number of the affected individual. Failure to provide such notice to the Plan Administrator will result in the person forfeiting their rights to continuation of coverage under this provision.
2. The Plan Administrator has thirty (30) days to notify the Claims Administrator of the qualifying event. Within fourteen (14) days of receiving notice of the qualifying event, the COBRA administrator will notify the Employee or Dependent of his right to continuation of coverage, and what process is required to elect continuation of coverage.
3. After receiving notice, the Employee or Dependent has sixty (60) days to decide whether to elect continued coverage. Each person who was covered under the Plan prior to the qualifying event has the right to elect continuation of coverage on an individual basis, regardless of family enrollment. The COBRA Administratormust receive this written notice no later than the last day of the sixty (60) day period. If the election is mailed, the election must be postmarked on or before the last day of the sixty (60) day period. This sixty (60) day period begins on the latter of the following:
    a. The date coverage under the Plan would otherwise end; or
    b. The date the person receives the notice from the Plan Administrator of his or her rights to continuation of coverage.
4. Within forty-five (45) days after the date the person notifies the COBRA Administrator that he has chosen tocontinue coverage, the person must make the initial payment. The initial payment will be the amount needed to provide coverage from the date continued benefits begin, through the last day of the month in which the initial payment is made. Thereafter, payments for the continued coverage are to be made monthly, and are due inadvance, on the first day each month.
5. The Employee or Dependent must make payments for the continued coverage.

COST OF COVERAGE

1. The Plan Administrator requires that Members pay the entire costs of their continuation coverage, plus a twopercent (2%) administrative fee. This must be remitted to the COBRA Administrator, by or before the first day of each month during the continuation period. The payment must be remitted each month in order to maintainthe coverage in force.
2. For purposes of determining monthly costs for continued coverage, a person originally covered as an Employee or as a spouse will pay the rate applicable to an Employee if coverage is continued for himself alone. Each child continuing coverage independent of the family unit will pay the rate applicable to an Employee.

WHEN CONTINUATION COVERAGE BEGINS

When continuation coverage is elected and the contributions paid within the time period required, coverage is reinstated back to the date of the loss of coverage, so that no break in coverage occurs. Coverage for Dependents acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the Plan.

FAMILY MEMBERS ACQUIRED DURING CONTINUATION

A spouse or dependent child newly acquired during continuation coverage is eligible to be enrolled as a Dependent. The standard enrollment provision of the Plan applies to enrollees during continuation coverage. A Dependent acquired and enrolled after the original qualifying event, other than a child born to or Placed for Adoption with a covered Employeeduring a period of COBRA continuation coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of coverage.

SUBSEQUENT QUALIFYING EVENTS

Once covered under continuation coverage, it is possible for a second qualifying event to occur, including:

1. Death of an Employee,
2. Divorce, legal separation or termination of Domestic Partnership from an Employee.
3. Employee's entitlement to Medicare, or
4. The child's loss of Dependent status.

If one of these subsequent qualifying events occurs, a Dependent may be entitled to a second continuation period. This period will in no event continue beyond thirty-six (36) months from the date of the first qualifying event.

Only a person covered prior to the original qualifying event or a child born to or Placed for Adoption with a covered Employee during a period of COBRA continuation is eligible to continue coverage again as the result of a subsequent qualifying event. Any other Dependent acquired during continuation coverage is not eligible to continue coverage as the result of a subsequent qualifying event.

END OF CONTINUATION

Continuation of coverage under this provision will end on the earliest of the following dates:

1. Eighteen (18) months from the date continuation began because of a reduction of hours or termination of employment of the Employee.
2. Thirty-six (36) months from the date continuation began for Dependents whose coverage ended because of the death of the Employee, divorce or legal separation from the Employee, or the child's loss of Dependent status.
3. The end of the period for which contributions are paid if the Member fails to make a payment on the datespecified by the Plan Administrator.
4. The date coverage under this Plan ends and the Employer offers no other group health benefit plan.
5. The date the Member first becomes entitled to Medicare after the date of election of COBRA continuationcoverage.
6. The date the Member first becomes covered under any other group health plan after the date of election of COBRA continuation coverage.

EXTENSION FOR DISABLED INDIVIDUALS

A person who is Totally Disabled may extend continuation coverage from eighteen (18) months to twenty-nine (29) months. The person must be disabled for Social Security purposes at the time of the qualifying event or within sixty (60) days thereafter. The disabled person must submit proof of the determination of disability by the Social Security Administration to the COBRA Administrator within the initial eighteen (18) month continuation coverage period and no later than sixty (60) days after the Social Security Administration's determination. The disabled person and the family members who were covered prior to the qualifying event are eligible for up to twenty-nine (29) months of continuation of coverage. The Plan Administrator may charge 150% of the contribution during the additional eleven (11) months ofcontinuation of coverage. Extended coverage will end on the month that begins thirty (30) days after the person is nolonger considered disabled.

MILITARY MOBILIZATION

If an Employee or an Employee's Dependent is called for active duty by the United States Armed Services (including the Coast Guard), the National Guard or the Public Health Service, the Employee or the Employee's Dependent may continue their health coverage, pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA).

When the leave is less than thirty-one (31) days, the Employee or Employee's Dependent may not be required to paymore than the Employee's share, if any, applicable to that coverage. If the leave is thirty-one (31) days or more than, then the Plan Administrator may require the Employee or Employee's Dependent to pay no more than 102% of the full contribution.

The maximum length of the continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) is the lesser of:

1. Twenty-four (24) months beginning on the day that the leave commences, or
2. A period beginning on the day that the leave began and ending on the day after the Employee fails to return toemployment within the time allowed.

Whether or not the individual elects continuation of coverage under USERRA, upon return from uniformed services, the Employee or the Employee's Dependent coverage will be reinstated the date of return to work, provided the uniformed service member was released under honorable conditions, and returns to work within the following timelines:

1. Following completion of the military service for a leave of less than thirty-one (31) days, upon the first full regularly scheduled work period after the expiration of eight (8) hours after a period allowing for the save transportation of the person from the place of service to the person's residence;
2. Within fourteen (14) days of completing military services for a leave of thirty-one (31) days to one hundred eighty (180) days;
3. Within ninety (90) days of completing military service for a leave of more than one hundred eighty (180) days. The Employee or the Employee's Dependent coverage will be reinstated without exclusions or a waiting period.

GENERAL PROVISIONS

PLAN ADMINISTRATOR AND FIDUCIARY

Amy's Kitchen, Inc. shall be the Plan Administrator and named Fiduciary of this Plan and as such, has the authority to control and manage the operation and administration of the Plan. The Plan Administrator intends to continue the Plan indefinitely, but reserves the right to terminate or amend the Plan in any way. No consent of any Member or anyother person referred to in the Plan will be required to terminate, modify, amend or change the Plan. The Plan Administrator may amend any provision, condition, limitation or exclusion of the Plan. Notice will be given to all covered Employees in compliance with applicable law. No agent is authorized to modify the Plan.

ASSIGNMENT

The Plan will pay benefits under this Plan to the Employee unless payment has been assigned to a Hospital, Physician,or other provider of service furnishing the services for which benefits are provided herein. No Assignment of Benefitsshall be binding on the Plan unless the Claims Administrator is notified in writing of such assignment prior to paymenthereunder. This Plan will pay benefits to the responsible party of an Alternate Recipient as designated in a qualified medical child support order.

Participating Providers normally bill the Plan directly. If services, supplies or treatment has been received from sucha provider, benefits are automatically paid to that provider. The Member's portion of the Negotiated Rate, after the Plan's payment, will then be billed to the Member by the Participating Provider.

BENEFITS NOT TRANSFERABLE

Except as otherwise stated herein, no person other than an eligible Member is entitled to receive benefits under this Plan. Such right to benefits is not transferable.

CIRCUMSTANCES BEYOND THE CONTROL OF THE PLAN

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

CLERICAL ERROR

No clerical Error on the part of the Plan Administrator or Claims Administrator shall operate to defeat any of the rights, privileges, services, or benefits of any Employee or any Dependent(s) hereunder, nor create or continue coverage which would not otherwise validly become effective or continue in force hereunder. An equitable adjustmentof contributions and/or benefits will be made when the Error or delay is discovered. No party shall be liable for the failure of any other party to perform.

CONFORMITY WITH STATUTE(S)

Any provision of the Plan which is in conflict with statutes which are applicable to this Plan is hereby amended to conform to the minimum requirements of said statute(s).

EFFECTIVE DATE OF THE PLAN

The Effective Date of the Plan January 1, 2024.

FREE CHOICE OF HOSPITAL AND PHYSICIAN

Nothing contained in this Plan shall in any way or manner restrict or interfere with the right of any person entitled tobenefits hereunder to select a Hospital or to make a free choice of the attending Physician or Professional Provider. However, benefits will be paid in accordance with the provisions of this Plan, and the Member will have higher Out-of-Pocket expenses if the Member uses the services of a Non-Participating Provider.

INCAPACITY

If, in the opinion of the Plan Administrator, a Member for whom a claim has been made is incapable of furnishing a valid receipt of payment due him and in the absence of written evidence to the Plan of the qualification of a

guardian or personal representative for his estate, the Plan Administrator may on behalf of the Plan, at his discretion, make anyand all such payments to the provider of services or other person providing for the care and support of such person. Any payment so made will constitute a complete discharge of the Plan's obligation to the extent of such payment.

INCONTESTABILITY

All statements made by the Plan Administrator or by the Employee covered under this Plan shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this Plan or be used indefense to a claim unless they are contained in writing and signed by the Plan Administrator or by the Member, as the case may be. A statement made shall not be used in any legal contest unless a copy of the instrument containing the statement is or has been furnished to the other party to such a contest.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the benefits from the Plan prior to the expiration of sixty (60) days after all information on a claim for benefits has been filed and the appeal process has been completed in accordance with the requirements of the Plan. No such action shall be brought after the expiration of one (1) year from the exhaustion of the administrative process.

LIMITS ON LIABILITY

Liability hereunder is limited to the services and benefits specified, and the Plan Administrator shall not be liable forany obligation of the Member Incurred in excess thereof. The Plan Administrator shall not be liable for the negligence,wrongful act, or omission of any Physician, Professional Provider, Hospital, or other institution, or their employees, or any other person. The liability of the Plan shall be limited to the reasonable cost of Covered Benefits and shall notinclude any liability for suffering or general damages.

LOST DISTRIBUTEES

Any benefit payable hereunder shall be deemed forfeited if the Plan Administrator is unable to locate the Member towhom payment is due, provided, however, that such benefits shall be reinstated if a claim is made by the Member forthe forfeited benefits within the time prescribed in Claim Filing Procedure.

MEDICAID ELIGIBILITY AND ASSIGNMENT OF RIGHTS

The Plan will not take into account whether an individual is eligible for, or is currently receiving, medical assistance under a State plan for medical assistance as provided under Title XIX of the Social Security Act ("State Medicaid Plan") either in enrolling that individual as a Member or in determining or making any payment of benefits to that individual. The Plan will pay benefits with respect to such individual in accordance with any assignment of rights made by or on behalf of such individual as required under a State Medicaid plan pursuant to § 1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to such individual under a State Medicaid Plan and this Plan has a legal liability to make payments for the same services, supplies or treatment, payment under the Plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to such individual to payment for such services, supplies or treatment under the Plan.

MEMBER RIGHTS AND RESPONSIBILITIES

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

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

MISREPRESENTATION

If the Member or anyone acting on behalf of a Member makes a false statement on the application for enrollment, or withholds information with intent to deceive or affect the acceptance of the enrollment application or the risks assumed by the Plan, or otherwise misleads the Plan, the Plan shall be entitled to recover its damages, including legal fees, fromthe Member, or from any other person responsible for misleading the Plan, and from the person for whom the benefitswere provided. Any material misrepresentation on the part of the Member in making application

for coverage, or anyapplication for reclassification thereof, or for service there under shall render the coverage under this Plan null and void.

PLAN IS NOT A CONTRACT

The Plan shall not be deemed to constitute a contract between the Employer and any Employee or to be a considerationfor, or an inducement or condition of, the employment of any Employee. Nothing in the Plan shall be deemed to giveany Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to terminate the employment of any Employee at any time.

PLAN MODIFICATION AND AMENDMENT

The Plan Administrator may modify or amend the Plan from time to time at its sole discretion, and such amendments or modifications which affect Members will be communicated to the Members. Any such amendments shall be in writing, setting forth the modified provisions of the Plan, the Effective Date of the modifications, and shall be signedby the Plan Administrator's designee.

An amendment to the Plan may be retroactively effective, but shall not adversely affect the rights of Members under this Plan for Covered Benefits provided after the Effective Date of the amendment but before the amendment is adopted.

Such modification or amendment shall be duly incorporated in writing into the master copy of the Plan on file with the Plan Administrator, or a written copy thereof shall be deposited with such master copy of the Plan.

PLAN TERMINATION

The Plan Administrator reserves the right to terminate the Plan at any time. Upon termination, the rights of the Members to benefits are limited to claims Incurred up to the date of termination. Any termination of the Plan will be communicated to the Members.

Upon termination of this Plan, all claims Incurred prior to termination, but not submitted to either the Plan Administrator or Claims Administrator within three (3) months of the Effective Date of termination of this Plan, will be excluded from any benefit consideration.

PRONOUNS

All personal pronouns used in this Plan shall include either gender unless the context clearly indicates to the contrary.

RECOVERY FOR OVERPAYMENT

Whenever payments have been made from the Plan in excess of the Maximum Amount of payment necessary, the Plan will have the right to recover these excess payments. If the company makes any payment that, according to the terms of the Plan, should not have been made, the Plan may recover that incorrect payment, whether or not it was made due to the Company’s own Error, from the person or entity to whom it was made or from any other appropriateparty.

REIMBURSEMENT DUE TO SURROGACY AGREEMENT

If you enter into a Surrogacy Arrangement, you must reimburse the Plan for Services, supplies, Prescription Drugs, or other care or treatment received related to conception, Pregnancy, delivery, or postpartum care in connection with that Surrogacy Arrangement. The reimbursed amount shall not exceed the payments or other compensation you or another person are entitled to receive under the Surrogacy Arrangement.

A “Surrogacy Arrangement” is one in which you agree to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not you receive payment for being a surrogate.

A Surrogacy Arrangement does not affect your obligation to pay any and all patient responsibility amounts for these services. These amounts will be taken into account at the time of the reimbursement.

After you surrender a baby to the legal parents, the Plan is not obligated to pay for any services that the baby receives (the legal parents are financially responsible for any services that the baby receives).

As set forth above, as a condition precedent to you receiving benefits under the Plan, you automatically assign to the Plan any right to receive payments that are payable to you or any other payee under the Surrogacy Arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure the Plan’s rights, the Plan will also have a lien on those payments and on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow, trust, or other account that holds those payments) shall first be applied to satisfy the Plan’s lien.

Within 30 days after entering into a Surrogacy Arrangement, you must send written notice of the arrangement to the Plan, including all of the following information:

1. Names, addresses, and telephone numbers of all parties to the arrangement;
2. Names, addresses, and telephone numbers of any escrow agent or trustee for the arrangement;
3. Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for the services the baby (or babies) receive(s), including names, addresses, and telephone numbers for any health insurance that will cover the services that the baby (or babies) receive(s);
4. A signed copy of any contracts and other documents explaining the details of the Surrogacy Arrangement; and
5. Any other information the Plan requests in order to satisfy its rights.

You must send this information to:

Surrogacy Arrangement Coordinator
c/o Meridian Resource Company, LLC
P.O. Box 659940
San Antonio, TX 78265-9939

or

E-mail: subroacctmgr@meridianresource.com

You must complete and send the Plan all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for the Plan to determine the existence of any rights the Plan may have under this Surrogacy Arrangement and to satisfy those rights. You may not agree to waive, release, or reduce the Plan's rights without the Plan's prior, written consent.

If your estate, parent, guardian, or conservator asserts a claim against a third party or insurer based on the Surrogacy Arrangement, the estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to the Plan's liens and other rights to the same extent as if you had asserted the claim against the third party or insurer. The Plan may assign its rights to enforce its liens and/or other rights.

SECONDARY COVERAGE

Members who are eligible for secondary coverage by any other health plan are encouraged to obtain such coverage. Failure to obtain secondary coverage may result in the Member incurring costs, which are not covered by the Plan and which would otherwise be covered by the secondary coverage. The Plan will not pay for any costs which are payable by such secondary coverage when said coverage is primary, except to the extent that such costs are payable in any event by the Plan.

STATUS CHANGE

If an Employee or Dependent has a status change while covered under this Plan (i.e. Dependent to Employee, COBRAto Active) and no interruption in coverage has occurred, the Plan will provide continuance of coverage with respect to any pre-existing condition limitation, Deductible(s), Coinsurance and Maximum Benefit Amount.

STATUTE OF LIMITATIONS

Before filing a lawsuit, a Claimant must exhaust all available levels of review as described in this Plan, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one (1) year from the exhaustion of the administrative process.

TIME EFFECTIVE

The effective time with respect to any dates used in the Plan shall be 12:00 a.m. (midnight) as may be legally in effectat the address of the Plan Administrator.

WORKERS' COMPENSATION NOT AFFECTED

This Plan is not in lieu of, and does not affect any requirement for, coverage by Workers' Compensation Insurance.

Definitions

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

Accidental Injury

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

Administrative Services Agreement

The agreement between the Claims Administrator and the Employer regarding the administration of certain elements of the health care benefits of the Employer's Group Health Plan.

Ambulatory Surgery Center

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

Authorized Service(s)

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

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

Benefit Booklet

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

Benefit Period

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

Benefit Period Maximum

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

Blue Distinction Centers for Specialty Care (BDCSC)

Health care providers designated by us as a selected facility for specified medical services. A provider participating in a BDCSC network has an agreement in effect with the Claims Administrator at the time services

are rendered. BDCSC agree to accept the Maximum Allowed Amount as payment in full for covered services. An In-Network Provider is not necessarily a BDCSC.

Claims Administrator

The company the Plan Sponsor chose to administer its health benefits. Anthem Blue Cross Life and Health ("Anthem") was chosen to administer this Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after you meet your Deductible. For example, if your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is $100, your Coinsurance would be $20 after you meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the "Schedule of Benefits" for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments (except as described in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section).

Consolidated Appropriations Act of 2021

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

Controlled Substances

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

Copayment

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

Cosmetic Services

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

Covered Services

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

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

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

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

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

Covered Transplant Procedure

Please refer to the "What's Covered" section for details.

Custodial Care

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

Custodial Care includes any type of care meant to help you with activities of daily living that does not require the skill of trained medical or paramedical workers. Examples of Custodial Care include:

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,
- Changing dressings of non-infected wounds, after surgery or chronic conditions,
- Preparing meals and/or special diets,
- Feeding by utensil, tube, or gastrostomy,
- Common skin and nail care,
- Supervising medicine that you can take yourself,
- Catheter care, general colostomy or ileostomy care,
- Routine services which the Plan decides can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
- Residential care and adult day care,
- Protective and supportive care, including education,
- Rest and convalescent care.

Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as in a Hospital or Skilled Nursing Facility, or at home.

Deductible

The amount you must pay for Covered Services before benefits begin under this Plan. For example, if your Deductible is $1,000, your Plan won't cover anything until you meet the $1,000 Deductible. The Deductible may not apply to all Covered Services. Please see the "Schedule of Benefits" for details.

Dependent

A Member of the Subscriber's family who meets the rules listed in the "Eligibility and Enrollment – Adding Members" section of this Benefit Booklet and who has enrolled in the Plan. Eligible Dependents are also referred to as Members.

Designated Pharmacy Provider

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

Diabetes Equipment and Supplies

The following items for the treatment of Insulin-using diabetes or non-Insulin-using diabetes and gestational diabetes as Medically Necessary or medically appropriate:

- glucose monitors
- blood glucose testing strips
- glucose monitors designed to assist the visually impaired
- Insulin pumps and related necessary supplies
- ketone urine testing strips
- lancets and lancet puncture devices
- pen delivery systems for the administration of Insulin
- podiatric devices to prevent or treat diabetes-related complications
- Insulin syringes
- visual aids, excluding eyewear, to assist the visually impaired with proper dosing of Insulin

Diabetes Outpatient Self-Management Training Program

Training provided to a qualified Member after the initial diagnosis of diabetes in the care and management of that condition, including nutritional counseling and proper use of Diabetes Equipment and Supplies; additional training authorized on the diagnosis of a Physician or other health care practitioner of a significant change in the qualified Member's symptoms or condition that requires changes in the qualified Member's self-management regime; and periodic or episodic continuing education training when prescribed by an appropriate health care practitioner as warranted by the development of new techniques and treatments for diabetes. Diabetes Outpatient Self-Management Training must be provided by a health care practitioner or Provider who is licensed, registered or certified in California to provide appropriate health care services.

Doctor

See the definition of "Physician."

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the "What's Covered" section.

Emergency Care

Please see the "What's Covered" section.

Employee

A person who is engaged in active employment with the Employer and is eligible for Plan coverage under the employment regulations of the Employer. The Employee is also called the Subscriber.

Employer

An Employer who has allowed its Employees to participate in the Plan by acting as the Plan Sponsor or adopting the Plan as a participating Employer by executing a formal document that so provides. The Employer or other organization has an Administrative Services Agreement with the Claims Administrator to administer this Plan.

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental or Investigational (Experimental / Investigational)

Any medical, surgical and/or other procedures, services, products, Drugs or devices including implants used for research except as specifically stated under the "Clinical Trials" provision from the "What's Covered" section.

Facility

A facility including but not limited to, a Hospital, freestanding Ambulatory Surgery Center, Chemical Dependency Treatment Facility, Residential Treatment Center, Skilled Nursing Facility, or mental health facility, as defined in this Booklet. The Facility must be licensed as required by law, satisfy our accreditation requirements, and be approved by us..

Fee(s)

The amount you must pay to be covered by this Plan.

Gender Dysphoria

A formal diagnosis used by psychologists and Physicians to describe people who experience significant dysphoria (discontent) with the sex they were assigned at birth and/or the gender roles associated with that sex.

Gender Transition

The process of changing one's outward appearance, including physical sex characteristics, to accord with his or her actual gender identity.

Generally Accepted Standards of Mental Health and Substance Use Disorder Care

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

Health Plan or Plan

An Employee welfare benefit plan as defined in Section 3 (1) of ERISA, established by the Employer, in effect as of the Effective Date.

Home Health Care Agency

A Provider, licensed when required by law and approved by us, that:

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

Hospice

A Provider which provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient's Physician. It must be licensed by the appropriate agency.

Hospital

A facility licensed as a Hospital as required by law that must satisfy our accreditation requirements and be approved by us. The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial Care
- Educational care
- Subacute care

Identification Card (ID Card)

The latest card given to you showing your identification and group numbers, the type of coverage you have and the date coverage became effective

In-Network Provider

A Provider that has a contract, either directly or indirectly, with the Claims Administrator, or another organization, to give Covered Services to Members through negotiated payment arrangements. A Provider that is In-Network for one plan may not be In-Network for another. Please see "How to Find a Provider in the Network" in the section "How Your Plan Works" for more information on how to find an In-Network Provider for this Plan.

In-Network Transplant Provider

Please refer to the "What's Covered" section for details.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Intensive In-Home Behavioral Health Program

A range of therapy services provided in the home to address symptoms and behaviors that, as the result of a mental disorder or substance use disorder, put the Members and others at risk of harm.

Intensive Outpatient Program

Structured, multidisciplinary treatment for Mental Health and Substance Use Disorders that provides a combination of individual, group and family therapy to Members who require a type or frequency of treatment that is not available in a standard outpatient setting.

Investigational Procedures (Investigational)

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

- have final approval from the appropriate government regulatory body; 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.

Late Enrollees

Employees or Dependents who enroll in the Plan after the initial enrollment period. A person will not be considered a Late Enrollee if he or she enrolls during a Special Enrollment period. Please see the “Eligibility and Enrollment – Adding Members” section for further details.

Maximum Allowed Amount

The maximum payment that the Claims Administrator will allow for Covered Services. For more information, see the “Claims Payment” section.

Medical Necessity (Medically Necessary)

Medically Necessary shall mean health care services that a Physician, exercising professional clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice,
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease,
- Not primarily for the convenience of the patient, Physician or other health care Provider, and
- Not more costly than an alternative services, including no service or the same service in an alternative setting or sequence of services that is medically appropriate and is likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s injury, disease, illness or condition. For example, the Plan will not provide coverage for an inpatient admission for surgery if the surgery could

have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a hospital if the drug could be provided in a Physician's office of the home setting.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician specialty society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

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

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

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

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

Member

People, including the Subscriber and his or her Dependents, who have met the eligibility rules, applied for coverage, and enrolled in the Plan. Members are called "you" and "your" in this Benefit Booklet.

Mental Health and Substance Use Disorder

A Mental Health Condition or Substance Use Disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of Mental Health and Substance Use Disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this Plan as long as a condition is commonly understood to be a mental health condition or substance use disorder by health care Providers practicing in relevant clinical specialties.

Open Enrollment

A period of time in which eligible people or their dependents can enroll without penalty after the initial enrollment. See the "Eligibility and Enrollment – Adding Members" section for more details.

Out-of-Network Provider

A Provider that does *not* have an agreement or contract with us, or our subcontractor(s), to give services to our Members under this Plan.

You will often get a lower level of benefits when you use Out-of-Network Providers. (**Note**: if you receive services from an In-Network Facility at which, or as a result of which, you receive non-Emergency Covered Services provided by an Out-of-Network Provider, you will pay the Out-of-Network Provider no more than the same cost sharing that you would pay for the same Covered Services received from an In-Network Provider. Please see "Member Cost Share" in the "Claims Payment" section for more information.)

Out-of-Network Transplant Provider

Please refer to the “What’s Covered” section for details.

Out-of-Pocket Limit

The most you pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket limit does not include your Fees, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn’t cover. Please see the “Schedule of Benefits” for details.

Partial Hospitalization Program

Structured, multidisciplinary treatment for Mental Health and Substance Use Disorders, including nursing care and active individual, group and family treatment for Members who require more care than is available in an Intensive Outpatient Program.

Pharmacy and Therapeutics (P&T) Process

A process to make clinically based recommendations that will help you access quality, low cost medicines within your Plan. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Pharmacy Benefits Manager (PBM)

A Pharmacy benefits management company that manages Pharmacy benefit on our behalf. Our PBM has a nationwide network of Retail Pharmacies, a Home Delivery Pharmacy, and clinical services that include Prescription Drug List management.

The management and other services the PBM provides include, but are not limited to: managing a network of Retail Pharmacies and operating a mail service Pharmacy. Our PBM, in consultation with us, also provides services to promote and assist Members in the appropriate use of Pharmacy benefits, such as review for possible excessive use, proper dosage, drug interactions or drug/pregnancy concerns.

Physician (Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery,
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.,
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor;
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and
- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.

Optometrists, Clinical Psychologists (PhD), and surgical chiropodists are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Plan

The arrangement chosen by the Plan Sponsor to fund and provide for delivery of the Employer's health benefits.

Plan administrator

The person or entity named by the Plan Sponsor to manage the Plan and answer questions about Plan details. ***The Plan Administrator is not the Claims Administrator.***

Plan Sponsor

The legal entity that has adopted the Plan and has authority regarding its operation, amendment and termination. ***The Plan Sponsor is not the Claims Administrator.***

Precertification

Please see the section "Getting Approval for Benefits" for details.

Primary Care Physician ("PCP")

A Physician who gives or directs health care services for you. The Physician may work in family/general practice, internal medicine, pediatrics, geriatrics or any other practice allowed by the Plan.

Primary Care Provider

A Physician, nurse practitioner, clinical nurse specialist, physician assistant, or any other Provider licensed by law and allowed under the Plan, who gives, directs, or helps you get a range of health care services.

Provider

A professional or Facility licensed when required by law that gives health care services within the scope of that license, must satisfy our accreditation requirements and be approved by us on behalf of the Employer. Details on our accreditation requirements can be found at [https://www.anthem.com/provider/credentialing/]. This includes any Provider that state law says must be covered under the Plan when they give you Covered Services. Providers that deliver Covered Services are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.

Psychiatric Emergency Medical Condition

A mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

- An immediate danger to himself or herself or to others.
- Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

Qualifying Payment Amount

The median Plan In-Network contract rate we pay In-Network Providers for the geographic area where the service is provided for the same or similar services.

Recognized Amount

For Surprise Billing Claims, the Recognized Amount is calculated as follows:

- For Air Ambulance services, the Recognized Amount is equal to the lesser of the Qualifying Payment Amount as determined under applicable law (generally, the median Plan In-Network contract rate we pay In-Network Providers for the geographic area where the service is provided for the same or similar services) or the amount billed by the Out-of-Network Air Ambulance service provider.
- For all other Surprise Billing Claims, the Recognized Amount is the lesser of the Qualifying Payment Amount or the amount billed by the Out-of-Network Provider or Out-of-Network Facility; or the amount approved under an applicable All-Payer Model Agreement under section 1115A of the Social Security Act.

Recovery

Please see the "Subrogation and Reimbursement" section for details.

Referral

Please see the "How Your Plan Works" section for details.

Residential Treatment Center(s)

An Inpatient Facility that provides multidisciplinary treatment for Mental Health and Substance Use Disorder conditions. The Facility must be licensed as a residential treatment center in the state in which it is located, satisfy our accreditation requirements and be approved by us.

The term Residential Treatment Center/Facility does not include a Provider, or that part of a Provider, used mainly for:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial Care
- Educational care

Service Area

The geographical area where you can get Covered Services from an In-Network Provider and the Claims Administrator is approved to arrange healthcare services consistent with network adequacy requirements.

Skilled Nursing Facility

An Inpatient Facility that provides multidisciplinary treatment for convalescent and rehabilitative care. It must be licensed as a skilled nursing facility in the state in which it is located that must satisfy our accreditation requirements and be approved by us.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, or a place for rest, educational, or similar services.

Special Enrollment

A period of time in which eligible people or their dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc. See the "Eligibility and Enrollment – Adding Members" section for more details.

Specialist (Specialty Care Physician \ Provider or SCP)

A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Specialty Drugs

Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

Subscriber

A person who is engaged in active employment with the Employer (the Employee) and is eligible for Plan coverage under the employment regulations of the Employer.

Surprise Billing Claim

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

Total Disability (or Totally Disabled)

A person who is unable because of the disability to engage in any occupation to which he or she is suited by reason of training or experience, and is not in fact employed.

Transplant Benefit Period

Please see the “What’s Covered” section for details.

Urgent Care Center

A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent care.

Utilization Review

Evaluation of the necessity, quality, effectiveness, or efficiency of medical or behavioral health services, Prescription Drugs (as set forth in the section Prescription Drugs Administered by a Medical Provider), procedures, and/or facilities.

Claims Disclosure Notice Required by ERISA

The plan document and this Booklet entitled "Benefit Booklet," contain information on reporting claims, including the time limitations on submitting a claim. Claim forms may be obtained from the Plan Administrator or from the Claims Administrator. (Note that the Claims Administrator is not the Plan Administrator nor the administrator for the purposes of ERISA.) In addition to this information, ERISA applies some additional claim procedure rules. The addition rules required by ERISA are set forth below.

Urgent Care. The Claims Administrator must notify you, within 72 hours after they receive your request for benefits, that they have it and what they determine your benefits to be. If your request for benefits does not contain all the necessary information, they must notify you within 24 hours after they get it and tell you what information is missing. Any notice to you by them will be orally, by telephone, or in writing by facsimile or other fast means. You have at least 48 hours to give them the additional information they need to process your request for benefits. You may give them the additional information they need orally, by telephone, or in writing by facsimile or other fast means.

If your request for benefits is denied in whole or in part, you will receive a notice of the denial within 72 hours after the Claims Administrator's receipt of the request for benefits, or 48 hours after receipt of all the information they need to process your request for benefits if the information is received within the time frame noted above. The notice will explain the reason for the adverse benefit determination and the plan provisions upon which the denial decision was based. You have 180 days to appeal their adverse benefit determination. You may appeal their decision orally, by telephone, or in writing by facsimile or other fast means. Within 72 hours after they receive your appeal, they must notify you of their decision, except as otherwise noted below. They will notify you orally, by telephone, or in writing by facsimile or other fast means. If your request for benefits is no longer considered urgent, it will be handled in the same manner as a Non-Urgent Care Pre-Service or Post-service appeal, depending upon the circumstances.

Non-Urgent Care Pre-Service (when care has not yet been received). The Claims Administrator must notify you within 15 days after they receive your request for benefits that they have it and what they have determined your benefits to be. If they need more than 15 days to determine your benefits, due to reasons beyond their control, they must notify you within that 15-day period that they need more time to determine your benefits. But, in any case, even with an extension, they cannot take more than 30 days to determine your benefits. If you do not properly submit all the necessary information for your request for benefits to them, they must notify you, within 5 days after they get it and tell you what information is missing. You have 45 days to provide them with the information they need to process your request for benefits. The time period during which the Claims Administrator is waiting for receipt of the necessary information is not counted toward the time frame in which the Claims Administrator must make the benefit determination.

If your request for benefits is denied in whole or in part, you will receive a written notice of the denial within the time frame stated above after the Claims Administrator has all the information they need to process your request for benefits, if the information is received within the time frame noted above. The written notice will explain the reason for the adverse benefit determination and the plan provisions upon which the denial decision is based. You have 180 days to appeal their adverse benefit determination. Your appeal must be in writing. Within 30 days after they receive your appeal, they must notify you of their decision about it. Their notice of their decision will be in writing.

Concurrent Care Decisions:

- **Reduction of Benefits –** If, after approving a request for benefits in connection with your illness or injury, the Claims Administrator decides to reduce or end the benefits they have approved for you, in whole or in part:

  - They must notify you sufficiently in advance of the reduction in benefits, or the end of benefits, to allow you the opportunity to appeal their decision before the reduction in benefits or end of benefits occurs. In

their notice to you, the Claims Administrator must explain their reason for reducing or ending your benefits and the plan provisions upon which the decision was made.

- To keep the benefits you already have approved, you must successfully appeal the Claims Administrator's decision to reduce or end those benefits. You must make your appeal to them at least 24 hours prior to the occurrence of the reduction or ending of benefits. If you appeal the decision to reduce or end your benefits when there is less than 24 hours to the occurrence of the reduction or ending of benefits, your appeal may be treated as if you were appealing an urgent care denial of benefits (see the section "Urgent Care," above), depending upon the circumstances of your condition.

- If the Claims Administrator receives your appeal for benefits at least 24 hours prior to the occurrence of the reduction or ending of benefits, they must notify you of their decision regarding your appeal within 24 hours of their receipt of it. If the Claims Administrator denies your appeal of their decision to reduce or end your benefits, in whole or in part, they must explain the reason for their denial of benefits and the plan provisions upon which the decision was made. You may further appeal the denial of benefits according to the rules for appeal of an urgent care denial of benefits (see the section "Urgent Care," above).

- **Extension of Benefits –** If, while you are undergoing a course of treatment in connection with your illness or injury, for which benefits have been approved, you would like to request an extension of benefits for additional treatments:

  - You must make a request to the Claims Administrator for the additional benefits at least 24 hours prior to the end of the initial course of treatment that had been previously approved for benefits. If you request additional benefits when there is less than 24 hours till the end of the initially prescribed course of treatment, your request will be handled as if it was a new request for benefits and not an extension and, depending on the circumstances, it may be handled as an Urgent or Non-Urgent Care Pre-service request for benefits.

  - If the Claims Administrator receives your request for additional benefits at least 24 hours prior to the end of the initial course of treatment, previously approved for benefits, they must notify you of their decision regarding your request within 24 hours of their receipt of it if your request is for urgent care benefits. If the Claims Administrator denies your request for additional benefits, in whole or in part, they must explain the reason for their denial of benefits and the plan provisions upon which the decision was made. You may appeal the adverse benefit determination according to the rules for appeal for Urgent, Pre-Service or Post-Service adverse benefit determinations, depending upon the circumstances.

Non - Urgent Care Post-Service (reimbursement for cost of medical care). The Claims Administrator must notify you, within 30 days after they receive your claim for benefits, that they have it and what they determine your benefits to be. If they need more than 30 days to determine your benefits, due to reasons beyond their control, they must notify you within that 30-day period that they need more time to determine your benefits. But, in any case, even with an extension, they cannot take more than 45 days to determine your benefits. If you do not submit all the necessary information for your claim to them, they must notify you, within 30 days after they get it and tell you what information is missing. You have 45 days to provide them with the information they need to process your claim. The time period during which the Claims Administrator is waiting for receipt of the necessary information is not counted toward the time frame in which the Claims Administrator must make the benefit determination.

If your claim is denied in whole or in part, you will receive a written notice of the adverse benefit determination within the time frame stated above, or after the Claims Administrator has all the information they need to process your claim, if the information is received within the time frame noted above. The written notice will explain the reason for the adverse benefit determination and the plan provisions upon which the denial decision is based. You have 180 days to appeal their decision. Your appeal must be in writing. Within 60 days after they receive your appeal, they must notify you of their decision about it. Their notice to you or their decision will be in writing.

Note: You, your beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits with the Claims Administrator and request a review of the denial. In connection with such a request:

- Documents pertinent to the administration of the Plan may be reviewed free of charge; and
- Issues outlining the basis of the appeal may be submitted.

You may have representation throughout the appeal and review procedure.

For the purposes of this provision, the meanings of the terms “urgent care,” “Non-Urgent Care Pre-Service,” and “Non - Urgent Care Post-Service,” used in this provision, have the meanings set forth by ERISA for a “claim involving urgent care,” “pre-service claim,” and “post-service claim,” respectively.

THE WHOLE YOU ANNUAL EXAM WELLNESS PROGRAM

Employer shall credit, in each Benefit Period, the amount equivalent to the individual Deductible or the amount equivalent to the family unit Deductible (for any other tier greater than Employee only), as elected under the Amy's Kitchen, Inc. Medical Plan, on behalf of each Employee and any participating spouse or domestic partner when the Employee and participating spouse or domestic partner satisfy the following under the Whole You Annual Exam Wellness Program requirements:

1. Obtain an annual exam, and;
2. Basic metabolic blood panel

For purposes of this section, the Employer shall provide Deductible credit accordingly:

1. Employee completes (1) and (2) above; Spouse or domestic partner does not: Employer credits the amount equivalent to the individual Deductible.
2. Spouse or domestic partner completes (1) and (2) above; Employee does not: Employer credits the amount equivalent to the individual Deductible.
3. Employee completes (1) and (2) above; Dependent children participate in the Plan; Spouse or domestic partner does not: Employer credits the amount equivalent to the family unit Deductible. (Children are not required to obtain an exam or blood panel).
4. Employee and spouse or domestic partner complete (1) and (2) above; Employer credits the amount equivalent to the family unit Deductible.

For Employees hired on or prior to August 31, the Employer shall credit for that Benefit Period, the amount equivalent to the individual Deductible or equivalent to the family unit Deductible (any other tier greater than Employee only) on behalf of each Employee and any participating spouse or domestic partner automatically, without applying the Wellness Program requirements set forth above. For the following Benefit Period, Employees (and any spouse or domestic partner, if applicable,) will need to satisfy the Wellness Program requirements set forth above to obtain the Deductible credit for the subsequent Benefit Period.

For Employees hired after August 31, the Employer shall credit for that Benefit Period and the subsequent Benefit Period the amount equivalent to the individual Deductible or equivalent to the family unit Deductible (any other tier greater than Employee only) on behalf of each Employee and any participating spouse or domestic partner automatically, without applying the Wellness Program requirements set forth above.

For Employees and/or Dependents that were not enrolled in the Plan during the preceding Benefit Period, and have enrolled in the Plan as of January 1 of the current Benefit Period, the Employer shall credit for that Benefit Period the amount equivalent to the individual Deductible or equivalent to the family unit Deductible (any other tier greater than Employee only) on behalf of each Employee and any participating spouse or domestic partner automatically, without applying the Wellness Program requirements set forth above. For the following Benefit Period, Employees (and any spouse or domestic partner, if applicable,) will need to satisfy the Wellness Program requirements set forth above to obtain the Deductible credit for the subsequent Benefit Period.

Hinge Health SPD Language (For DMC)

Hinge Health Overview

Hinge Health is available effective June 1, 2022. Through the Hinge Health Digital Musculoskeletal (MSK) Clinic, participants have access to personalized MSK care programs depending on their specific MSK needs. Participants will register online through the Hinge Health website or app, complete a clinically validated screener to determine which program best fits their MSK needs. The programs include:

(a) Prevention - Program designed to increase education with regards to key strengthening and stretching activities around healthy habits. The Prevention program is software based and offered through the Hinge Health app.
(b) Chronic - Program designed to address long term back and joint pain which includes personalized app-guided exercise therapy sessions, 1:1 access to a personalized health coach, personalized education content, and behavioral health support. Participants in the chronic program may also be offered access to virtual sessions with a licensed Physical Therapist and/or the non-invasive ENSO High Frequency Impulse Therapy™ pain management device and service, as appropriate, for symptomatic relief.
(c) Acute - Program designed to address recent injuries which includes live virtual sessions with a dedicated licensed Physical Therapist along with software guided rehabilitation and education.
(d) Surgery - Program designed to address pre/post surgery rehab for the most common MSK Surgeries which includes personalized app-guided exercise therapy sessions, 1:1 access to a personalized health coach and physical therapist, personalized education content, and behavioral health support.
(e) Expert Medical Opinion - Service offering second opinions for elective MSK procedures.

For applicable programs a participant may obtain up to six virtual physical therapy sessions per episode prior to in-person healthcare provider or physical therapy care (additionally, other statelaws may limit access without a physician's referral).

Eligibility

To be eligible for the Hinge Health programs, you, and your eligible dependents must meet each of the following requirements: (i) be enrolled in Anthem Medical plan, (ii) be age 18 or older (iii) be located in the United States, and (iiii) be approved through the clinical suitability evaluation performed by Hinge Health prior to enrollment.

Cost

If you are eligible, Hinge Health is offered at no cost to you.

Hinge Health Contact Information

To get started with Hinge Health, visit hingehealth.com/amys1 to enroll.

If you have any questions regarding Hinge Health, email help@hingehealth.com or call (855) 902-2777.

PRESCRIPTION DRUG BENEFIT SCHEDULE

Your prescription drug coverage and network are provided through CVS Caremark.

PHARMACY PROVISIONS		
Annual Pharmacy Deductible	$0	
Annual Pharmacy Out-of-Pocket Maximum	$2,000 per Member	
	PARTICIPATING PHARMACIES	**NON-PARTICIPATING PHARMACIES**
Pharmacy Retail Option - 30 Day Supply	**Member Pays**	
Generic Drugs/Certain Brand Name Drugs	$10 Copayment/drug	$20 Copayment/drug
Preferred Brand Name Drugs	$20 Copayment/drug	$40 Copayment/drug
Non-Preferred Brand Name Drugs	$40 Copayment/drug	$80 Copayment/drug
Specialty Drugs	No cost when you enroll in the PrudentRx Copay Program. **If you do not enroll in the program, you will pay 30% of the cost of the medication.**	

PrudentRx Copay Program for Specialty Medications

The PrudentRx Copay Program assists Members by helping them enroll in manufacturer copay assistance programs. If you or a covered family member are not currently taking, but will start taking, a new medication covered under the PrudentRx Copay Program, you can reach out to PrudentRx, or they will proactively contact you so that you can take full advantage of the PrudentRx program. PrudentRx can be reached at 1-800-578-4403.

To view the PrudentRx program list, visit the Amy's benefits website at benefits.filice.come/amys. You can also request a list by contacting the Amy's Benefits Help Desk at (541) 414-6131 or at employeehelp@amys.com

Pharmacy Retail or Mail Order Option - 90 Day Supply (Maintenance Medication Only)		
Generic Drugs/Certain Brand Name Drugs	$20 Copayment/drug	Not Covered
Preferred Brand Name Drugs	$40 Copayment/drug	Not Covered
Non-Preferred Brand Name Drugs	$80 Copayment/drug	Not Covered

Dispensed-As-Written (DAW) Penalties: Applied when multi-source brand (MSB) medications are chosen over generic equivalents. This Plan implements DAW 1 and DAW 2 penalties.

- DAW 1: Physician prescribes multi-source brand drug over generic drug
- DAW 2: Covered Person requests multi-source brand drug over generic drug

When DAW penalties apply, the Covered Person will pay:

- Usual copay and;
- The difference between the cost of the multi-source brand name drug and the cost of the generic drug.

The Prescriber may complete a written request for Covered Person to receive the prescribed multi-source brand name medication instead of a generic alternative. The Prescriber's written request must show clinical necessity for the brand name medication. DAW penalty will be waived if the written request is approved and the Covered Person will pay only the brand copayment. The appropriate request form can be obtained directly from CVS Pharmacy or the Plan Administrator.

Health Center Prescription Drug Option *Applies when prescription is written by an Amy's Family Health Center Provider.*	**Participating Pharmacies Only**
Pharmacy Retail - 30 Day Supply	**Member Pays**
Generic Drugs/Certain Brand Name Drugs	$5 Copayment/drug
Preferred Brand Name Drugs	$10 Copayment/drug
Non-Preferred Brand Name Drugs	$20 Copayment/drug
Pharmacy Retail/Mail Order - 90 Day Supply (Maintenance Medication Only)	
Generic Drugs/Certain Brand Name Drugs	$10 Copayment/drug
Preferred Brand Name Drugs	$20 Copayment/drug
Non-Preferred Brand Name Drugs	$40 Copayment/drug

Maintenance Prescription Drug Program (Generic mandated when available)	**Participating Pharmacies**	**Non-Participating Pharmacies**
Diabetes	**Member Pays**	
Metformin Basaglar Tresiba Novolog Amaryl (glimepiride) Glyburide Glipizide/Glucotrol	$5 Copayment/drug	Not Covered

Hypertension		
Lisinopril Atenolol Carvedilol Metoprolol Amlodipine Doxazosin Chlorthalidone Candseartan Losartan Losartan-Hydrochlorothiazide Furosemide/Lasix Diltiazem Verapamil Enalapril	$5 Copayment/drug	Not Covered
Cholesterol		
Simvastatin Lovastatin Pravastatin Lipitor (atorvastatin) Rosuvastatin	$5 Copayment/drug	Not Covered
Asthma		
ProAir (albuterol) Advair (fluticasone/salmeterol) Budesonide/formoterol Flovent (fluicasone diskus) Qvar (beclomethasone) Montelukast Sodium	$5 Copayment/drug	Not Covered
Behavioral Health		
Citalopram Sertraline Escitalopram/Lexapro Venlafaxine (Standard and XR) Bupropion (Standard, IR and XR) Trazodone	$5 Copayment/drug	Not Covered
This summary provides a condensed explanation of Plan benefits. Certain limitation, restrictions and exclusions may apply. Please refer to the Prescription Drug Program section for complete information on benefits.		

PRESCRIPTION DRUG PROGRAM

There are three (3) aspects of the Prescription Drug Program for Preventive Prescription Services and Non-Preventive Prescription Services.

RETAIL OPTION

Participating pharmacies have contracted with the Plan to charge Members reduced fees for covered prescription drugs.

The Copayment is applied to each covered pharmacy drug charge and is shown on the Schedule of Benefits. The Copayment amount is not a Covered Benefit under the Medical Expense Benefit. Any one prescription is limited to a thirty (30) day supply. Maintenance drugs (drugs which are prescribed for long-term usage) may be dispensed in a ninety (90) day supply.

If a drug is purchased from a Participating Pharmacy or a Non-Participating Pharmacy when the Member's ID card is not used, the Member must pay the entire cost of the prescription, including Copayment, and then submit the receipt to the prescription drug card vendor for reimbursement. If the Plan covers services from nonparticipating pharmacies and a Non-Participating Pharmacy is used, the Member will be responsible for the Copayment, plus the difference in cost between what the Plan would have paid to a Participating Pharmacy less the Program's Copayment and the cost the Member Incurred at the Non-Participating Pharmacy, including the Program's Copayment. Please review the Prescription Drug Benefit Schedule to determine if services by a Non-Participating Pharmacy are covered or not covered.

DISPENSE AS WRITTEN (DAW) PENALTY

If you or your doctor requests a brand-name medicine when a generic alternative is available, your prescription cost will be higher.

The Dispense As Written (DAW) Penalty is the amount you pay for a brand name drug when a Generic Drug is available. In these instances, you will pay the difference between the brand name drug and the Generic Drug plus the appropriate Copayment (depending on whether the prescription is a Preferred Brand drug or Non-Preferred Brand Drug. See the Prescription Drug Benefits Schedule for additional information.

If the Member purchases a brand name drug when a Generic Drug equivalent is available, the Dispense As Written (DAW) Penalty will be applied and the Member will be required to pay the brand name Copayment, plus the difference between generic and brand name; unless the Physician has issued a DAW.

MAIL ORDER OPTION

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, cholesterol, etc.).

The Copayment is applied to each covered mail order prescription charge and is shown on the Schedule of Benefits. The Copayment is not a Covered Benefit under the Medical Expense Benefit. Any one prescription is limited to a ninety (90) day supply.

PRUDENTRX COPAYMENT PROGRAM FOR SPECIALTY MEDICATIONS

In order to provide a comprehensive and cost-effective prescription drug program for you and your family, Amy's Kitchen, Inc. Medical Plan has contracted with PrudentRx to offer the PrudentRx Copay Program for certain specialty medications. The PrudentRx Copay Program assists Members by helping them enroll in manufacturer Copayment assistance programs. Medications in the specialty tier will be subject to a 30% Coinsurance. However, enrolled Members who get a Copayment card for their specialty medication (if applicable), will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Copay Program.

Copayment assistance is a process in which drug manufacturers provide financial support to Members by covering all or most of the Member cost share for select medications - in particular, specialty medications. The PrudentRx Copay Program will assist Members in obtaining Copayment assistance from drug manufacturers to reduce a Member's cost share for eligible medications thereby reducing out-of-pocket expenses. Participation in the program requires certain data to be shared with the administrators of these Copayment assistance programs, but please be assured that this is done in compliance with HIPAA.

If you currently take one or more medications included in the PrudentRx Program Drug List, you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program as it pertains to your medication. All eligible Members will be automatically enrolled in the PrudentRx program, but you can choose to opt out of the program. You must call 1-800-578-4403 to opt-out. Some manufacturers require you to sign up to take advantage of the Copayment assistance that they provide for their medications – in that case, you must speak to someone at PrudentRx at 1-800-578-4403 to provide any additional information needed to enroll in the copayment program. PrudentRx will also contact you if you are required to enroll in the Copayment assistance for any medication that you take. If you do not return their call, choose to opt-out of the program, or if you do not affirmatively enroll in any Copayment assistance as required by a manufacturer you will be responsible for the full amount of the 30% Coinsurance on specialty medications that are eligible for the PrudentRx program.

If you or a covered family member are not currently taking, but will start a new medication covered under the PrudentRx Copay Program, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx program. PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Copay Program.

The PrudentRx Program Drug List may be updated periodically by the Plan.

Copayments for these medications, whether made by you, your Plan, or a manufacturer's copay assistance program, will not count toward your Plan Deductible.

Because certain specialty medications do not qualify as "essential health benefits" under the Affordable Care Act, Member cost share payments for these medications, whether made by you or a manufacturer copayment assistance program, do not count towards the Plan's Maximum Out-of-Pocket Amount. A list of specialty medications that are not considered to be "essential health benefits" is available. An exception process is available for determining whether a medication that is not an essential health benefit is Medically Necessary for a particular individual.

PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Copay Program.

The Specialty Pharmacy Program is available for select specialty drugs including select injectable and oral medications used in certain branches of medicine or for certain medical conditions, as follows:

1. Allergic Asthma
2. Crohn's Disease
3. Enzyme replacement for Lysosomal Storage Disorder
4. Gaucher's Disease
5. Growth hormone disorders
6. Hematopoietics
7. Hemophilia, Von Willebrand disease and related bleeding disorders
8. Hepatitis C
9. Hormonal therapies
10. Immune deficiencies
11. Multiple Sclerosis
12. Oncology
13. Osteoarthritis
14. Psoriasis
15. Pulmonary Arterial Hypertension
16. Pulmonary disease
17. Renal disease
18. Respiratory Syncytial Virus
19. Rheumatoid Arthritis
20. Other Disorders

To take advantage of this program, the covered Member will need to transfer the related prescription to Caremark. To transfer a prescription, call (800) 237-2767. A representative of Caremark will call the covered Members Physician and take care of the appropriate paperwork.

The medication will be shipped to a location of the covered Members choice from the Caremark specialty pharmacy. For details regarding the applicable Copayment and supply limitations, please refer to the Prescription Drug Benefit Schedule, Prescription Drug Program, Pharmacy Option and Mail Order Option.

MAINTENANCE PRESCRIPTION DRUG PROGRAM

The Maintenance Prescription Drug Program option is available for certain maintenance medications that may be prescribed for diabetes, high blood pressure, behavioral health or asthma. Covered Members should refer to the section, Schedule of Benefits, Maintenance Prescription Drug Program for a listing of eligible drugs and applicable Copayments.

COVERED PRESCRIPTION DRUGS

The following drugs and items are covered under the Prescription Drug Program when they are prescribed by an appropriately licensed practitioner:

1. All drugs prescribed by a Physician that require a prescription either by federal or state law, including injectables and insulin, except drugs excluded by the Plan.

2. All compounded prescriptions containing at least one prescription ingredient with a therapeutic quantity.

3. Insulin, insulin needles and syringes and diabetic supplies, including blood sugar measurement devices.

4. Drugs used in the treatment of erectile dysfunction.

5. Drugs used in the treatment of infertility, subject to the limitation specified on the Schedule of Benefits.

6. Growth hormones.

7. Anorexiants.

8. Any other drug which, under the applicable state law, may be dispensed only upon the written prescription of a qualified prescriber.

ROUTINE PREVENTIVE DRUGS

Covered Expenses shall include the following preventive therapy drugs recommended by the United States Preventive Services Task Force (USPSTF):

1. Generic prescription or over-the-counter aspiring to prevent cardiovascular disease (CVD) for Members age forty-five (45) and older when the potential benefit of a reduction in myocardial infarction or ischemic stroke outweighs the potential harm of an increase in gastrointestinal hemorrhage.

2. Generic or brand prescription, or over-the-counter iron supplements for asymptomatic children age twelve
(12) months and younger who are at increased risk for iron deficiency anemia.

3. Generic or brand prescription for oral fluoride supplements at currently recommended doses to preschool children age six (6) years and younger whose primary water source is deficient in fluoride.

4. Generic or brand prescription, or over-the-counter folic acid supplements for all women age fifty-five (55) and younger planning and capable of Pregnancy.

5. Generic prescription nicotine replacement products (nicotine patch, gum and lozenges) and treatment with generic Zyban or Chantix for Members who use tobacco products. Benefits include prescription and overthe-counter tobacco cessation products.

6. The full range of FDA-approved prescription contraceptive methods for covered women, including oral contraceptives, emergency contraceptives, injectable contraceptives, intrauterine devices, subdermal rods, vaginal rings, transdermal patches, and barrier methods (diaphragms and cervical caps). Benefits are limited to Generic Drug products. If no generic is available, Covered Expenses shall include single sourced brand name drugs and products.

Covered Expenses for routine preventive drugs shall be payable as specified in the Schedule of Benefits. Routine preventive drugs that may be legally purchased over-the-counter must have a written prescription from the Physician in order to e be a Covered Expense under this benefit.

LIMITS TO THIS BENEFIT

This benefit applies only when a Member incurs a covered prescription drug charge. The covered drug charge for any one prescription will be limited to:

1. Refills only up to the number of times specified by a Physician.

2. Refills up to one year from the date of order by a Physician.

PRESCRIPTION DRUG EXCLUSIONS

The following items are excluded from coverage in the Prescription Drug Program

1. A drug or medicine that can legally be purchased without a written prescription. This does not apply to injectable insulin.

2. Devices of any type, even though such devices may require a prescription. These include, but are not limited to: therapeutic devices, artificial appliances, braces, support garments, or any similar device.

3. Immunization agents or biological sera, blood or blood plasma.

4. A drug or medicine labeled: “Caution - limited by federal law to investigational use.”

5. Experimental drugs and medicines, even though a charge is made to the Member.

6. Any charge for the administration of a covered prescription drug.

7. Any drug or medicine that is consumed or administered at the place where it is dispensed.

8. A drug or medicine that is to be taken by the Member, in whole or in part, while Hospital confined. This includes being confined in any institution that has a Facility for dispensing drugs.

9. A charge for prescription drugs which may be properly received without charge under local, state or federal programs.

10. A charge for minerals.

11. A charge for medications that is cosmetic in nature (i.e. treating hair loss, wrinkles, etc.).

12. A charge for Hematinics.

13. A charge for non-legend drugs, other than as specifically listed herein.

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

A Member may designate another individual to be an Authorized Representative and act on his or her behalf and communicate with the Plan with respect to a specific benefit claim or appeal of a denial. This authorization must be in writing, signed and dated by the Member, and include all the information required in the Authorized Representative form. The appropriate form can be obtained from the Plan Administrator or the Claims Administrator.

Should a Member designate an Authorized Representative, all future communications from the Plan will be conducted with the Authorized Representative instead of the Member, unless the Plan Administrator is otherwise notified in writing by the Member. A Member can revoke the Authorized Representative designation at any time. A Member may authorize only one person as an Authorized Representative at a time.

Recognition as an Authorized Representative is completely separate from a Provider accepting an Assignment of Benefits, requiring a release of information, or requesting completion a similar form. An Assignment of Benefits by a Member shall not be recognized as a designation of the Provider as an Authorized Representative.

APPEALING A DENIED POST-SERVICE PRESCRIPTION DRUG CLAIM

The "named fiduciary" for purposes of an appeal of a denied Post-Service Prescription Drug Claim, as described in U.S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the Claims Administrator.

A covered Member or the covered Members authorized representative may request a review of a denied claim by making a written request to a named fiduciary within one hundred eighty (180) calendar days from receipt of notification of the denial and stating the reasons the covered Member feels the claim should not have been denied.

The following describes the review process and rights of the covered Member:

1. The covered Member has the right to submit documents, information and comments and to present evidence and testimony.

2. The covered Member has the right to access, free of charge, relevant information to the claim for benefits.

3. The appeal should be addressed to:

   Prescription Claim Appeals MC 109
   P.O. Box 52084
   Phoenix, AZ 85072-2084

4. Before a final determination on appeal is rendered, the covered Member will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the Plan in connection with the claim. Such information will be provided as soon as possible and sufficiently in advance of the notice of final internal determination to give the covered Member a reasonable opportunity to respond prior to that date.

5. The review takes into account all information submitted by the covered Member, even if it was not considered in the initial benefit determination.

6. The review by a named fiduciary will not afford deference to the original denial.

7. The named fiduciary will not be:

   a. The individual who originally denied the claim, nor
   b. Subordinate of the individual who originally denied the claim.

8. If original denial was, in whole or in part, based on medical judgment:

   a. The named fiduciary will consult with a Professional Provider who has appropriate training and experience in the field involving the medical judgment; and
   b. The Professional Provider utilized by the named fiduciary will be neither:

      i. An individual who was consulted in connection with the original denial of the claim, nor
      ii. A subordinate of any other Professional Provider who was consulted in connection with the original denial.

9. If requested, the named fiduciary will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

NOTICE OF BENEFIT DETERMINATION ON A POST-SERVICE PRESCRIPTION DRUG APPEAL

The Plan Administrator (or its designee) shall provide the covered Member (or authorized representative) with written Notice of the appeal decision within sixty (60) calendar days of receipt of a written request for the appeal.

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the Decision, including:

1. The specific reasons for the denial.

2. Reference to specific Plan provisions on which the denial is based.

3. A statement that the covered Member has the right to access, free of charge, relevant information to the claim for benefits.

4. A statement of the covered Members right to request an external review and a description of the process for requesting such a review.

5. A statement that if the covered Members appeal is denied, the Member has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.

6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:

    a. A copy of that criterion, or
    b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.

7. If the denial was based on medical necessity, Experimental/Investigational treatment or similar exclusion or limit, the Plan Administrator (or its designee) will supply either:

    a. An explanation of the scientific or clinical judgment, applying the terms of the Plan to the claimant's medical circumstances, or
    b. A statement that such explanation will be supplied free of charge, upon request.

EXTERNAL APPEAL

The covered Member (or authorized representative) may request a review of a denied appeal (if the claim determination involves medical judgment or a rescission) by making written request to the named fiduciary within four (4) months of receipt of notification of the final internal denial of benefits. Medical judgment includes, but is not limited to:

1. Medical necessity;
2. Appropriateness;
3. Experimental or Investigational treatment;
4. Health care setting;
5. Level of care; and
6. Effectiveness of a Covered Expense.

If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be made by the first day of the fifth month following the receipt of the notice of final internal denial of benefits. Note: If the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1, or the next day if March 1st falls on a Saturday, Sunday or Federal holiday. The Plan may charge a filing fee to the Member requesting an external review, subject to applicable laws and regulations.

RIGHT TO EXTERNAL APPEAL

Within five (5) business days of receipt of the request, the Claims Administrator will perform a preliminary review of the request to determine if the request is eligible for external review, based on confirmation that the final internal denial was the result of:

1. Medical judgment; or
2. Rescission of coverage under this Plan.

NOTICE OF RIGHT TO EXTERNAL APPEAL

The Plan Administrator (or its designee) shall provide the covered Member (or authorized representative) with a written notice of the decision as to whether the claim is eligible for external review within one (1) business day after completion of the preliminary review.

The Notice of Right to External Appeal shall include the following:

1. The reason for ineligibility and the availability of the Employee Benefits Security Administration at (866) 444-3272, if the request is complete but not eligible for external review.
2. If the request is incomplete, the information or materials necessary to make the request complete and the opportunity for the covered Member to perfect the external review request by the later of the following:
   a. The four (4) month filing period; or
   b. Within the forty-eight (48) hour time period following the covered Members receipt of notification.

INDEPENDENT REVIEW ORGANIZATION

An Independent Review Organization (IRO) that is accredited by URAC or a similar nationally recognized accrediting organization shall be assigned to conduct the external review. The assigned IRO will timely notify the covered Member in writing of the request's eligibility and acceptance for external review.

NOTICE OF EXTERNAL REVIEW DETERMINATION

The assigned IRO shall provide the Plan Administrator (or its designee) and the covered Member (or authorized representative) with a written notice of the final external review decision within forty-five (45) days after receipt of the external review request.

The Notice of Final External Review Decision from the IRO is binding on the covered Member, the Plan and Claims Administrator, except to the extent that other remedies may be available under State or Federal law.

EXPEDITED EXTERNAL REVIEW

The Plan Administrator (or its designee) shall provide the covered Member (or authorized representative) the right to request an expedited external review upon the covered Members receipt of either of the following:

1. A denial of benefits involving a medical condition for which the timeframe noted above for completion of an internal appeal would seriously jeopardize the health or life of the covered Member or the covered

Members ability to regain maximum function and the covered Member has filed an internal appeal request.

2. A final internal denial of benefits involving a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the health or life of the covered Member or the covered Members ability to regain maximum function or if the final determination involves any of the following: a. An admission,
    b. Availability of care,
    c. Continued stay, or
    d. A health care item or service for which the covered Member received emergency services, but has not been discharged from a Facility.

Immediately upon receipt of the request for Expedited External Review, the Plan will do all of the following:

1. Perform a preliminary review to determine whether the request meets the requirements in the subsection, Right to External Appeal.
2. Send notice of the Plan's decision, as described in the subsection, Notice of Right to External Appeal.

Upon determination that a request is eligible for external review, the Plan will do all of the following:

1. Assign an IRO as described in the subsection, Independent Review Organization.
2. Provide all necessary documents or information used to make the denial of benefits or final denial of benefits to the IRO either by telephone, facsimile, electronically or other expeditious method.

The assigned IRO will provide notice of final external review decision as expeditiously as the covered Member's medical condition or circumstances require, but in no event more than seventy-two (72) hours after receipt of the expedited external review request. The notice shall follow the requirements in the subsection, Notice of External Review Determination. If the notice of the expedited external review determination was not in writing, the assigned IRO shall provide the Plan Administrator (or its designee) and the covered Member (or authorized representative) written confirmation of its decision within forty-eight (48) hours after the date of providing that notice.

Before filing a lawsuit, the claimant must exhaust all available levels of review as described in this Plan, unless an exception under applicable law applies. A legal action to obtain benefits must be commended within one (1) year of the date of the notice of determination on the final level of internal or external review, whichever is applicable.

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish
Usted tiene derecho a recibir ayuda en su idioma en forma gratuita. Simplemente llame al número de Servicios para Miembros que figura en su tarjeta de identificación.

Chinese
您有權免費獲得透過您使用的語言提供的幫助。請撥打您的 ID 卡片上的會員服務電話號碼。若您是視障人士，還可索取本文件的其他格式版本。

Vietnamese
Quý vị có quyền nhận miễn phí trợ giúp bằng ngôn ngữ của mình. Chỉ cần gọi số Dịch vụ dành cho thành viên trên thẻ ID của quý vị. Bị khiếm thị? Quý vị cũng có thể hỏi xin định dạng khác của tài liệu này."

Korean
귀하는 자국어로 무료지원을 받을 권리가 있습니다. ID 카드에 있는 멤버 서비스번호로 연락하십시오.

Tagalog
May karapatan ka na makakuha ng tulong sa iyong wika nang libre. Tawagan lamang ang numero ng Member Services sa iyong ID card. May kapansanan ka ba sa paningin? Maaari ka ring humiling ng iba pang format ng dokumentong ito.

Russian
Вы имеете право на получение бесплатной помощи на вашем языке. Просто позвоните по номеру обслуживания клиентов, указанному на вашей идентификационной карте. Пациенты с нарушением зрения могут заказать документ в другом формате.

Armenian
Դուք իրավունք ունեք ստանալ անվճար օգնություն ձեր լեզվով: Պարզապես զանգահարեք Անդամների սպասարկման կենտրոն, որի հեռախոսահամարը նշված է ձեր ID քարտի վրա:

Farsi
"شما این حق را دارید تا به صورت رایگان به زبان مادری تان کمک دریافت کنید. کافی است با شماره خدمات اعضا (Member Services) درج شده روی کارت شناسایی خود تماس بگیرید." دچار اختلال بینایی هستید؟ می توانید این سند را به فرمت های دیگری نیز درخواست دهید.

French
Vous pouvez obtenir gratuitement de l'aide dans votre langue. Il vous suffit d'appeler le numéro réservé aux membres qui figure sur votre carte d'identification. Si vous êtes malvoyant, vous pouvez également demander à obtenir ce document sous d'autres formats.

Arabic
لك الحق في الحصول على مساعدة بلغتك مجانًا. ما عليك سوى الاتصال برقم خدمة الأعضاء الموجود على بطاقة الهوية. هل أنت ضعيف البصر؟ يمكنك طلب أشكال أخرى من هذا المستند.

Japanese
お客様の言語で無償サポートを受けることができます。IDカードに記載されているメンバーサービス番号までご連絡ください。

Haitian
Se dwa ou pou w jwenn èd nan lang ou gratis. Annik rele nimewo Sèvis Manm ki sou kat ID ou a. Èske ou gen pwoblèm pou wè? Ou ka mande dokiman sa a nan lòt fòma tou.

Italian
Ricevere assistenza nella tua lingua è un tuo diritto. Chiama il numero dei Servizi per i membri riportato sul tuo tesserino. Sei ipovedente? È possibile richiedere questo documento anche in formati diversi

Polish
Masz prawo do uzyskania darmowej pomocy udzielonej w Twoim języku. Wystarczy zadzwonić na numer działu pomocy znajdujący się na Twojej karcie identyfikacyjnej.

Punjabi
ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮੁਫ਼ਤ ਵਿੱਚ ਮਦਦ ਹਾਸਲ ਕਰਨ ਦਾ ਿਂਅਧਕਾਰ ਹੈ। ਬਸ ਆਪਣy ਆਈਡੀ ਕਾਰਡ ਤੇ ਿਦੱਤੇ ਸਿਰਦਸ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। ਨਜ਼ਰ ਕਮਜ਼ੋਰ ਹੈ? ਿਸ ਦਸਤਾਵੇਜ਼ ਦੇ ਹੋਰ ਰੂਪਾਂਤਰ ਮੰਗ ਸਕਦੇ ਹੋ।

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. By calling Member Services, our members can get free in-language support, and free aids and services if you have a disability. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TTD: 711). If you think we failed in any of these areas, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

ADOPTION STATEMENT

Amy's Kitchen, Inc. has caused this Medical Plan to take effect as of January 1, 2023 at Petaluma, California 94954.

I have read the document herein and certify the document reflects the terms and conditions of the Employee BenefitPlan as established by Amy's Kitchen, Inc.

Sign:_____

Print:_____

Date:_____