DIRECT PAY MEDICAL PLAN BENEFITS

Exclusive Provider Option (EPO) Plan

(For Active Employees and Non-Medicare Retirees/ Dependents of Retirees)

For benefits effective July 1, 2019 this Exclusive Provider Option (EPO) Direct Pay Medical Plan is only available to employees and retirees who were enrolled in the Anthem Blue Cross HMO Program as of June 30, 2019. The Anthem Blue Cross HMO contract has been terminated. This section applies only to employees who are enrolled in the Exclusive Provider Option (EPO) Direct Pay Medical Plan. If you are enrolled in the Direct Pay PPO Option, your benefits are described in another section of the Summary Plan Description. If you are enrolled in the Kaiser medical plan, a separate Evidence of Coverage is available which describe those benefits.

Introduction

The Board of Trustees has contracted with Anthem Blue Cross for the purpose of making their expansive Prudent Buyer Network of preferred providers available to employees and their eligible dependents who are covered under the Direct Pay Medical Plan.

Anthem Blue Cross has established a network of "Preferred Providers." These providers have agreed to participate in the Anthem Blue Cross preferred provider organization program, called PPO for short.

The Anthem Blue Cross PPO is called the Prudent Buyer Plan. Therefore, whenever you see the term Prudent Buyer just remember it is the Anthem Blue Cross PPO. This Plan is called the Exclusive Plan Option (EPO) because, with limited exceptions, the Plan will only pay benefits from providers that are part of the Anthem Blue Cross Prudent Buyer PPO network. Except for a few services, such as emergency services, benefits are not payable to providers that are not part of the network.

Non-emergency out of network claims will receive no reimbursement whatsoever under this Plan. The expenses you or your dependents incur for non-emergency out of network care will not be accounted against any individual or family out of pocket maximum under this Plan. The only exception to the foregoing exclusion is for out of network emergency care.

To receive benefits under the Exclusive Plan Option (EPO) Direct Pay Medical Plan, it is imperative that you make certain you are using a Prudent Buyer provider for all hospital and doctor services.

When you think of a PPO, you probably think of doctors and hospitals, which is correct. However, there are other health care providers, which are neither physicians nor hospitals. The Anthem Blue Cross Prudent Buyer Network includes an expanded list of providers in addition to doctors and hospitals. For example, ambulatory surgical centers, home health care agencies, home infusion therapy providers, skilled nursing facilities and medical products and services.

These Prudent Buyer preferred providers have agreed to provide health care for covered persons and accept the Plan's payment for a covered service plus the covered person's share of the covered charge (i.e. co-insurance, co-payment, penalty amount [if any]) as payment in full.

It is your responsibility to verify current Prudent Buyer status of the provider before you obtain services. Remember to ask your doctor if he/she is an Anthem Blue Cross Prudent Buyer Preferred Provider. You can also locate Prudent Buyer doctors online at ***www.anthem.com/ca*** or by calling the Fund Office.

You will receive an identification card, which identifies you as being eligible to use the Anthem Blue Cross Prudent Buyer network of Preferred Providers. To be eligible for coverage you must work the required hours and be eligible for benefits as explained in the Eligibility section (Article II of the Rules and Regulations).

Anthem Blue Cross Website

Participating health care providers in the Prudent Buyer network include hospitals, physicians, and laboratory and radiology facilities. From time to time providers are added or deleted from the network.

There is a quick and easy way to find participating Prudent Buyer health care providers - including doctors and hospitals. To find a provider, simply go to the Anthem Blue Cross web site and use the online provider finder resource.

Follow these easy steps to find a participating California provider:

- Go to ***http://www.anthem.com /ca/find-care***

- If you are a currently enrolled in the Direct Pay Plan, log in for a personalized search, or use your member ID for a basic search.
- If you are not currently enrolled in the Direct Pay Plan, click “Basic search as a guest.”

1. Select the type of plan or network: Medical Plan
2. Select the state of California
3. Select how you get health insurance: Medical (Employer-Sponsored)
4. Select the plan or network: Prudent Buyer CA Only
5. Click Continue
6. Type of Provider - select a provider type (e.g., health facility, physician, specialist, etc.)
7. Specialty (optional) - you may select a specialty to refine your search. To select multiple specialties, hold down the control key and click on each specialty name.
8. Location or Name - enter location or name criteria. Receive your search results via a listing, map or downloadable directory.

Alternately to the above, you can:

- Inquire of a physician or other provider if he/she is an Anthem Blue Cross Prudent Buyer Provider.
- Contact the Fund Office at (800) 297-4595. Remember, **it is your responsibility** to make certain that you are receiving medical services from a Prudent Buyer provider.

Prior Authorization Review and Approval Program

Inpatient Admissions

All non-emergency in-patient admissions to a hospital, skilled nursing facility or approved treatment facility must be approved (prior authorization) by Anthem Blue Cross **BEFORE** you are admitted. In the event of a medical emergency (requiring surgery or inpatient admission), you must notify Anthem Blue Cross within 48 hours of being admitted as an inpatient or as soon thereafter as possible.

These approval requirements will provide you with assurance that you are being treated in the most efficient and appropriate health care setting and can help manage the rising costs of health care.

The inpatient admissions approval program applies to the following:

- Pre-service review determines the medical necessity of scheduled non-emergency admission.
- Concurrent review determines whether services continue to be medically necessary and appropriate when pre-service review is not required or has been performed as required.
- Retrospective review is performed when Anthem Blue Cross has not been notified and therefore has been unable to perform the appropriate pre-service or concurrent review.

Failure to obtain a prior authorization for an inpatient admission will result in a decrease of hospital room and board covered benefits. This amount is an out-of-pocket expense and may not be applied toward the medical deductible or out-of-pocket maximum.

Also, Anthem Blue Cross will perform a retrospective review of the inpatient stay and no Plan benefits will be provided for any inpatient days which are determined to not be medically necessary.

Other Services

In addition to review for all inpatient services, prior approval by Anthem Blue Cross is required for certain other services. If prior approval is not obtained for the following services, benefits may be denied in whole or in part based on a retrospective medical review giving consideration to medical necessity and that the charges incurred are for a covered service:

- Transplants
- Home health care
- Hospice care
- Home infusion therapy
- Potentially cosmetic/investigative services
- Certain durable medical equipment or prosthetics

Prior approval determines only the medical necessity of a specific service and/or an admission and an allowable length of stay. Prior approval does not guarantee your eligibility for coverage. Eligibility and benefits are based on the date you receive the services. An approval does not guarantee payment or that you will receive the highest level of benefits. For example, services not listed as covered, services received after you lose eligibility under the Plan and services that are not medically necessary will be denied.

Contact Anthem Blue Cross at (800) 274-7767 for all prior authorization reviews.

Your Benefits for the
Teamsters Local 856 Health and Welfare EPO Plan

It's important to remember:

- The benefits of this *plan* are given only for those services that the Group finds are *medically necessary.*

- Care must be received from your *primary care doctor* or another *Anthem Blue Cross Prudent Buyer PPO Provider* to be a covered service under this *plan.* If you do not use an *Anthem Blue Cross Prudent Buyer PPO provider,* your entire claim will be denied unless:

  The services are for *emergency* or out-of-area *urgent care.*

- Just because a *doctor* orders a service, it doesn't mean that:

  The service is *medically necessary;* or
  This *plan* covers it.

- If you have any questions about what services are covered, read this booklet, or give us a call at the number on your Member ID card.

- All benefits are subject to coordination with benefits available under certain other plans.

- We have the right to be repaid by a third party for medical care we cover if your injury, disease or other health problem is their fault or responsibility.

- The Teamsters Local Union 856 Health and Welfare Trust Fund has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. *Members* seeking *emergency services,* out-of-area *urgent care* services in accordance with this *plan* from *non-Anthem Blue Cross Prudent Buyer PPO provider* could be balanced billed by the *non-Anthem Blue Cross Prudent Buyer PPO provider* for those services that are determined to be not payable as a result of these review processes and meets the criteria set forth in any applicable state regulations adopted pursuant to state law. A claim may also be determined to be not payable due to a provider's failure to submit medical records with the claims that are under review in these processes.

What are Copays?

A *copay* is a set amount you pay for each medical service. You need to pay a *copay* for some services given under this *plan,* but many other supplies and services do not need a *copay.* Usually, you must pay the *copay* at the time you get the services. The *copays* you need to pay for services are shown in the next section.

Non-emergency out of network claims will receive no reimbursement whatsoever under this Plan. The expenses you or your dependents incur for non-emergency out of network care will not be accounted against any individual or family out of pocket maximum under this Plan. The only exception to the foregoing exclusion is for emergency out of network care.

What We Cover

We list benefits for the services and supplies in this section. Any *copays* you must pay are shown next to the service or supply. We list things **we do NOT cover in the next section.**

Non-emergency out of network claims will receive no reimbursement whatsoever under this Plan. The expenses you or your dependents incur for non-emergency out of network care will not be accounted against any individual or family out of pocket maximum under this Plan. The only exception to the foregoing exclusion is for out of network emergency care.

COVERED SERVICES	COPAY
Doctor Care (or services of a Health Professional)	
Office visits for a covered illness, injury or health problem.	$15
Home visits, when approved, at the *doctor's* discretion.	$15
Injectable or infused medications[1] given by the *doctor* in the office.	20% with a maximum copay of $150
Surgery in *hospital, surgery center* or *medical group* and surgical assistants.	No charge
Anesthesia services.	No charge
Doctor visits during a *hospital stay.*	No charge
Visit to a *specialist.*	$15
Preventive Care Services 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 preventive care services are covered with no deductible (if applicable) or copay when you use an *Anthem Blue Cross Prudent Buyer PPO provider.*	
Full physical exams and periodic check-ups ordered by your *primary care doctor* including well-woman visits.	No charge
Vision or hearing screenings[2].	No charge
Immunizations prescribed by your *primary care doctor.*	No charge
Health education programs given by your *primary care doctor.*	No charge

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This does not include immunizations prescribed by your *primary care doctor* nor allergy serums.

Vision screening includes a vision check by your *primary care doctor* to see if it is *medically necessary* for you to have a complete vision exam by a vision *specialist.* If OK'd by your *primary care doctor,* this may include an exam with diagnosis, a treatment program and refractions. Hearing screenings include tests to diagnose and correct hearing.

COVERED SERVICES	COPAY
Health screenings as prescribed by your *doctor* or *health care provider.* Health screenings include mammograms, Pap tests and any cervical cancer screening tests including human papillomavirus (HPV), prostate cancer screenings, and other medically accepted cancer screening tests, screenings for high blood pressure, type 2 diabetes mellitus, cholesterol, and obesity.[1]	No charge
Preventive services for certain high-risk populations as determined by your *doctor,* based on clinical expertise.	No charge
Counseling and intervention services as part of a full physical exam or periodic check-up for the purpose of education or counseling on potential health concerns, including sexually transmitted infections, human immunodeficiency virus (HIV), contraception, and smoking cessation counseling.	No charge
HIV testing, regardless of whether testing is related to a primary diagnosis.	No charge
Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following: • Breast feeding support, supplies, and counseling ordered by your *primary care doctor.* One breast pump will be covered per pregnancy under this benefit. • Gestational diabetes screening. • Preventive prenatal care. • Screening for iron deficiency anemia in pregnant women. • Breast cancer (BRCA) testing, if appropriate, in conjunction with genetic counseling and evaluation.	No charge
Telehealth Telephonic or videoconference visits with a Physician by are paid as any other office visit.	$15
Diabetes	
Equipment and supplies used for the treatment of diabetes (see below). • Blood glucose monitors, including monitors designed to help the visually impaired, and blood glucose testing strips. • Insulin pumps. • Pen delivery systems for insulin administration (non- disposable). • Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin.	See "Medical Equipment"
Podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes-related complications.	See "Prosthetic Devices"
Diabetes education program services supervised by a *doctor* which include: • Teaching you and your family members about the disease process and how to take care of it; and • Training, education, and nutrition therapy to enable you to use the equipment, supplies, and medicines needed to manage the disease. Screenings for gestational diabetes are covered under your Preventive Care Services benefit. Please see that provision for further details.	$15

[1] This list is not exhaustive. Preventive tests and screenings with a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF), or those supported by the Health Resources and Services Administration (HRSA) will be covered at no charge.

COVERED SERVICES	COPAY
General Medical Care (In a Non-Hospital-Based Facility)	
Hemodialysis treatment, including treatment at home if approved.	$15
Medical social services.	No charge
Chemotherapy.	No charge
Radiation therapy.	No charge
Infusion therapy, including but not limited to Parenteral Therapy and Total Parenteral Nutrition (TPN).	$15
Allergy tests and care. *The creation of an allergy serum is covered at 100% and the administration of the injection of the serum is covered at $150/visit after a $15 copayment.*	$15
X-ray and laboratory tests:	
• *Advanced imaging procedures*	No charge per test
• Genetic testing (not including *medically necessary* genetic testing of the fetus or newborn or BRCA testing).	No charge
• All other x-ray and laboratory tests, including COVID-19 testing.	No charge
Smoking cessation programs for nicotine dependency.	No charge
Pregnancy or Maternity Care Medical services for an enrolled *member* are provided for pregnancy and maternity care, including the following services: Prenatal, postnatal, and postpartum care, ambulatory care services (including ultrasounds, fetal non-stress tests, *doctor* office visits, and other *medically necessary* maternity services performed outside of a *hospital),* involuntary complications of pregnancy, diagnosis of genetic disorders in cases of high-risk pregnancy, and inpatient *hospital* care including labor and delivery.	
Office visit.	$15
Doctor's services for normal delivery or cesarean section.	No charge
Hospital services:	
• Inpatient services	No charge
• Outpatient covered services	No charge
Genetic testing, when *medically necessary.*	No charge
Prenatal testing administered by the State Department of Public Health for the California Prenatal Screening Program.	No charge
Hospital services for routine nursery care of your newborn child if the newborn child's natural mother is an enrolled *member.* Routine nursery care of a newborn child includes screening of a newborn for genetic diseases, congenital conditions, and other health conditions provided through a program established by law or regulation. Certain services are covered under the "Preventive Care Services" benefit. Please see that provision for further details. **Note:** For inpatient *hospital* services related to childbirth, we will provide at least 48 hours after a normal delivery or 96 hours after a cesarean section, unless the mother and her *doctor* decide on an earlier discharge.	No charge

COVERED SERVICES	COPAY
Infertility and Birth Control Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive Care Services" benefit.	
Diagnosis and testing for *infertility.*	50%
Sterilization for females.	No charge
Sterilizations for females will be covered under the "Preventive Care Services" benefit. Please see that provision for further details.	
Sterilization for males.	$50
Family planning services.	$15
Shots and implants for birth control.	No charge
Intrauterine contraceptive devices (IUDs) and diaphragms, dispensed by a *doctor***.*	No charge
Doctor's services to prescribe, fit and insert an IUD or diaphragm[2].	No charge
Mastectomy	
Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.	See *copays* that apply
Reconstructive surgery of both breasts performed to restore symmetry following a mastectomy.	See *copays* that apply
Reconstructive Surgery	
Reconstructive surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either the following: (a) improve function; or {b) create a normal appearance, to the extent possible. This includes surgery performed to restore and achieve symmetry following a *medically necessary* mastectomy. This also includes *medically necessary* dental or orthodontic services that are an integral part of *reconstructive surgery* for cleft palate procedures. "Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate. This does not apply to orthognathic surgery. Please see the "Dental Care" benefit below for a description of this coverage.	See *copays* that apply
Rehabilitative Care You may have **up to a 60 day period of care** after an illness or injury. The 60 day period of care starts with the first visit for rehabilitative care. The 60 day limit does not limit the number of visits or treatments you get within the 60 day period. If you need more than the 60 day period of care, you must get an approval. It must be shown that more care is *medically necessary.* While there is no limit on the length of the covered period of care or the number of covered visits for *medically necessary* rehabilitative care, you must get an approval for the longer time period and extra visits in advance. Rehabilitative care as described above is also provided for a *member* who is being treated for a *severe mental disorder* or for pervasive developmental disorder or autism. This care is provided even though the *member* may not have suffered an illness or injury. If more than a 60-day period of care is needed, the longer time period and additional visits must be approved in advance.	

Note: The **50%** *copay* made for *infertility* services will not be applied to the "*Copay Limits."*

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

Note: 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.

COVERED SERVICES	COPAY
Visits for rehabilitation, such as physical therapy, chiropractic services, occupational therapy or speech therapy. Services rendered by a massage therapist are not covered.	$15
Inpatient Hospital Services	
A *hospital* room with two or more beds, or a private room only if *medically necessary,* ordered by your *primary care doctor* and approved. Inpatient hospital services and supplies include the following: • Operating room and special treatment room; • Special care units; • Nursing care; • *Drugs* and medicines, and supplies you get during your *stay.* This includes oxygen; • Laboratory, cardiology, pathology and radiology services; • Physical therapy, occupational therapy, speech therapy, radiation therapy, chemotherapy and hemodialysis; and • Blood transfusions. This includes the cost of blood, blood products or blood processing.	No charge When a participant uses an in-network facility for services but receives services that are not in-network, without being given an option, such services shall be covered be covered at no copay.
Outpatient (In a Hospital or Surgery Center)	
Emergency room use, supplies, other services, *drugs* and medicines. This includes oxygen. Out-of-network emergency services shall be paid at the higher of: (1) the average amount which would be paid to an in-network provider for the same service; (2) the amount which would be paid under the UCR formula without reduction for out-of-network cost sharing generally applicable under the Plan; (3) the amount which Medicare would pay for the service excluding any in-network co-payment or co-insurance imposed with respect to the Participant or Beneficiary. It is the intent of the Trustees that out-of-network emergency services at all times be paid consistent with the requirements of applicable regulations including but not limited to 29 C.F.R. 2590.715-2719 A(b).	$50 When a participant uses an in-network facility for services but receives services that are not in-network, without being given an option, such services shall be covered be covered at no copay.
Care given when surgery is done. This includes operating room use, supplies, *drugs* and medicines, oxygen, and other services.	No charge When a participant uses an in-network facility for services but receives services that are not in-network, without being given an option, such services shall be covered be covered at no copay.
X-ray and laboratory tests:	
• Advanced *imaging procedures.*	No charge per test
• All other x-ray and laboratory tests.	No charge
Other outpatient *hospital* services and supplies, including physical therapy, occupational therapy, or speech therapy.[2]	$15
However, for the following outpatient services, your copay will be:	
• Chemotherapy.	$15
• Radiation therapy.	$15
• Hemodialysis treatment.	$15
• Infusion therapy, including but not limited to Parenteral Therapy and Total Parenteral Nutrition (TPN).	$15
*These rehabilitative services are limited to a 60 day period of care after an illness or injury. If you need more than the 60 day period of care, you must get an approval. (See "Rehabilitative Care" above.)	

Urgent Care *Urgent care* is not an *emergency.* It is care that is needed right away to relieve pain, find out what is wrong, or treat the health problem. You must call within 48 hours if you are admitted to a *hospital.*	
Doctors office visit or urgent care facility use, supplies, other services, *drugs* and medicines. This includes oxygen.	$15[3]

You don't have to pay the **$50** if you are admitted as an inpatient.

These rehabilitative services are limited to a 60 day period of care after an illness or injury. If you need more than the 60 day period of care, your *primary care doctor* must get an approval. (See “Rehabilitative Care” above.)

You don't have to pay the **$15** if you are admitted as an inpatient to a *hospital.*

COVERED SERVICES	COPAY
Care given when surgery is done. This includes operating room use, supplies, *drugs* and medicines, oxygen, and other services.	No charge
Skilled Nursing Facility Services	
You can get these kinds of care in a *skilled nursing facility* for **up to 100 days** in a **calendar year.** Services and supplies provided by a *skilled nursing facility* • A room with two or more beds; • Special treatment rooms; • Regular nursing services; • Laboratory tests; • Physical therapy, occupational therapy, speech therapy, or respiratory therapy; • *Drugs* and medicines given during your *stay.* This includes oxygen; • Blood transfusions; and • Needed medical supplies and appliances.	No charge
Home Health Care We will cover home health care furnished by a *home health agency* (HHA) for **up to 100 visits in a calendar year**.	
Home health care services provided by a *home health agency.* Home health care services include the following: • Care from a registered nurse or licensed vocational nurse who works under a registered nurse or a *doctor.* • Physical therapy, occupational therapy, speech therapy, or respiratory therapy. • Visits with a medical social service worker. • Care from a health aide who works under a registered nurse with the HHA (one visit equals four hours or less).	No charge
Medically necessary supplies from the HHA. When available in your area, 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 Conditions/Substance Abuse" section below.	No charge
Hospice Care We will cover *hospice* care services shown below for the palliative care of pain and other symptoms if you have an illness that may lead to death within one year or less. Palliative care is care that controls pain and relieves symptoms but is not intended to cure the illness. The *hospice* must send a written care to the Group for approval every 30 days.	
Interdisciplinary team care to develop and maintain a plan of care.	No charge
Short-term inpatient *hospital* care in periods of crisis or as respite care. Respite care is provided on an occasional basis for up to five consecutive days per admission.	No charge
Physical therapy, occupational therapy, speech therapy and respiratory therapy.	No charge
Social services and counseling services.	No charge
Skilled nursing services given by or under the supervision of a registered nurse.	No charge
Certified home health aide services and homemaker services given under the supervision of a registered nurse.	No charge
Diet and nutrition advice; nutrition help such as intravenous feeding or hyperalimentation.	No charge
Volunteer services given by trained *hospice* volunteers directed by a *hospice* staff member.	No charge

COVERED SERVICES	COPAY
Drugs and medicines prescribed by a *doctor.*	No charge
Medical supplies, oxygen and respiratory therapy supplies.	No charge
Care which controls pain and relieves symptoms.	No charge
Bereavement services, including assessing the needs of the bereaved family and developing a care plan to meet those needs, both before and after death. Bereavement services are available to covered members of the immediate family (spouse, children, step-children, parents, brothers and sisters) for up to one year after the employee's or covered family *member's* death.	No charge
Dental Care	
Inpatient *hospital* services. Inpatient *hospital* services are limited to 3 days when the *stay* is: • Needed for dental care because of other medical problems you may have. • Ordered by a *doctor* (M.D.) or a dentist (D.D.S. or D.M.D.) • Approved by the *Group.*	No charge
General anesthesia and facility services when dental care must be provided in an outpatient *hospital* or *surgery center.* These services are covered when: • You are less than seven years old; • You are developmentally disabled; or • Your health is compromised and general anesthesia is *medically necessary.* **Note:** No benefits are provided for the dental procedure itself or for the professional services of a dentist to do the dental procedure.	No charge
Emergency care for accidental injury to natural teeth. • The care is not covered if you hurt your teeth while chewing or biting unless the chewing or biting results from a medical or mental condition. • This *plan* does not cover any other kind of dental care.	No charge
Orthognathic surgery for a physical abnormality that prevents normal function of the upper or lower jaw and is *medically necessary* to attain functional capacity of the affected part.	No charge
Medically necessary dental or orthodontic services that are an integral part of *reconstructive surgery* for cleft palate procedures.	No charge
"Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.	
Transgender Services	
Services and supplies provided in connection with gender transition when you have been diagnosed with gender identity disorder or gender dysphoria by a *doctor.* This coverage is provided according to the terms and conditions of the plan that apply to all other covered medical conditions, including medical necessity requirements, medical management, and exclusions for *cosmetic services,* except as specifically stated in this provision. Coverage includes, but is not limited to, *medically necessary* services related to gender transition such as transgender surgery, hormone therapy, psychotherapy, and vocal training. Coverage is provided for specific services according to *plan* benefits that apply to that type of service generally, if the *plan* includes coverage for the service in question. If a specific coverage is not included, the service will not be covered. For example, transgender surgery would be covered on the same basis as any other covered, *medically necessary* surgery; hormone therapy would be covered under the *plan's prescription drug* benefits (if such benefits are included). You must obtain our approval in advance in order for transgender services to be covered.	

COVERED SERVICES	COPAY
We will also pay for certain travel expenses incurred in connection with an approved transgender surgery, when the *hospital* at which the surgery is performed is 75 miles or more from your place of residence, provided the expenses are authorized in advance by us. We will provide benefits for lodging, transportation, and other reasonable expenses up to the current limits set forth in the Internal Revenue Code, not to exceed **$10,000** per transgender surgery, or series of surgeries (if multiple surgical procedures are performed), for travel expenses listed below, incurred by you and one companion. This travel expense benefit is not available for non-surgical transgender services. • Ground transportation to and from the *hospital* when it is 75 miles or more from your place of residence. • Coach airfare to and from the *hospital* when it is 300 miles or more from your residence. • Lodging, limited to one room, double occupancy. • Other reasonable expenses. Tobacco, alcohol, drug, and meal expenses are excluded. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement. You must obtain our approval in advance in order for travel expenses to be covered.	
Transgender services.	See *copays* that apply
Transgender travel expense.	No charge[1]
Medical Equipment	
Medical equipment and supplies.	No charge
You can get long-lasting medical equipment (called durable medical equipment) and supplies that are rented or bought for you if they are: • Ordered by your *primary care doctor.* • Used only for the health problem. • Used only by the person who needs the equipment or supplies. • Made only for medical use. Equipment and supplies are **not** covered if they are: • Only for your comfort or hygiene. • For exercise. • Only for making the room or home comfortable, such as air conditioning or air filters.	
Pediatric Asthma Equipment and Supplies	
Nebulizers, including face masks and tubing.	No charge
These items are not subject to any limits or maximums that apply to coverage for Medical Equipment.	
Inhaler spacers and peak flow meters.	
These items are subject to the copay for *brand name drugs*.	
Pediatric asthma education program services to help you use the items listed above.	$15
Organ and Tissue Transplants	
Services and supplies are given if: • You are receiving the organ or tissue.	
Services given with an organ or tissue transplant.	See *copays* that apply

[1] Our maximum payment will not exceed **$10,000** per transgender surgery, or series of surgeries (if multiple surgical procedures are performed).

COVERED SERVICES	COPAY
Ambulance	
Ambulance services are covered when you are transported by a state licensed vehicle that is designed, equipped, and used to transport the sick and injured and is staffed by Emergency Medical Technicians (EMTs), paramedics, or other licensed or certified medical professionals Ambulance services are covered when one or more of the following criteria are met: For ground ambulance, you are transported: • From your home, or from the scene of an accident or medical *emergency,* to a *hospital,* • Between *hospitals,* including when you are required to move from a *hospital* that does not contract with Anthem Blue Cross to one that does, or • Between a hospital and a skilled nursing facility or other approved facility. For air or water ambulance, you are transported: • From the scene of an accident or medical *emergency* to a *hospital,* • Between hospitals, including when you are required to move from a hospital that does not contract with us to one that does, or • Between a hospital and another approved facility. Non-emergency ambulance services are subject to medical necessity reviews by your Trust Fund. *Emergency* ground ambulance services do not require pre-service review. When using an air ambulance in a non-emergency situation, your Trust Fund reserve the right to select the air ambulance provider. If you do not use the air ambulance selected in a non-emergency situation, no coverage will be provided. You must be taken to the nearest facility that can provide care for your condition. In certain cases, coverage may be approved for transportation to a facility that is not the nearest facility. Coverage includes *medically necessary* treatment of an illness or injury by medical professionals from an ambulance service, even if you are not transported to a *hospital.* Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your *family members* or *doctor* are not a covered service. Other non-covered ambulance services include, but are not limited to, trips to: • A *doctor's* office or clinic; • A morgue or funeral home. If provided through the 911 emergency response system, ambulance services are covered if you reasonably believed that a medical *emergency* existed even if you are not transported to a *hospital.*	
Your copays for covered ambulance services are:	
Base charge and mileage.	No charge per trip
Disposable supplies.	No charge
Monitoring, EKG's or ECG's, cardiac defibrillation, CPR, oxygen, and IV solutions.	No charge
IN SOME AREAS, THERE IS A 9-1-1 EMERGENCY RESPONSE SYSTEM. THIS SYSTEM IS TO BE USED ONLY WHEN THERE IS AN *EMERGENCY.* IF YOU REASONABLY BELIEVE THAT YOU ARE EXPERIENCING AN EMERGENCY, YOU SHOULD CALL 9-1-1 OR GO DIRECTLY TO THE NEAREST HOSPITAL EMERGENCY ROOM. PLEASE USE THE 9-1-1 SYSTEM FOR MEDICAL EMERGENCIES ONLY.	

COVERED SERVICES	COPAY
Important information about air ambulance coverage. Coverage is only provided for air ambulance services when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a *hospital* than the ground ambulance can provide, this plan will cover the air ambulance. Air ambulance will also be covered if you are in a location that a ground or water ambulance cannot reach. Air ambulance will not be covered if you are taken to a *hospital* that is not an acute care *hospital* (such a skilled nursing facility), or if you are taken to a *doctor's* office or to your home. **Hospital to hospital transport:** If you are being transported from one *hospital* to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the *hospital* that first treats you cannot give you the medical services you need, certain specialized services are not available at all *hospitals.* For example, burn care, cardiac care, trauma care, and critical care are only available at certain *hospitals.* For services to be covered, you must be taken to the closest *hospital* that can treat you. Coverage is not provided for air ambulance transfers because you, your family, or your *doctor* prefers a specific *hospital* or *doctor.*	
Prosthetic Devices You can get devices to take the place of missing parts of your body.	
Surgical implants (including, but not limited to, cochlear implants).	No charge
Artificial limbs or eyes.	No charge
The first pair of contact lenses or eye glasses when needed after a covered and *medically necessary* eye surgery.	No charge
Breast prostheses following a mastectomy.	No charge
Prosthetic devices to restore a method of speaking when required as a result of a laryngectomy.	No charge
Therapeutic shoes and inserts designed to treat foot complications due to diabetes.	No charge
Certain types of orthotics (braces, boots, splints). Covered services include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.	No charge
Colostomy supplies.	No charge
Supplies needed to take care of these devices.	No charge
Mental Health Conditions/Substance Abuse You can get services for the *medically necessary* treatment of *mental health conditions* and substance abuse or to prevent the deterioration of chronic conditions. These services do not include programs to stop smoking, or to help with nicotine or tobacco abuse. Before you get services for facility-based care for the treatment of mental health conditions and substance abuse, you must get our approval first.	
Inpatient *facility-based care* for the treatment of *mental health conditions* and substance abuse. Inpatient services include hospital services and services from a residential treatment center (including crisis residential treatment) as stated in the "Inpatient Hospital Services" provision of this section, for Inpatient services and supplies.	No charge
Inpatient *doctor* visits during a *stay* for the treatment of *mental health conditions* and substance abuse.	No charge
Outpatient *facility-based care,* including *partial hospitalization programs* and *intensive outpatient programs,* for the treatment of *mental health conditions* and substance abuse.	No charge

COVERED SERVICES	COPAY
Other outpatient services include multidisciplinary treatment in an intensive outpatient psychiatric treatment program, behavioral health treatment for Pervasive Developmental Disorder or autism in the home, and psychological testing.	
Office visits and *intensive in-home behavioral health services* (when available in your area), received from a *doctor* for the treatment of *mental health conditions* and substance abuse.	No charge
Office visits include those for the following: • individual and group mental health evaluation and treatment, • nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa, • drug therapy monitoring, • individual and group chemical dependency counseling, • medical treatment for withdrawal symptoms, • methadone maintenance treatment.	
Behavioral health treatment for pervasive developmental disorder or autism in an office. Inpatient services, outpatient items and services, and office visits, are covered under this section. You must get our approval first for all behavioral health treatment services for the treatment of pervasive developmental disorder or autism in order for these services to be covered by this *plan.* No benefits are payable for these services if our approval is not obtained.	No charge
Hearing Aid Services	
Covered hearing aids. The following hearing aid services are covered when ordered by or purchased as a result of a written recommendation from: • an otolaryngologist; or • a state-certified audiologist. Services include: • 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 the *plan* benefits for office visits to *doctors.* • Hearing aids (monaural or binaural) including: ear mold(s), the hearing aid instrument; and batteries, cords and other ancillary equipment. • Visits for fitting, counseling, adjustments and repairs for a one year period after receiving the covered hearing aid. No benefits will be provided for the following: • Charges for a hearing aid which exceeds specifications prescribed for the correction of hearing loss. • Surgically implanted hearing devices (i.e., cochlear implants, audient bone conduction devices). *Medically necessary* surgically implanted hearing devices may be covered under your *plan's* benefits for *prosthetic devices* (see "Prosthetic Devices"). • Charges for a hearing aid which is not determined to be *medically necessary*.	No charge for audiological evaluations and visits. Hearing aids will be paid at 80% of usual, customary and reasonable fees, up to $2,000 per ear in any three-year period including the hearing aid(s), the cost of a hearing exam, and the fitting or repair of the hearing aid. Reimbursement of hearing aids purchased at an "over the counter" provider is only allowed with a prescription.

COVERED SERVICES	COPAY
Chiropractic Care	
Office visit	$15[1]
You may have up to **20** visits, combined with visits for acupuncture services, in a calendar year for covered services that are determined to be *medically/clinically necessary.* Covered services include: • An initial new patient exam provided by a *chiropractor* to determine the appropriateness of chiropractic services. An initial new patient exam is only covered if the *member* seeks services from a *chiropractor* for any injury, illness, disease, functional disorder or condition with regard to which the *member* is not, at that time, receiving services from a *chiropractor.* You are required to pay a Copay. • Follow-up office *visits,* as set forth in a treatment plan approved, including manipulation of the spine, joints and/or musculoskeletal soft tissue, re-evaluation, and/or other services, in various combinations, provided by a *chiropractor.* All follow-up office visits must be *medically/clinically necessary.* You are required to pay a Copay. • An established patient exam performed by a *chiropractor* when determined to be *medically/clinically necessary* to assess the need to continue, extend or change a treatment plan already approved. An established patient exam is only covered when used to determine the appropriateness of chiropractic services. You are required to pay a Copay. • Adjunctive physiotherapy modalities and procedures, as set forth in a treatment plan that has been approved, including therapies such as ultrasound, hot packs, cold packs, electrical muscle stimulation, and other therapies provided by a *chiropractor.* Adjunctive physiotherapy modalities and procedures are covered only when provided during the same course of treatment, and in conjunction with, chiropractic manipulation of the spine, joints and/or musculoskeletal soft tissue. All adjunctive physiotherapy modalities and procedures must be *medically/clinically necessary* for the treatment of neuromusculoskeletal disorders and provided in conjunction with chiropractic services. If adjunctive therapy is provided separately from an office *visit,* you are required to pay a Copay. Your *chiropractor* is responsible for submitting a treatment plan to the Group for prior approval.	
X-rays and laboratory tests when prescribed by a *chiropractor* and approved by the Group.	No Copay
Covered services include radiological consultations when determined by the Group to be *medically/clinically necessary* and provided by a licensed chiropractic radiologist, medical radiologist, radiology group or hospital which has contracted with the Group to provide those services.	
Chiropractic appliances, up to **$50** in a calendar year, when prescribed by a *chiropractor* and approved as *medically/clinically necessary.*	No Copay

[1] Only one Copay will be required per visit regardless of the number of covered services furnished during the visit.

COVERED SERVICES	COPAY
Covered chiropractic appliances are limited to: • Elbow supports, back supports (thoracic), lumbar braces and supports, rib supports, or wrist supports; • Cervical collars or cervical pillows; • Ankle braces, knee braces, or wrist braces; • Heel lifts; • Hot or cold packs; • Lumbar cushions; • Rib belts or orthotics; and • Home traction units for treatment of the cervical or lumbar regions.	
Acupuncture Services	
Office visit You may have up to **20** visits, combined with visits for chiropractic care, in a calendar year for covered services that are determined to be *medically/clinically necessary.* Covered services include: • An initial new patient exam provided by an *acupuncturist* to determine the appropriateness of acupuncture services. An initial new patient exam is only covered if the *member* seeks services from an *acupuncturist* for any injury, illness, disease, functional disorder or condition with regard to which the *member* is not, at that time, receiving services from an *acupuncturist.* You are required to pay a Copay. • Follow-up office visits, as set forth in a treatment plan approved, including acupuncture services and/or re-evaluation provided by an *acupuncturist.* All follow- up visits must be *medically/clinically necessary.* You are required to pay a Copay. • An established patient exam performed by an *acupuncturist* when determined to be *medically/clinically necessary* to assess the need to continue, extend or change a treatment plan already approved. An established patient exam is only covered when used to determine the appropriateness of acupuncture services. You are required to pay a Copay. • Adjunctive therapy, as set forth in a treatment plan approved, including therapies such as acupressure, cupping, moxibustion, or breathing techniques provided by an *acupuncturist.* Adjunctive therapy is covered only when provided during the same course of treatment, and in conjunction with, acupuncture. All adjunctive therapy must be *medically/clinically necessary* for the treatment of neuromusculoskeletal disorders, nausea or pain and provided in conjunction with acupuncture services. If adjunctive therapy is provided separately from an office visit, you are required to pay a Copay.	$15
Gene Therapy Benefits for FDA approved, medically necessary Gene Therapy shall be covered on a similar basis as all other medical benefits. Gene Therapy benefits require pre-certification.	

Only one Copay will be required per visit regardless of the number of covered services furnished during the visit.

What We Do Not Cover

Non-emergency out of network claims will receive no reimbursement whatsoever under this Plan. The expenses you or your dependents incur for non-emergency out of network care will not be accounted against any individual or family out of pocket maximum under this Plan. The only exception to the foregoing exclusion is for out of network emergency care.

It's important for you to know that we are not able to cover all the care you may want. Some services and supplies are not covered and some have limited benefits.

Kinds of Services You Cannot Get with this Plan

- **Care Not Covered.** Services you got before you were on the *plan,* or after your coverage ended.
- **Care Not Listed.** Services not listed as being covered by this *plan.*
- **Care Not Needed.** Any services or supplies that are not *medically necessary.*
- **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.
- **Procedures which are considered experimental, or which are not in accordance with generally accepted standards in the United States.**
- **Family Members.** Services prescribed, ordered, referred by or given by a member of your immediate family, including your *spouse, child,* brother, sister, parent, in-law or self.
- **Government Treatment.** Any services actually given to you by a local, state or federal government agency, or by a public school system or school district, except when this *plan's* benefits, must be provided by law. We will not cover payment for these services if you are not required to pay for them or they are given to you for free. You are not required to seek any such services prior to receiving *medically necessary* health care services that are covered by this *plan.*
- **Non-Licensed Providers.** Treatment or services rendered by non-licensed health care providers and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed provider under the supervision of a licensed *doctor,* except as specifically provided or arranged by us. This exclusion does not apply to the *medically necessary* services to treat *severe mental disorders* or serious emotional disturbances of a child as required by state law.
- **Services Received Outside of the United States.** Services rendered by providers located outside the United States, unless the services are for *emergencies,* emergency ambulance services and *urgent care.*
- **Services Not Needing Payment.** Services you are not required to pay for or are given to you at no charge.
- **Work-Related.** Care for health problems that are work-related if such health problems are or can be covered by workers' compensation, an employer's liability law, or a similar law.

We will provide care for a work-related health problem, but we have the right to be paid back for that care.

Other Services Not Covered

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

- **Blood.** Benefits are not provided for the collection, processing and storage of self-donated blood unless it is specifically collected for a planned and covered surgical procedure.

- **Braces or Other Appliances or Services** for straightening the teeth (orthodontic services) except as specifically stated in "Reconstructive Surgery" and "Dental Care" under the section What We Cover.

- **Clinical Trials.** Services and supplies in connection with clinical trials.

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

  This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to *medically necessary* treatments for morbid obesity or for treatment of anorexia nervosa or bulimia nervosa.

- **Consultations** given using telephones, facsimile machines, or electronic mail. This exclusion does not apply to the *medically necessary* services to treat *severe mental disorders* or serious emotional disturbances of a child as required by state law.

- **Cosmetic Surgery.** Surgery or other services done to change or reshape normal parts or tissues of the body to improve appearance.

- **Custodial Care or Rest Cures.** Room and board charges for a *hospital stay* mostly for a change of scene or to make you feel good. Services given by a rest home, a home for the aged, or any place like that.

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

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

  This exclusion does not apply to the following:

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

- **Drugs Given to you by a Doctor.** The following exclusions apply to *drugs* you receive from a *doctor.*

  Delivery Charges. Charges for the delivery of *prescription drugs.*

- **Food or Dietary Supplements.** Nutritional and/or dietary supplements, except as provided in this *plan* or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist. This exclusion does not apply to the *medically necessary* services to treat *severe mental disorders* or serious emotional disturbances of a child as required by state law.

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

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

- **Immunizations.** Immunizations needed to travel outside the USA.

- **In-vitro Fertilization.** Services or supplies for in-vitro fertilization (IVF) for purposes of pre- implant genetic diagnosis (PGD) of embryos, regardless of whether they are provided in connection with infertility treatment.

- **Infertility Treatment.** Any *infertility* treatment including artificial insemination or in vitro fertilization, and sperm banks.

- **Lifestyle Programs.** Programs to help you change how you live, like fitness clubs, or dieting programs.

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

  Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.

  Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.

  Enhancements to standard equipment and devices that is not *medically necessary.*

  Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is *medically necessary* in your situation.

  This exclusion does not apply to *medically necessary* treatment as specifically stated in "Medical Equipment" under the section What We Cover.

- **Educational or Academic Services.** This plan does not cover:

  Educational or academic counseling, remediation, or other services that are designed to increase academic knowledge or skills.

  Educational or academic counseling, remediation, or other services that are designed to increase socialization, adaptive, or communication skills.

  Academic or educational testing.

  Teaching skills for employment or vocational purposes.

  Teaching art, dance, horseback riding, music, play, swimming, or any similar activities.

  Teaching manners and etiquette or any other social skills.

  Teaching and support services to develop planning and organizational skills such as daily activity planning and project or task planning.

  This exclusion does not apply to the *medically necessary* services to treat *severe mental disorders* or serious emotional disturbances of a child as required by state law.

- **Non-Prescription Drugs.** Non-prescription, over-the-counter drugs or medicines, except as specifically stated in this booklet.

- **Foot Orthotics.** Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes.

- **Personal Care and Supplies.** Services for your personal care, such as: help in walking, bathing, dressing, feeding, or preparing food. Any supplies for comfort, hygiene or beauty purposes.

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

- **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 does not apply to the *medically necessary* services to treat *severe mental disorders* or serious emotional disturbances of a child, as required by state or federal law.

- **Routine Physicals and Immunizations.** Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the “Preventive Care Services” under the section What We Cover. This exclusion does not apply to the *medically necessary* services to treat *severe mental disorders* or serious emotional disturbances of a child as required by state law.

- **Scalp Hair Prostheses.** Scalp hair prostheses, including wigs or any form of hair replacement.

- **Sexual Problems.** Treatment of any sexual problems unless due to a medical problem, physical defect, or disease.

- **Sterilization Reversal.** Surgery done to reverse an elective sterilization.

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

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

Definitions

When used in this section, the following words and phrases have the meanings explained here.

Allowed Expense is any needed, 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 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.

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, except when by law Medicare's benefits are secondary to those of any private insurance program or another non-governmental program.

Each contract or arrangement for coverage listed above will be considered a separate plan. The rules of these provisions will apply only when the other plan has coordination of benefits provisions.

Primary Plan is the plan which will have its benefits figured first.

This Plan is the part of this *plan* that 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 primary plan, then we will figure out its benefits first without taking into account any other plan.

2. If This Plan isn't the primary plan, then we may reduce its benefits so that the benefits of all the plans aren't more than the allowed expense.

3. The benefits of This Plan will never be more than the benefits we would have paid if you were covered only under this *plan.*

If This Plan isn't the primary plan, you may be billed by a health care provider. If you receive a bill, you should submit it to this *medical plan.*

Order of Benefits Determination

The following rules determine the order in which benefits will be paid:

1. A plan with no coordination provision will pay its benefits first. This always includes Medicare except when by law This Plan must pay before Medicare.

2. A plan which covers you through your employer pays before a plan which covers you as a family member. But if you have Medicare and are also a dependent of an active employee under another employer plan, this rule might change. If Medicare's rules say that Medicare pays after the plan that covers you as a dependent but before your employer's plan, then the plan that covers you as a dependent pays before a plan which covers you through your employer. This might happen if you are covered under This Plan as a retiree.

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 year. But if one plan doesn't have a birthday rule provision, that plan's provisions will determine the order of benefits.

   Exception to rule 3: If a dependent child's parents are divorced or separated, the following rules will be used instead of rule 3:

   a. The plan of the parent who has custody, will pay first, unless he or she has remarried.

   b. If the parent with custody has remarried, then the order is 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. However, if there is a court decree which holds one parent responsible for that child's health care coverage, the plan which covers that child as a dependent of the responsible parent pays first.

4. The plan covering you as a laid-off or retired employee or as such employee's dependent pays after another plan covering you. But if either plan doesn't have a rule about laid-off or retired employees, rule 6 applies.

5. A plan covering you under a state or federal continuation of coverage pays after another plan. However, if the other plan doesn't have this rule, this rule won't apply.

6. When the rules above don't apply, the plan that has covered you longer pays first unless two of the plans have the same effective date. In this case, allowed expense is split evenly between the two plans.

Our Rights Under This Provision

Responsibility For Timely Notice. We aren't responsible for coordination of benefits unless we get information from the asking party.

Reasonable Cash Value. If you get benefits from another plan in the form of services, the value of services in cash will be considered allowed expense and a benefit paid.

Facility of Payment. If another plan pays benefits that this plan should have paid, we will pay the other plan an amount determined by us. This will be considered a benefit paid under this *plan,* and will fully satisfy what we are responsible for.

Right of Recovery. If we pay benefits that are more than we should have paid under this provision, we may make appropriate adjustment to claims or recover the extra amounts from one or more of the following:

- The persons to or for whom payments were made;
- Insurance companies or service plans; or
- Other organizations.

In most instances such recovery or adjustment activity shall be limited to the *calendar year* in which the error is discovered.

Important Words to Know

The meanings of key terms used in this booklet are shown below.

Advanced imaging procedures are imaging procedures, including, but not limited to, Magnetic Resonance Imaging (MRI), Computerized Tomography (CT scans), Positron Emission Tomography **(PET** scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography, and nuclear cardiac imaging.

Anthem Blue Cross (Anthem) is a health care service plan, regulated by the California Department of Managed Health Care.

Binding Arbitration is a process used to resolve complaints. It is used instead of going to a court of law. In binding arbitration, you and Anthem agree to meet with an arbitrator and go by the decision of the arbitrator.

COBRA is a special law that gives you a chance to keep your health plan even if you lose your job, have a reduction in hours or a change in dependents status. You will usually have to pay the monthly charges to keep the *plan* under COBRA.

Copay is the amount you pay to get a *medically necessary* service with an *Anthem Blue Cross HMO provider.* Anthem pays the provider the rest. It is also the amount you pay when you buy *drugs* or medicines from a *drugstore* or through the home delivery program.

Copay Limit is the most you will have to pay in one calendar year in *copays.*

Cosmetic services are services or surgery performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance.

Custodial care is care for your personal needs. This includes help in walking, bathing or dressing. It also includes: preparing food or special diets; feeding by utensil, tube or gastrostomy; suctioning; and giving medicine which you usually do yourself, or any other care for which the services of a health care provider are not needed.

If *medically necessary,* benefits will be provided for feeding (by tube or gastrostomy) and suctioning.

Doctor means a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is given.

Drug means a prescribed drug approved by the State of California or the federal government for use by the public. Under this *plan,* insulin is thought of as a *prescription drug.*

Drugstore means a store where you get medicine from a licensed pharmacist.

Emergency or Emergency Medical Condition means a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity including severe pain such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient's health or the health of another person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

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

An *emergency medical condition* includes a *psychiatric emergency medical condition,* which is a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following: a) an immediate danger to himself or herself or to others, or b) immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

Out-of-network emergency services shall be paid at the higher of:

(1) The average amount that would be paid to an in-network provider for the same service;
(2) The amount which would be paid under the Usual, Customary and Reasonable (UCR) formula of the Direct Pay PPO Plan without reduction for out-of-network cost sharing generally applicable that Plan;
(3) The amount which Medicare would pay for the service excluding any in-network co-payment or co-insurance imposed with respect to the Participant or Beneficiary.

It is the intent of the Trustees that our-of-network emergency services shall at all times be paid consistent with the requirements of the applicable regulations including but not limited to 29 S.F.R. 2590.715-2719A(b).

Emergency services are services given because of a medical or psychiatric *emergency.*

Experimental procedures are those that are not in accordance with generally accepted standards in the United States.

Facility-based care is inpatient or outpatient care provided in a *hospital, psychiatric health facility,* or *residential treatment center* for the treatment of *mental health conditions* or substance abuse.

Formulary drug is a *drug* listed on the *Prescription Drug Formulary.*

Generic drugs are *prescription drugs* that we classify as *generic drugs* or that our PBM has classified as *generic drugs* through use of an independent proprietary industry database. *Generic drugs* have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the *brand name drug.*

Health care provider means the kinds of providers, other than M.D.s or D.O.s, that take care of your health and are covered under this *plan.* The provider must:

- Have a license to practice where the care is given and provide a service covered by that license; or
- Be permitted by California law to provide behavioral health treatment services for the treatment of pervasive developmental disorder or autism only; or
- Give you a service that is paid for under this *plan.*

For nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa, “health care provider” includes registered dietitians or another nutritional professional with a master's or higher degree in a field covering clinical nutrition sciences, from a college or university accredited by a regional accreditation agency, who is deemed qualified to provide these services by the referring M.D. or D.O.

Home health agencies are licensed providers who give you skilled nursing and other services in your home. Medicare must approve them as home health providers and/or be recognized by the Joint Commission on the Accreditation of Healthcare Organizations.

Hospice is an agency or organization that gives a specialized form of interdisciplinary care that controls pain and relieves symptoms and helps with the physical, emotional, social, and spiritual discomforts of a terminally ill person, as well as giving support to the primary caregiver and the patient’s family. A hospice must be currently licensed as a hospice according to Health and Safety Code section 1747 or a licensed *home health agency* with federal Medicare certification according to Health and Safety Code sections 1726 and 1747.1. You may ask for a list of *hospices.*

Hospital is a place which provides diagnosis, treatment and care supervised by *doctors.* It must be licensed as a general acute care hospital.

The term hospital will also include *psychiatric health facilities* (only for acute care of a *mental health condition* or substance abuse) and *residential treatment centers.*

Independent practice association (IPA) is a *medical group* made up of a group of *doctors* who practice in private offices. The IPA has an agreement with Anthem to provide health care.

Infertility means: (1) you have a health problem your *doctor* sees as the reason you are unable to have a baby; or (2) you are unable to get pregnant or to carry a pregnancy to a live birth after a year or more of having sex without birth control or after 3 cycles of artificial insemination.

Intensive In-Home Behavioral Health Program is a range of therapy services provided in the home to address symptoms and behaviors that, as the result of a *mental health condition* or substance abuse disorder, put a *member* and others at risk of harm.

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

Interchangeable Biologic Product is a type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product. In addition to meeting the biosimilarity standard, it is expected to produce the same clinical result as the reference product in any given patient.

Investigative procedures or medications are those that have progressed to limited use on humans, but which are not generally accepted as proven and effective within the organized medical community.

Medical group is a group of *doctors* with an agreement with Anthem to provide health care.

Medically necessary means that each service or supply meets all of the following tests:

(a) It is rendered for the treatment or diagnosis of an injury or disease, including premature birth, congenital defects, and birth defects;
(b) It is appropriate for the symptoms, consistent with the diagnosis, and is otherwise in accordance with generally accepted medical practice and professionally recognized standards;
(c) It is not mainly for the convenience of the Participant or of the Participant's physician or other provider; and
(d) It is the most appropriate supply or level of service needed to provide safe and adequate care. When applied to confinement in a Hospital or other facility, this test means that the Participant needs to be confined as an inpatient due to the nature of the services rendered or due to the Participant's condition and that the Participant cannot receive safe and adequate care through outpatient treatment.

Member is the person who gets the health plan from his or her employer or an enrolled family member. An employee may enroll in only one health plan which is sponsored by the *group.*

Mental health conditions include conditions that constitute *severe mental disorders* and serious emotional disturbances of a child, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), as well as any mental health condition identified as a "mental disorder" in the DSM, Fourth Edition Text Revision (DSM IV). Substance abuse means drug or alcohol abuse or dependency.

NO SURPRISE BILLING ACT CLAIMS, BENEFITS AND APPEALS.

(1) The provisions of this Section govern, 'Covered Claims' as defined below incurred on and after July 1, 2022.

(2) Covered Claims are: (a) all out-of-network medically necessary emergency facility and professional medical expense; (b) subsequent medically necessary post emergency care at out-of-network facilities until the patient can be safely transferred to a network facility; (c) all medically necessary air ambulance charges; (d) all medically necessary out-of-network services delivered at or ordered by an in-network facility or provider except for so-called, '72 hour excepted services' as described below and (e) continuity of care medically necessary services and supplies for eligible patients as described below.

(3) The Plan, within 30 days of receipt of a medically necessary Covered Claim as described above, shall issue to the provider or provider's representative, payment equivalent to the median in-network PPO charge for the same medically necessary service or goods by or at network providers. In network deductible and co-payments apply. This median PPO charge shall be calculated by the Plan's PPO network provider.

(4) Except for regular out-of-pocket and deductible charges, providers of medically necessary Covered Claims as described above may appeal for further payment only from the Plan and only in conformity with applicable federal regulations governing the 30 day open negotiation, final offer and arbitration process of the federal No Surprises Act and related regulations.

(5) In general, if a provider or a facility ceases to be an in-network provider because of termination of contract, certain continuity of care protections apply to individuals who meet the definition of a continuing care patient and who are furnished items or services by the provider or facility for medically necessary services.

When a provider's or facility's contract termination leads to a change in network status, the Plan will issue timely notification to each individual enrolled who is a potential continuing care patient of the termination and their right to elect transitional care from the provider or facility by completing and returning a required form. An individual so qualifying as a continuing care patient will be able to elect to have the same benefits provided under the same terms and conditions which would have applied under the Plan had the contract termination not occurred with the course of treatment furnished by the provider or facility subject to the following limitations. The election for continuing continuity care last until the earlier of 90 days from notification of termination or the date the individual is no longer a continuing care patient with the provider or facility.

A continuing care patient is an eligible Participant or Dependent who is undergoing treatment from the terminated provider or facility for a serious complex condition which in the case of an acute illness is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm and in the case of a chronic illness or condition, is a condition that is life threatening, degenerate, potentially disabling or congenital and requires specialty medical care over a prolonged period of time. Alternatively, the continuing care patient must be undergoing a course of institutional or in-patient care from the provider or facility. Alternatively, the continuing care patient must be scheduled to undergo non-elective surgery from the provider or facility, including receipt of prospective postoperative care from such provider or facility with respect to such surgery. Alternatively, the continuing care patients will always include pregnant individuals undergoing treatment for pregnancy from the provider or facility. Continuing care patients will always include terminally ill individuals receiving medically necessary treatment for such terminal illness from the provider or facility.

In no event shall an election by a continuing care patient for continuity care last longer than the earlier of 90 days or notification of the change in network status or the date when the individual is no longer a continuing care patient with the provider or facility.

(6) 72 hour exception services are not Covered Claims under this Section. Benefits for any such medical services are considered as non-network claims and are not covered.

(7) The provisions of this Section do not apply to any claim payable under Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care or TRICARE.

Partial Hospitalization Program is a structured, short-term behavioral health treatment that offers nursing care and active treatment in a program that operates no less than 6 hours per day, 5 days per week.

Plan is the set of benefits talked about in this booklet. From time to time, there may be some changes in what is covered depending on the *agreement* we have with your employer. If changes are made to the plan, you will get a new booklet or a copy of an amendment showing the changes that were made.

Prescription means a written order or refill notice issued by a licensed prescriber for medication.

Preventive Care Services include routine examinations, screenings, tests, education, and immunizations administered with the intent of preventing future disease, illness, or injury. Services are considered

preventive if you have no current symptoms or prior history of a medical condition associated with that screening or service. These services shall meet requirements as determined by federal and state law, and are to become effective in accordance with those laws, including but not limited to, the Patient Protection and Affordable Care Act (PPACA). Sources for determining which services are recommended include the following:

- Services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF);
- Immunizations 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 provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.

Please call us at the Member Services number listed on your ID card for additional information about services that are covered by this *plan* as preventive care services. You may also refer to the following websites that are maintained by the U.S. Department of Health & Human Services:

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

Primary care doctor is a *doctor* who is a member of the *medical group* you have chosen to give you health care. *Primary care doctors* include general and family practitioners, internists and pediatricians. Certain *specialists* as we may approve may also be designated *primary care doctors*.

Prior plan is a plan sponsored by your employer which was replaced by this *plan* within 60 days of when it ended. You are considered covered under the prior plan if you:

- Were covered under the prior plan on the date that plan ended;
- Properly enrolled for coverage within 31 days of this *plan's* effective date; and
- Had coverage terminate solely due to the prior plan's ending.

Prosthetic devices take the place of a body part that does not work or is missing. These include orthotic devices, rigid or semi-supportive devices which may support the motion of a weak or diseased part of the body.

Psychiatric emergency medical condition is a mental disorder that manifests itself by acute symptoms of sufficient severity that the patient is either:

- An immediate danger to himself or herself or to others, or
- Immediately unable to provide for or utilize food, shelter, or clothing due to the mental disorder.

Psychiatric health facility is a 24-hour facility, that is:

- Licensed by the California Department of Health Services.
- Qualified to provide short-term inpatient treatment.
- Accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHCO).
- Staffed by a professional staff which includes a *doctor* as medical director.

Reconstructive surgery is surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (a) improve function; or (b) create a normal appearance, to the extent possible.

Reproductive or Sexual Health Care Services as described in California state law which are the following:

- Medical care related to the prevention or treatment of pregnancy.
- Medical care related to the diagnosis or treatment of an infectious, contagious, or communicable disease, if such disease is required for reporting to a local health officer, or is a related sexually-transmitted disease.

- Medical care related to the prevention of a sexually-transmitted disease.
- For alleged rape or sexual assault, medical care related to the diagnosis or treatment of the condition, and the collection of medical evidence after an alleged rape or sexual assault.
- HIV testing.

Residential treatment center is an inpatient treatment facility where the *member* resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation of *mental health conditions* and substance abuse. The facility must be licensed to provide psychiatric treatment of *mental health conditions* and substance abuse according to state and local laws and requires a minimum of one *doctor* visit per week in the facility. The facility must be fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

Self-Administered Hormonal Contraceptives are products with the following routes of administration:

- Oral;
- Transdermal;
- Vaginal;
- Depot Injection.

Severe mental disorders include severe mental illness as specified in California Health and Safety Code section 1374.72: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, and bulimia.

"Severe mental disorders" also includes serious emotional disturbances of a child as indicated by the presence of one or more mental disorders as identified in the Diagnostic and Statistical Manual (DSM) of Mental Disorders, other than primary substance abuse or developmental disorder, resulting in behavior inappropriate to the child's age according to expected developmental norms. The child must also meet one or more of the following criteria:

1. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community and is at risk of being removed from the home or has already been removed from the home or the mental disorder has been present for more than six months or is likely to continue for more than one year without treatment.
2. The child is psychotic, suicidal, or potentially violent.
3. The child meets special education eligibility requirements under California law (Education Code Section 56320).

Skilled nursing facility is a place that gives 24-hour skilled nursing services. It must be licensed and be seen as a skilled nursing facility under Medicare.

Stay is when you are admitted as an inpatient to a *hospital* or nursing facility. It starts when you are admitted to a facility and ends when you are discharged from that facility.

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 care center means a center that is accredited or designated by an agency of the State of California or the federal government or by a voluntary national health organization having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

Standing referral means a referral by a *primary care doctor* to a *specialist* for more than one visit to the *specialist,* as indicated in the treatment plan, if any, without the *primary care doctor* having to provide a specific referral for each visit.

Surgery center is a facility (not a *hospital* or *doctor's* office) that does surgery when you do not have to stay overnight. The center must be licensed and meet the standards of JCAHCO.

Urgent care means the services you get for a sudden, serious, or unexpected illness, injury or condition to keep your health from getting worse. It is not an *emergency.* Care is needed right away to relieve pain, find out what is wrong, or treat the health problem.