Benefit Booklet

Table of Contents

02 Tf1 0 0 1 12 792 reW* nBT/F3 10.02 Tf1 0 0 1 502.36 521.08 Tm0 g0 G

5

Modifications

Consolidated Appropriations Act of 2021 Notice

Consolidated Appropriations Act of 2021 (CAA)

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

Surprise Billing Claims

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

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

No Surprises Act Requirements

Emergency Services

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

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

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

Note that if you receive Emergency Services from an Out-of-Network Provider, your Out-of-Pocket costs will be limited to amounts that would apply if the Covered Services had been furnished by an In-Network Provider. However, Out-of-Network cost-shares (i.e., Copayments, Deductibles and/or Coinsurance) will apply to your claim if the treating Out-of-Network Provider determines you are stable, meaning you have been provided necessary Emergency Care such that your condition will not materially worsen and the Out-of-Network Provider determines:

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

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

How Cost-Shares Are Calculated

Your cost shares for Emergency Services or for Covered Services received by an Out-of-Network Provider at an In-Network Facility, will be calculated using the median Plan In-Network contract rate that the Claims Administrator pays In-Network Providers for the geographic area where the Covered Service is provided. Any Out-of-Pocket cost shares you pay to an Out-of-Network Provider for either Emergency Services or for Covered Services provided by an Out-of-Network Provider at an In-Network Facility will be applied to your In-Network Out-of-Pocket Limit.

Appeals

If you receive Emergency Services from an Out-of-Network Provider or Covered Services from an Out-of-Network Provider at an In-Network Facility or Out-of-Network Air Ambulance Services and believe those services are covered by the No Surprises Act, you have the right to appeal that claim. If your appeal of a Surprise Billing Claim is denied, then you have a right to appeal the adverse decision to an Independent Review Organization as set out in the “Your Right To Appeals” section of this Benefit Book.

Provider Directories

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

Transparency Requirements

The Claims Administrator provides the following information on its website:

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

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

Cost sharing information for 500 defined services, 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 designn th00912 0 612 792 reW* nBT/F1 10.02 Tf1 0 0 1 143.72 155.6 Tm0 g0

Identification Card or refer to our website, www.anthem.com/ca/sisc. For children, you may designate a pediatrician as the PCP.

Access to Obstetrical and Gynecological (ObGyn) Care

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

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

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

Mental Health Parity and Addiction Equity Act

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 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 you 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, contact your school district.

COMPLAINT NOTICE

All complaints and disputes relating to coverage under this Plan must be resolved in accordance with the Plan's

Introduction

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

SISC III and your employer have agreed to be subject to the terms and conditions of the Administrator's Provider agreements which may include Pre-service Review and utilization management requirements, coordination of benefits, timely filing limits, and other requirements to administer the benefits under this Plan.The Plan benefits described in this Benefit Booklet are for eligible Members only. The health care services are subject to the Limitations

How to Get Language Assistance

The Claims Administrator 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

Schedule of Benefits

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

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

IMPORTANT NOTE: To get the highest benefits at the lowest out-of-pocket cost, you must get Covered Services from an In-Network Provider. Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service, **except for Surprise Billing Claims, when you use Out-of-Network Providers you will not pay any amount exceeding the Maximum Allowed Amount in addition to any non-covered charges. This amount can be substantial. Please read the "Claims Payment" section for more details.**

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

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

Ambulatory patient services,

Emergency services,

Hospitalization,

Maternity and newborn care,

Mental health and substance use disorder services, including behavioral health treatment,

Rehabilitative and habilitative services and devices,

Laboratory services,

Preventive and wellness services, and

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

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

Reminder: Your Coinsurance will be based on the Maximum Allowed Amount, except for Surprise Billing Claims, if you use an Out-of-Network Provider, you will not pay any amount exceeding the Maximum Allowed Amount.

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

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

Out-of-Pocket Limit	
Member	$1,000
Family	$3,000

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

Expense for covered outpatient services and supplies provided by an Out-of-Network hospital, including outpatient surgery.

Expense for Co-Payments and Coinsurance you make for covered services and supplies provided by an Out-of-Network provider, except emergency services and supplies.

Expense which is in excess of the Out-of-Network provider amount for inpatient hospital services.

Expense which is in excess of the Maximum Allowed Amount Amounts you pay for non-Covered Services or supplies.

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 Coinsurance or Copayments for the rest of the Benefit Period, except for the services listed above.

Important Notice about Your Cost Shares

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

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

This Plan has two types of Providers:

In-Network

â%à á ð 1H'' ^ 'Îî"^ ‘ ` ! a''ëñ ñ h˜Ri à „ó ëñ î..D O ' H S H O G H O F \ ŽàhŽ82 p Sfh‰€ æp OCmî ‘ a''á I P.D @ à

Benefits	
Acupuncture	See “Therapy Services.”

Benefits	In-Network	Out-Of-Network
Bariatric Surgery **Bariatric surgery is covered only when performed at a designated Blue Distinction (BD) and Blue Distinction+ (BD+)**		
Inpatient Services (designated Hospital)	No Coinsurance	Not covered
Outpatient Facility Services (designated Hospital or Ambulatory Surgery Center)	No Coinsurance	Not covered
Travel expense Bariatric travel expense coverage is available when the closest Blue Distinction (BD) or Blue Distinction+ (BD+) Facility is 50 miles or more from the Member's residence	No Copayment	Not covered
For the Member and one companion (limited to three (3) maximum trips – one pre-operative trip, one surgery trip and one post-operative trip (if needed)		
– For transportation to the Blue Distinction (BD) or Blue Distinction+ (BD+)	Covered up to $3,000 per surgery	
– Flight	Economy / Coach (preferred seats for surgery trip when aisle seat is not available)	
– Check in bag fees	1 bag each for each flight	
– Ground Transportation (rental) Travel benefit includes rental car rate, taxes and insurance for the planned dates. Any additional products or services that are purchased are not covered	Economy / Intermediate / Standard Mileage reimbursement is based on current limits set forth in the Internal Revenue Code, not to exceed the maximum amount specified above	
- Ground Transportation (personal car)		

Benefits	
Clinical Trials	Benefits are based on the setting in which Covered Services are received

Benefits	
Dental Services	Benefits are based on the setting in which Covered Services are received

Benefits	
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.

Benefits	
Diagnostic Services	Benefits are based on the setting in which Covered Services are received. Please see

Benefits	In-Network	Out-Of-Network
Emergency Room Services		
Emergency Room		
Emergency Room Facility Charge	$100***** Copayment per visit, then No Coinsurance	$100***** Copayment per visit, then No Coinsurance
Urgent Care Facility Charge	$100***** Copayment per visit, then No Coinsurance	$100***** Copayment per visit, then No Coinsurance
*Your Copayment will not apply if you are admitted to the Hospital as inpatient immediately following Emergency Room treatment.		
Emergency Room Doctor Charge (ER Physician, Radiologist, Anesthesiologist, Surgeon, etc.)	No Coinsurance	No Coinsurance
Emergency Room Doctor Charge (Mental Health / Substance Use Disorder)	No Coinsurance	No Coinsurance
Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)	No Coinsurance	No Coinsurance
Advanced Diagnostic Imaging (including MRIs, CAT scans)	No Coinsurance	No Coinsurance

For Emergency room services from an Out of Network Provider, you will pay the Out-of-Network Provider no more than the

Benefits		
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.

Benefits	In-Network	Out-Of-Network
Hinge Health		

Benefits	In-Network	Out-Of-Network
Home Health Care		
Home Health Care Visits from a Home Health Care Agency, including private duty nursing (benefit maximum of 100 combined visits per Benefit Period, up to 4 hours each visit, In- and Out-of-Network combined) The limit does not apply to Home Infusion Therapy or Home Dialysis. The limit includes Therapy Services (e.g., physical, speech, occupational, cardiac and pulmonary rehabilitation given as part of the Home Health Care benefit.	No Coinsurance	No Coinsurance $150 per day benefit maximum not to exceed the maximum allowed amount*
*The Plan will pay the lesser of the benefit maximum or the Maximum Allowed Amount. Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount or benefit maximum.		
Dialysis	No Coinsurance	No Coinsurance $350 per day benefit maximum not to exceed the maximum allowed amount*
*The Plan will pay the lesser of the benefit maximum or the Maximum Allowed Amount. Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount or benefit maximum.		
Home Infusion Therapy/Chemotherapy	No Coinsurance	No Coinsurance $600 per day benefit maximum not to exceed the maximum allowed amount*
*The Plan will pay the lesser of the benefit maximum or the Maximum Allowed Amount. Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount or benefit maximum.		

Benefits	In-Network	Out-Of-Network
Hospice Care		
Home Hospice Care	No Copayment or Coinsurance	No Coinsurance
Bereavement	No Copayment or Coinsurance	No Coinsurance
Inpatient Hospice	No Copayment or Coinsurance	No Coinsurance
Outpatient Hospice	No Copayment or Coinsurance	No Coinsurance
Respite Care	No Copayment or Coinsurance	No Coinsurance

Out-

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. 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.)

The requirements described below do not apply to the following:

Cornea and kidney 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.

Transplant Benefit Period	In-Network Transplant Provider	In-Network Provider for this Plan	Out-of-Network Provider for this Plan
Precertification required	Starts one day before a Covered Transplant Procedure 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	Not covered	Not covered

Covered Transplant Procedure during the Transplant Benefit Period	In-Network Transplant Provider	In-Network Provider for this Plan	Out-of-Network Provider for this Plan
	During the Transplant Benefit Period, No Coinsurance You will **not** have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount. Before and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending on where the service is performed.	Not covered	Not covered
Inpatient Professional and Ancillary (non-Hospital) Services	No Copayment or Coinsurance	Not covered	Not covered
Outpatient Facility Services	No Copayment or Coinsurance	Not covered	Not covered
Outpatient Facility Professional and Ancillary (non-hospital) Services	No Copayment or Coinsurance	Not covered	Not covered
Transportation and Lodging	No Copayment or Coinsurance	Not covered	Not Covered
Transportation and Lodging Limit	Covered, as approved by the Plan Administrator; limited to $10,000 per transplant		
Unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants for a Covered Transplant Procedure	No Coinsurance	Not covered	Not Covered
Donor Search Limit	Covered, as approved by the Plan Administrator; limited to $30,000 per transplant		
Live Donor Health Services	No Coinsurance	Not covered	Not Covered
Inpatient Facility Services	No Coinsurance	Not covered	Not covered
Outpatient Facility Services	No Coinsurance	Not covered	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.

Benefits	In-Network	Out-Of-Network
Inpatient Services		
Facility Room & Board Charge:		
Hospital / Acute Care Facility	No Coinsurance	No Coinsurance $600* per day benefit maximum not to exceed the maximum allowed amount**

* The maximum does not apply to Emergency Medical Conditions.

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

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

Hip Replacement, Knee Replacement or Spine Surgery*	No Coinsurance	Not covered
Total Knee Replacement*	No Coinsurance	Not covered
Revision Knee Replacement*	No Coinsurance	Not covered
Total Hip Replacement*	No Coinsurance	Not covered
Revision Hip Replacement*	No Coinsurance	Not covered
Discectomy*	No Coinsurance	Not covered
Decompression (without fusion)*	No Coinsurance	Not covered
Primary Fusion*	No Coinsurance	Not covered
Revision Fusion*	No Coinsurance	Not covered

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

Hotel accommodations

– Flight

Benefits	In-Network	Out-Of-Network
Mental Health and Substance Use Disorder (Chemical Dependency) Services (includes behavioral health treatment for Autism Spectrum Disorders)		
Inpatient Services		
Inpatient psychiatric hospitalization	No Coinsurance	No Coinsurance $600* per day benefit maximum not to exceed the maximum allowed amount**
**The Plan will pay the lesser of the benefit maximum or the Maximum Allowed Amount. Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount or benefit maximum.		

Outpatient Office Visits (Including In-Person and/or Virtual Visits and Intensive In-Home Behavioral Health Programs) Individual / group mental health evaluation and treatment Individual / group chemical dependency counseling Medical treatment for withdrawal symptoms	No Copayment	No Coinsurance

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

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

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

Benefits	In-Network	Out-Of-Network
Office and Home* Visits		
*Home visits are not the same as Home Health Care. For Home Health Care benefits please see the "Home Health Care" section.		
Primary Care Physician / Provider (PCP) (Including In-Person and/or Virtual Visits)	No Copayment per visit	No Coinsurance
Specialty Care Physician / Provider (SCP) (Including In-Person and/or Virtual Visits)	No Copayment per visit	No Coinsurance
Retail Health Clinic Visit	No Copayment per visit	No Coinsurance
Virtual Visits by LiveHealth Online (LHO) (Including Primary Care and Mental Health & Substance Use Disorder Services)	$10 Copayment per visit	No Coinsurance
Other Virtual Visits (including Primary Care and Mental Health & Substance Use Disorder Services)	No Copayment per visit	No Coinsurance
Additional Services in an Office Setting In addition to the applicable Office Visit Copayment listed above, if you receive any services listed below that have a Coinsurance cost share, the cost share for those services will also apply.		
Counseling – Includes Family Planning and Nutritional Counseling (Other Than Eating Disorders)	No Coinsurance	No Coinsurance
Nutritional Counseling for Eating Disorders	No Coinsurance	No Coinsurance
Allergy Testing	No Coinsurance	Not covered
Allergy Shots / Injections (other than allergy serum)	No Coinsurance	No Coinsurance
Allergy Shots / Injections (including allergy serum)	No Coinsurance	No Coinsurance
Diagnostic Labs and diagnostic x-rays	No Coinsurance	Not covered*

*Benefits for diagnostic services will not be covered if rendered 553.32 209.78 0.47998 30p TJ33.74 583.6

Advanced Diagnostic Imaging (including MRIs, CAT scans)	No Coinsurance	No Coinsurance $800 per procedure benefit maximum not to exceed the maximum allowed amount**
**The Plan will pay the lesser of the benefit maximum or the Maximum Allowed Amount.		
Office Surgery	No Coinsurance	No Coinsurance
Therapy Services: - Physical Therapy/ Occupational Therapy/ Chiropractic/		

Benefits	
Orthotics	See “Durable Medical Equipment (DME), Medical Devices and Supplies.”

Benefits	
Other Eligible Providers	No Coinsurance plus all charges in excess of the Maximum Allowed Amount
Nurse anesthetists and blood banks do not enter into participating agreements with us, and these Providers must be licensed according to state and local laws to provide covered medical services.	

Ambulatory Surgical Facility - Facility Surgery	No Coinsurance	No Coinsurance $350 per day benefit maximum not to exceed the maximum allowed amount**

*Benefits for diagnostic services will not be covered if rendered by an Out-of-Network Provider.

**The Plan will pay the lesser of the benefit maximum or the Maximum Allowed Amount.

Doctor Surgery Charges	No Coinsurance	No Coinsurance
Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant)	No Coinsurance	No Coinsurance
Other Facility Charges (for procedure rooms or other ancillary services)	No Coinsurance	No Coinsurance

Additional Services in an Outpatient Facility Setting
If you receive only one or more of the services listed below, you will be responsible only for the cost shares for those services. You will not in addition have to pay the Facility charge.

Shots / Injections (other than allergy serum)	No Coinsurance	No Coinsurance
Allergy Shots / Injections (including allergy serum)		

No

Benefits	
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.

Benefits	In-Network	Out-Of-Network
Transgender Services	No Coinsurance	No Coinsurance
Precertification required		
Travel expense	No Copayment or Coinsurance, Covered up to $10,000 per surgery or series of surgeries	No Copayment or Coinsurance, Covered up to $10,000 per surgery or series of surgeries
For an approved transgender 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 75 miles or more from the Member's place of residence. Coach airfare to and from the Hospital when it is 300 miles or more from the Member's place of residence. Lodging, limited to one room, double occupancy. - Other reasonable expenses. Meals, tobacco, alcohol and drug expenses are excluded from coverage.		

Benefits	In-Network	Out-Of-Network
Urgent Care Services		
Urgent Care Center Charge	No Copayment	No Coinsurance
Urgent Care Office Visit Charge	No Coinsurance	No Coinsurance
Allergy Testing	No Coinsurance	Not covered
Shots / Injections (other than		

Benefits	
Virtual Visits (Telehealth/Telemedicine Visits)	See the “Office Visits” section. For Mental Health and Substance Use Disorder Services, also refer to the “Mental Health and Substance Use Disorder (Chemical Dependency) Services” section.
If Preventive Care is provided during a Virtual Visit, it will be covered under the “Preventive Care” benefit, as required by law. Please refer to that section for details.	

Benefits	
Vision Services (All Members / All Ages) (for medical and surgical treatment of injuries and/or diseases of the eye). Certain vision screenings required by Federal law are covered under the “Preventive Care” benefit.	Benefits are based on the setting in which Covered Services are received

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.

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.

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 and/or Copayments 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.

Claims 3ET Precertification will be done by the 0045004800550003>1480 2C0047004800510057004C004950.00J544>26

The Out-of-Network Provider can charge you the Plan's Maximum Allowed Amount plus any Coinsurance and/or Copayments, unless your claim involves a Surprise Billing Claim;

You may have higher cost sharing amounts (i.e., 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.

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

Network Provider. You may also ask your Physician to refer you to an In-Network Provider to receive a second opinion.

Continuity of Care

Transition Assistance for New Members

Transition Assistance is a process that allows for continuity of care for new Members receiving services from an Out-of-Network Provider. If you are a new Member, you may re`quest 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

If your In-Network Provider leaves our network for any reason other than termination of cause, or if coverage under this Plan ends because your Group's Contract ends, or because your Group changes plans, and you are in active treatment, you may be able to continue seeing that Provider for a limited period of time and still get the In-Network benefits.

1. The Member must be under the care of the In-Network Provider at the time of the termination of the

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

The BlueCard Program

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

Identification Card

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

Getting Approval for Benefits

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

Reviewing Where Services Are Provided

A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is reviewed, services that can be safely given to you in a lower level of care or lower cost setting / place of care, will not be Medically Necessary if they are given in a higher level of care, or higher cost setting / place of care. This means that a request for a

Who is Responsible for Precertification?

Typically, In-Network Providers know which services need Precertification and will get any Precertification when needed. Your Primary Care Physician and other In-Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with us to ask for a Precertification review ("requesting Provider"). We will work with the requesting Provider for the Precertification request. However, you may request a Precertification or you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsibility to Get Precertification	Comments

The Claims Administrator also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests

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, 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 Center, an Outpatient Facility, or an Inpatient Facility. Benefits will often vary depending on where and from whom you choose to receive Covered Services, and this can result in a change in the amount you will need to pay. Please see the "Schedule of Benefits" for more details.

Acupuncture

Please see "Therapy Services" later in this section.

Allergy Services

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

Ambulance Services

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

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

For ground ambulance, you are taken:

From your home, scene of accident or medical Emergency to a Hospital;

- Between Hospitals, including when the Claims Administrator requires you to move from an Out-of-Network Hospital to an In-Network Hospital; or
- Between a Ho3ul 10.92 reW* nBT[ )]TJETQq0.00000912 0 612 792 reW*uSdoreW*uSdoreW*uSdoreW

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

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

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 (Chemical Dependency) Services” later in this section.

Cardiac Rehabilitation

Please see “Therapy Services” later in this section.

Chemotherapy

Please see “Therapy Services” later in this section.

Chiropractor Services

Please see “Therapy Services” later in this section.

Clinical Trials

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

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

b) Either of the following applies:

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

   ii. You provide medical and scientific information establishing that your par g125.2 258.44 Tm0.2 g0.2 G[pa)4(r g1

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.

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 prepare for transplants. Covered Services include:

Evaluation
Dental x-rays
Extractions, including surgical extractions
Anesthesia

Treatment of Accidental Injury

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

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

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

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

Under seven (7) years of age; 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:

1. The following Diabetes Equipment and Supplies:

    Glucose monitors, including monitors designed to assist the visually impaired.

Insulin pumps and related necessary supplies.

Pen delivery systems for Insulin administration.

Podiatric devices, such as therapeutic shoes and shoe inserts, to prevent and treat diabetes-related complications are limited to a maximum of two therapeutic shoes and two inserts per calendar year. 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.

Tests ordered prior to a surgical procedure or admission.

Benefits for diagnostic services will not be covered if rendered by an Out-of-Network Provider.

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

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

Is for the exclusive 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.

Artificial limbs and accessories.

One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes).

Breast prosthesis (whether internal or external) and surgical bras after a mastectomy, as required by the Women's Health and Cancer Rights Act, and up to three brassieres required to hold a prosthesis every 12 months as required for Medically Necessary mastectomy.

Colostomy supplies.

Restoration prosthesis (composite facial prosthesis).

Prosthetic devices (except electronic voice producing machines) to restore a method of speaking after laryngectomy.

Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury or congenital defect.

Benefits are also available for cochlear implants.

Hearing aids. This includes bone-anchored hearing aids.

Benefits for prosthetics will not be covered if rendered by an Out-of-Network Provider.

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;

Condition. It includes any further medical or behavioral health exams and treatment required to stabilize the patient.

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

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

- At the time of check-in, the hotel staff will require your credit card for incidental charges and/or security deposit.

Approved rate limits for GSA gov lodging are found in website:
http://www.gsa.gov/portal/category/100120.

Reimbursement:

- After your trip, HealthBase will send you the expense reimbursement form. You can submit the form to HealthBase with your receipts by fax or postal mail. HealthBase will process the expense reimbursement form and send you a check to your home address for the approved expenses.

Home Health Care Services

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

Covered Services include but are not limited to:

Intermittent skilled nursing services by an R.N. or L.P.N.

Medical / social services

Diagnostic services

Nutritional guidance

Training of the patient and/or family/caregiver

Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the home health care Provider. Other organizations may give services only when approved by the Claims Administrator, and their duties must be assigned and supervised by a professional nurse on the staff of the home health care Provider or other Provider as approved by the Claims Administrator.

Therapy Services

Medical supplies

Durable medical equipment

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 (Chemical Dependency) Services."

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 and Substance Use Disorder Services" section below.

Home Infusion Therapy

Please see "Therapy Services" later in this section.

Hospice Care

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

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

Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.

Nursing care services on a continuous basis or short-term Inpatient Hospital care when needed in periods of crisis.

Short-term respite care for the Member only when necessary to relieve the family members or other persons caring for the Member.

Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.

Medical social services under the direction of a Physician.

Social services and counseling services from a licensed social worker.

Nutritional support such as intravenous feeding and feeding tubes or hyperalimentation.

Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.

Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.

Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to the patient and those individuals who are closely linked to the patient, including the immediate family, the primary or designated care giver and individuals with significant personal ties, for one year after the Member's death.

Volunteer services provided by trained Hospice volunteers under the direction of a Hospice staff member.

Medical direction, with the medical director being also responsible for meeting the general medical needs of the Member to the extent that these needs are not met by an attending Physician.

Your Doctor must agree t

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

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

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 and coordinated discharge planning including the planning of such continuing care as may be necessary, both medically and as a means of preventing possible early re-hospitalization.

Benefits for room, board, and nursing services include:

A room with two or more beds.

A private room. The most the Plan will cover for a private room is the Hospital’s average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.

A room in a special care unit approved by the Claims Administrator. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.

Routine nursery care for newborns during the mother’s normal Hospital stay.

Meals, special diets.

General nursing services.

Benefits for ancillary services include:

Operating, childbirth, and treatment rooms and equipment.

Prescribed Drugs.

skilled level of care which must be above the level of custodial or intermediate care. A Skilled Nursing Benefit Period ends on the date the Member has not been an inpatient in a Hospital or Skilled Nursing Facility, receiving a skilled level of care, for 60 consecutive days. A new Skilled Nursing Benefit Period can begin only after any existing Skilled Nursing Benefit Period ends. A prior three-day stay in an acute care Hospital is not required to commence a Skilled Nursing Benefit Period.

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.

Injectable Drugs and Implants for Birth Control

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

Sterilization Services

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

Abortion Services

Benefits include all abortion and abortion-related services, including pre-abortion and follow-up services. For outpatient abortion services, Precertification is not required. Covered services are not subject to the 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

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

Covered Services include diagnostic tests to find the cause of Infertility, such as diagnostic laparoscopy, endometrial biopsy, semen analysis and services to treat the underlying medical conditions that cause

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, we 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.

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,

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 Doctor and Primary Care Provider visits in the home are different than the "Home Health Care" benefit described earlier in this Benefit Booklet.

Retail Health Clinic Care for limited basic medical care services to Members on a "walk-in" basis. These

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.

Chol

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

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

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

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.

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 Coinsurance and/or Copayment provisions otherwise applicable under the Plan.

Temporomandibular Joint (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). Prior authorization is available for surgical treatment of temporomandibular and craniomandibular disorders or conditions.

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.

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.

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.

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, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis.

Infusion Therapy – Nursing, durable medical equipment and Prescription Drug that are delivered and administered to you through an I.V. in your home. Also includes: Total Parenteral Nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See the section "Prescription Drugs Administered by a Medical Provider" for more details. Benefits will not be covered for durable medical equipment or laboratory services by an Out-of-Network Provider.

Pulmonary Rehabilitation – Includes outpatient short-term respiratory care to restore your health after an illness or injury.

Cognitive rehabilitation therapy – Only when Medically Necessary 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 588..90000912 0 612 792 reW* nBT/F1 10.02 Tf1 0 0 1 108.02 576.76 Tmr(lungs)-4Tmr(lueq/F1us)5(s10

travel tickets; prepayments or deposits; services for a condition that is not directly related to, or a direct result of, the transgender procedure; telephone calls; laundry; postage; or entertainment.

Transplant Services

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

Urgent Care Services

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

X-ray services;

Care for broken bones;

Tests such as flu, urinalysis, pregnancy test, rapid strep;

Lab services;

Stitches for simple cuts; and

Draining an abscess.

Virtual Visits (Telehealth / Telemedicine Visits)

Covered Services include virtual Telehealth/Telemedicine visits that are appropriately provided through the internet via video, chat or voice. This includes visits with Providers who also provide services in person, as well as online-only Providers.

“Medical Chat” means Covered Services accessed through our mobile app, website with a Provider via

your Identification Card.

Vision Services

Benefits include medical and surgical treatment of injuries and illnesses of the eye. Certain vision screenings required by Federal law are covere] ˆ Ğ ѝ L ¤ ∂

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 health 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. Benefits for Drugs that you inject or get through your Pharmacy benefits (i.e., self-administered Drugs) are not covered under this section.

Precertification

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

For a list of Prescription Drugs that need precertification, please call the phone number on the back of your Identification Card. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under your Plan. Your Provider may check with the Claims Administrator

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/ca/sisc.

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 Not Supported by Medical Records Charges for services not described in your medical records.

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.

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 federal law. "Clinically equivalent" means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card or visit the website at www.anthem.com/ca/sisc.

If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with the Claims Administrator. The other Prescription Drug will be covered only if it's agreed that it is Medically Necessary and appropriate over the clinically equivalent Drug. Benefits for the Prescription Drug will be reviewed from time to time to make sure the Drug is still Medically Necessary.

Cold Caps any form of cold therapy/scalp cooling including devices for the prevention of hair loss during chemotherapy.

Compl8.88 TW3(in)on foof/ds-86(abr)5(7ices)]86(1e)-2(col8(ld)-698to)-1282on

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 federal 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 Anthem.

Drugs Prescribed for Cosmetic Purposes.

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) or other Drugs provided

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.

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

c. Non-Medically Necessary enhancements to standard equipment and devices.

d. 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 Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is your responsibility.

e. 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.

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

Non-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 Any services or supplies that are not Medically Necessary as defined. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.

Nutritional or Dietary Supplements Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by federal law. This Exclusion includes, but is not limited to, 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 we must cover it by federal law or if we approve it.

Oral Surgery Extraction of teeth, surgery for impacted teeth and other oral surgeries for to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet.

Personal Care and Convenience

a. Items for personal comfort, convenience, protection, cleanliness or beautification such as air conditioners, humidifiers, air or water purifiers, sports helmets, raised toilet seats, and shower chairs.

b. 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, disposable sheaths and supplies).

c. Home workout or therapy equipment, including treadmills and home gyms.

d. Pools, whirlpools, spas, or hydrotherapy equipment.

e. Hypo-allergenic pillows, mattresses, or waterbeds.

f. Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).

Prescription Drugs Prescription drugs you get at a drugstore, retail pharmacy or mail order pharmacy are not covered under this plan (carved out). Benefits for prescription drugs that you take yourself are covered by another plan provided by SISC III. Prescription drugs are covered when administered to you by a Medical Provider

Private Contracts Services or supplies provided pursu 6122Qq0.s1251 0 0 1i 612000912]TJ5hhandr792 rnpBTi

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

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 or Amount owed by you, except for Surprise Billing Claims*, when you receive services from an Out-of-Network Provider, you may be billed by the Provider for the difference between their charges and the Maximum Allowed Amount and the Provider's actual charges. In many situations, this difference could be significant.

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

We have provided two examples below, which illustrate how the Maximum Allowed Amount works. These examples are for illustration purposes only.

Example: The plan has no Coinsurance for In-Network Provider services.

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 pays no Coinsurance when an In-Network surgeon is used. The plan pays 100% of $1,000, or $1,000. The In-Network surgeon accepts the total of $1,000 as reimbursement for the surgery regardless of the charges.

Example: For Out-of-Network Provider services, you are subject to pay any amounts exceeding the Maximum Allowed Amount.

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 pays

M

non-Emergency Covered Services received from an In-Network Provider, but you may have to pay the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount, as well as any applicable Coinsurance or Copayment. 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 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 at which, or as a result of which, you receive non-Emergency Covered Services from an Out-of-Network

Authorized Referrals

In some circumstances, we may authorize In-Network Provider cost share amounts (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 we have been contacted. If we authorize 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 also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge, unless your claim involves a Surprise Billing Claim. Please contact Member

claim form. The same information that would be given on the claim form must be included in the written notice of claim, including:

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

Out-of-Network claims must be submitted within 180 days after the date of service. In certain cases, federal law may allow additional time to file a claim, if you could not reasonably file within the 180-day period. The claim must have the information we need 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 we need 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.

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 federal law requires an extension. Please contact Member Services if you have any questions or concerns about how to

who is recognized under a “Qualified Medical Child Support Order” as having a right to enrollment under the Group’s Plan), or that person’s custodial parent or designated representative. Any payments made by the Claims Administrator (whether to any Provider for Covered Service or You) will discharge the Plan’s obligation to pay for Covered Services. You cannot assign your right to receive payment to anyone, except as required by a “Qualified Medical Child Support Order” as defined by, and if subject to, any applicable Federal law.

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

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

Inter-Plan Arrangements

Out-of-Area Services

Overview

Anthem has a variety of relationships with other Blue Cross and Blue Shield Licensees. Generally, these relationships are called “Inter-Plan Arrangements.” These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association

underestimation of past pricing of claims as well as
price Anthem uses for your claim because they will not be applied after a claim has already been paid.

[redacted]

100

[redacted] also t

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.

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

Not actively working as defined by federal law.

In cases where exceptions 1 or 2 apply, payment will be determined according to the provisions in the section entitled Coordination of Benefits and the provision "Coordinating Benefits With Medicare", below.

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

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

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

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

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

and B), whether or not you are actually enrolled in Medicare Parts A or B. At

Subrogation a

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

You must promptly notify the Plan of how, when and where an accident or incident resulting in personal injury or illness to You occurred, all information regarding the parties involved and any other information requested by the Plan.

You must notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to Your injury, illness or condition.

You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

You and your agents shall provide all information requested by the Plan, the Claims Administrator or

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

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

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

Discretion

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

SISC III Member Rights and Responsibilities

As a SISC III Member you have rights and responsibilities when receiving health care. As your health care partner, the Claims Administrator wants to make sure your rights are respected while providing your health benefits. That means giving you access to the Claims Administrator's network of Doctors and other healthcare professionals, who will help make the best decisions for your health.

These are your rights and responsibilities:

You have the right to:

Speak freely and privately with your Doctors and other healthcare professionals about health care options and treatment needed for your condition, no matter what the cost or whether it is covered under your Plan.

Work with your Doctors and other healthcare professionals to make choices about your health care.

Be treated with respect and dignity.

Expect us to keep your personal health information private by following the Claims Administrator's privacy policies, and state and Federal laws.

Receive the information you need to fully engage with your Health Plan, and share your feedback. This includes:

- The Claims Administrator's company and services.
- The Claims Administrator's network of Doctors and other health care professionals.
- Your rights and responsibilities.
- The way your Health Plan works.

Make a complaint or file an appeal about:

- Your health Plan and any care you receive
- Any Covered Service or benefit decision that your health Plan makes.

Say no to care, for any condition, sickness or disease, without having an effect on any care you may receive in the future. This includes asking your Doctors and other healthcare professionals to tell you how that may affect your health now and in the future.

Get the most up-to-date information from a Doctor about the cause of your illness, your treatment and what may result from it. You can ask for help if you do not understand this information.

You have the responsibility to:

Read all information about your benefits under the Plan and ask for help if you have questions.

Follow all Plan rules and policies.

Choose a Network Primary Care Physician, also called a PCP, if your health plan requires it.

Treat all healthcare professionals and staff with respect.

Keep all scheduled appointments. Call your health care Provider's office if you may be late or need to cancel.

Understand your health challenges as well as you can and work with your Doctors and other healthcare professionals to create an agreed upon treatment plan.

Inform your Doctors and other healthcare professionals if you don't understand the type of care you're getting or what they want you to do as part of your care plan.

Follow the treatment plan that you have agreed upon with your Doctors and other healthcare professionals.

Share the information needed with us, your Doctors and other healthcare professionals to help you get the best possible care. This may include information about other health and insurance benefits you have in addition to your coverage under this Plan.

Let the Claims Administrator's Member Services department know if you have any changes to your name, address or family members covered under your Plan.

If you need more information or would like to contact the Claims Administrator, please go to www.anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your ID card.

We are here to provide high quality benefits and service to Members. Benefits and coverage for services given under the Plan are governed by the Booklet and not by this Member Rights and Responsibilities statement.

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:

You will be provided with a written notice of the denial; and

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

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

Notification of the Outcome of the Appeal

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

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

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

Appeal Denial

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

If, after the denial, the Claims Administrator considers, rely on or generate any new or additional evidence in connection with your claim, the Claims Administrator will provide you with that new or additional evidence, free of charge. The Claims Admi

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

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

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

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 but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan.

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

BINDING ARBITRATION

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this plan or

claims court, suit must be filed within one (1) year from the issuance by the claim's administrator of its decision following appeal. Failure to demand arbitration or file in small claims court within one (1) year of the issuance by the claims administrator of its decision following appeal shall result in the forfeiture of any right to arbitration or to take any other legal action. Any written demand should be sent to the plan administrator at the address shown below:

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

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

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

- d. The two persons are not related by blood in a way that would prevent them from being married to each other in California.
- e. Both persons are at least 18 years of age.
- f. Either of the following: i. Both persons are members of the same sex; or ii. One or both of the persons meet the eligibility criteria under Title II of the Social Security Act as defined in 42 U.S.C. Section 402(a) for old-age insurance benefits or Title XVI of the Social Security Act as defined in 42 U.S.C. Section 1381 for aged members. Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a domestic partnership unless one or both of the persons are over the age of 62 and are registered with the State of California.66
- g. Both persons are capable of consenting to the domestic partnership.
- h. Neither person has previously filed:

  (1) a Declaration of Domestic Partnership with the California Secretary of State, or a similar form with another governing jurisdiction, that has not been terminated pursuant to the laws of California, or of that other jurisdiction, or if

  (1) does not apply,

  (2) an affidavit with SISC III declaring they are part of a domestic partnership that they have not been terminated by giving SISC III written notice that it has.
- i. It has been at least six months since:

  (1) the date that the Notice of Termination of Domestic Partnership was filed with the California Secretary of State, or similar form was filed with another governing authority; or, if (1) does not apply,

  (2) either person has given written notice to SISC III that the domestic partnership they declared in an affidavit, given to SISC III, has terminated. This item does not apply if the previous domestic partnership ended because one of the partners died or married.

j. Both partners:

- i. If they reside in the State of California, must file a Declaration of Domestic Partnership with the California Secretary of State pursuant to Division 2.5 of the California Family Code to establish their domestic partnership. The subscriber must provide SISC III with a certified copy of the Declaration of Domestic Partnership that was filed with the California Secretary of State.
- ii. If they reside in another state or governing jurisdiction that registers domestic partnerships, they must register their domestic partnership with that state or governing jurisdiction. The subscriber must provide SISC III with a certified copy of the document

residence but intends to return. "Basic living expenses" means shelter, utilities, and all other costs directly related to the maintenance of the common household of the common residence of the domestic partners. It also means any other cost, such as medical care, if some or all of the cost is paid as a benefit because a person is another person's domestic partner. "Joint responsibility" means that each partner agrees to provide for the other partner's basic living expenses if the partner is unable to provide for herself or himself. Persons to whom these expenses are owed may enforce this responsibility if, in extending credit or providing goods or services, they relied on the existence of the domestic partnership and the agreement of both partners to be jointly responsible for those specific expenses.

Child is the subscriber’s, spouse's or domestic partner’s, natural child, stepchild, legally adopted child, or a child for whom the subscriber, spouse or domestic partner has been appointed legal guardian by a court of law or has legal custody according to a court of law, subject to the following:

- a. The child is under 26 years of age.67
- b. The unmarried child is 26 years of age, or older and:

  (i) continues to be dependent on the subscriber, spouse or domestic partner for financial support and maintenance as defined by IRS rules. A child is considered chiefly dependent for support and maintenance if he or she is claimed as a dependent for federal income tax purposes; and

  (ii) is incapable of self-sustaining employment due to a physical or mental condition and the disability existed prior to reaching age 26 and has remained continuously disabled since age 26, as cer

(ii) is incapable of self

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

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

Important Note for Newborn and Newly Adopted Children. If the subscriber (or spouse or domestic partner, if the spouse or domestic partner is enrolled) is already covered: (1) any child born to the subscriber, spouse or domestic partner will be covered from the moment of birth; and (2) any child being adopted by the subscriber, spouse or dom

Late Enrollees

Changes in address;

Marriage or divorce;

Death of an enrolled family member (a different type of coverage may be necessary);

Enrollment in another health plan or in Medicare;

Eligibility for Medicare;

Dependent child reaching the Dependent Age Limit (see “Termination and Continuation of Coverage”);

Enrolled Dependent child either becomes totally or permanently disabled or is no longer disabled.

- Overage disabled children must be claimed as a tax dependent by either you or your spouse/domestic partner. Documentation for the appropriate child type (as noted above) and a copy of the front page of the employee/retiree’s most recent federal tax return that includes the child.
- Licensed physician certification certifying that the child is incapable of self-sustaining employment due to a physical or mental condition and that the disability existed prior to reaching age 26 and has remained continuously.

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

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

Nondiscrimination

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

Statements and Forms

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

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

Termination and Continuation of Coverage

Termination of Coverage

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

1. Subscriber

    a. If the participation agreement between the participating employer and SISC III terminates, the

covered under this plan, (ii) still chiefly dependent on the subscriber, spouse or domestic partner for support and maintenance as defined by IRS rules, and (iii) incapable of self-sustaining employment due to a physical or mental condition.

A physician must certify in writing that the child has a physical or mental condition that makes the child incapable of obtaining self-sustaining employment. The Plan Administrator will notify the subscriber that the child's coverage will end when the child reaches the plan's upper age limit at least 90-days prior to the date the child reaches that age. The subscriber must send SISC III proof of the child's physical or mental condition within 60-days of the date the subscriber receives The Plan Administrators notice. If SISC III does not complete their determination of the child's continuing eligibility by the date the child reaches the plan's upper age limit, the child will remain covered pending determination by SISC III. When a period of two years has passed, SISC III may request proof of continuing dependency due to a continuing physical or mental condition, but not more often than once each year. This exception will last until the child is no longer chiefly dependent on the subscriber, spouse or domestic partner for support and maintenance or a physical or mental condition no longer exists. A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

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

Note: If a marriage or domestic partnership terminates, the subscriber must give or send to SISC III written notice of the termination. Coverage for a former spouse or domestic partner, if any, ends according to the "Eligible Status" provisions. If SISC III suffers a loss as a result of the subscriber failing to notify them of the termination of their marriageonditie1 0 0kp.00000912 0 612 5(ar)-26 Tm4C0032SItermi0 n7912 o005(l)-62(i)6(n n795400

Removal of Members

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

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

If the Plan Administrator Offers Retirement Coverage

If y

beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.)

Trade Adjustment Act Eligible Individual

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

When COBRA Coverage Ends

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

A covered individual reaches the end of the maximum coverage period;

A covered individual fails to pay a required premium on time;

A covered individual becomes covered under any other group health plan after electing COBRA;

A covered individual becomes entitled to Medicare after electing COBRA; or

The Group terminates all of its group welfare benefit plans.

Other Coverage Options Besides COBRA Continuation Coverage

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

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

1. The date the Participation Agreement terminates;
2. The end of the period for which required monthly contributions are last paid; or
3. The date the maximum benefits of this Plan are paid.

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

Coverage For Surviving Spouse Of Certified Members

If the Subscriber dies while covered under this Plan as a certificated Subscriber or a certificated retired employee, coverage continues for an enrolled spouse until one of the following occurs:

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

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

Continuation During Labor Dispute

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

1. **Required Monthly Contributions**: Required monthly contributions are determined by SISC III as stated in the Participation Agreement. These required monthly contributions become effective on the required monthly contribution due date after work stops.
2. **Collection of Required Monthly Contributions:** The Participating Employer is responsible for collecting required monthly contributions from those Subscribers who choose to continue coverage. The Participating Employer is also responsible for submitting required monthly contributions to SISC III on or before each required monthly contribution due date.
3. **Cancellation if participation falls below 75%:** SISC III must

General Provisions

Acts Beyond Reasonable Control (Force Majeure)

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

The Claims Administrator wW* n6weir respective obligations.

Confidentiality and Release of Information

Applicable state and federal law requires us to undertake efforts to safeguard your medical information.

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

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

Conformity with Law

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

Entire Agreement

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

Form or Content of Booklet

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

Fraud

Fraudulent statements on Plan enrollment forms or on electronic submissions will invalidate any payment or claims for services and be grounds for voiding the Member's coverage.

Government Programs

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

Governmental Health Care Programs

Under federal law, for groups with 20 or more Employees, all active Employees (regardless of age) can remain on the Group's Health Plan and receive group benefits as primary coverage. Also, spouses (regardless of age) of active Employees can remain on the Group's Health Plan and receive group benefits as primary coverage. Direct any questions about Medicare eligibility and enrollment to your local Social Security Administration office.

Medicare

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

Except when federal law requires us to be the primary payer, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Part B. Where Medicare is the responsible payer, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to us, to the extent we have made payment for such services. If you do not enroll in Medicare Part B when you are eligible, you may have large out-of-pocket costs. Please refer to Medicare.gov

We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as

Reserve Funds

No Member is entitled to share in any reserve or other funds that may be accumulated or established by us, unless we grant a right to share in such funds.

Responsibility to Pay Providers

In accordance with the Claims Administrator's In-Network Provider agreements, Members will not be required to pay any In-Network Provider for amounts owed to that Provider by the Plan (not including Copayments and services or supplies that are not a benefit of this Booklet), even in the unlikely event that the Claims Administrator fails to pay the Provider. Members are liable, however, to pay Out-of-Network Providers for any amounts not paid to those Providers by the Claims Administrator. 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. You will not owe the Out-of-Network Provider more than the In-Network cost sharing for such non-Emergency Covered Services, but you may have to pay the difference between the Outfrom an In

Value-Added Programs

We may offer health or fitness related programs to Members, through which you may access discounted rates from certain vendors for products and services available to the general public. We may also offer value-added services that include discounts on pharmacy products (over the counter drugs, consultations and biometrics). In

Workers' Compensation

The benefits under this Plan are not designed to duplicate benefits that you are eligible for under Worker's Compensation Law. All money paid or owed by Worker's Compensation for services provided to you shall be paid back by, or on yourn

Definitions

If a word or phrase in this 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

Benefit Period Maximum

The most the Plan will cover for a Covered Service during a Benefit Period.

Blue Distinction (BD)

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

Blue Distinction

The Blue distinction requirement does not apply to the following:

- Members under the age of 18
- Emergencies
- Urgent surgery to treat a recent fracture
- Additional

Copayment

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

Domestic Partner (Domestic Partnership)

Both persons have filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code and, at the time of filing, all additional requirements of Domestic Partnership under the California Family Code have been met.

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the “What’s Covered” section.

Emergency Care

Please see the “What’s Covered” section.

Employee

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

Employer

Is an employer that has a Participation Agreement in effect with SISC as of the subscriber’s effective date.

Excluded Services (Exclusion)

Health care services your Plan doesn’t cover.

Experimental or Investigational (Experimental / Investigational)

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

Facility

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

Gender Identity Disorder (Gender Dysphoria)

Gender Identity Disorder (GID), also known as Gender Dysphoria, is 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

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 see 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 behavioral health treatment that provides a combination of individual, group and family therapy in a program that operates no less than 3 hours per day, 3 days per week.

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

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.

Other Eligible Providers

Nurse anesthetists and blood banks that do not enter into participating agreements with us, and these Providers must be licensed according to state and local laws to provide covered medical services.

Out-of-Network Provider

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

Plan Sponsor

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

Precertification

Please see the section “Getting Approval for Benefits” for details.

Predetermination

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 specialize in family/general practice, internal medicine, pediatrics, obstetrics, gynecologist, OB/GYN and nurse practitioner .

Retail Health Clinic

A Facility that provides limited basic medical care services to Members on a “walk-in” basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physician Assistants and nurse

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

Those services necessary to prevent serious deterioration of your health or, in the case of pregnancy, the health of the unborn child, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed. Urgent Care services are not Emergency services.

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.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID card.

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda**.** (TTY/TDD: 711)

Albanian
Keni të drejtën të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për ndihmë, telefononi numrin e shërbimeve për anëtarët, të shënuar në kartën tuaj ID. (TTY/TDD: 711)

Amharic

(TTY/TDD:
711)

Arabic
كبقصلخلا فيعتلاةظفحىلع دوجوملاءضعلا تامدخ مقبلصاتا ًاجم كغبلقىعاسملاو تامولعملاهذه ىلع لوصحلاكلقحي
.)TTY/TDD: 711(ةىعاسملل

Armenian

ID

(TTY/TDD: 711)

Bassa
Ǹ ɓeɖe dyi-bɛ̀ɖɛ̀in-ɖɛ̀ɔ̀ ɓɛ́ m̀ ke bɔ̃nia kɛ ke gbo-kpa-

Burmese

(TTY/TDD: 711)

Chinese

ID (TTY/TDD: 711)

Dinka

në I.D kat du yic. (TTY/TDD: 711)

Dutch

U hebt het recht om deze informatie en hulp gratis in uw taal te krijgen. Bel het ledendienstennummer op uw ID-kaart voor ondersteuning. (TTY/TDD: 711)

Farsi

eኣ⅂ɘ к⅂ eኣɔуꟻƆ ЧƆoħ к⅂ ꟻƆ ኣмx дv н ЧኣЛьГꟻ жуꟻ кv МуƆꟻС ꟻƆ Цј жуꟻ ኣдЇ
ϾЗ ЙƆ Ƴ Ӝ к⅂ t дм ђУኣϾуƆС ϾꟻϾ⅂~.Мфиv ђУኣуƆС eኣϾƆСоÞ

Polish
Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Portuguese-Europe
Tem o direito de receber gratuitamente estas informações e ajuda no seu idioma. Ligue para o número dos Serviços para Membros indicado no seu cartão de identificação para obter ajuda. (TTY/TDD: 711)

Punjabi

Yoruba
O ní ẹ̀t ọ ẹ ˆ 2 ‡ & ęЙ L t ¯ C C ęę
fún ìrànw

That’s why we follow federal civil rights laws in our health programs and activities. We don’t discriminate, exclude

disabilities, we offer free aids and services. 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/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinato

NOTICE OF PROTECTION PROVIDED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

Effective April 14, 2003, a Federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires that health plans like the Self-Insured Schools of California (SISC) group health plan (hereafter referred to as the "Plan"), maintain the privacy of your personally identifiable health information (called **Protected Health Information or PHI**).

The term **"Protected Health Information" (PHI)** includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you

Health Care Operations includes, but is not limited to:

a. Business planning and development, such as conducting

was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes