OTSUKA AMERICA, INC.

January 1, 2024

HSA Gold Rx

(Prescription Plan C)

Prescription Drug Plan Benefit Booklet

Dear *Plan Member*:

This *Benefit Booklet* ("*benefit booklet*") provides an explanation of *your* benefits, limitations and other *plan* provisions which apply to *you* if *you* are covered under the *Prescription Drug plan* that is a part of the Otsuka America, Inc Health and Welfare *Plan*. This *plan* works in conjunction with *your* medical *plan* and *you* should refer to both booklets when reviewing *your* benefits coverage and eligibility.

Subscribers and covered *dependents* ("*members*") are referred to as "*you*" and "*your*". The *plan administrator* is referred to as "*we*", "*us*" and "*our*".

All italicized words have specific definitions. These definitions can be found either in the specific section or in the DEFINITIONS section of this *benefit booklet*.

Please read this *benefit booklet* carefully so that *you* understand the benefits *your plan* offers. Keep this *benefit booklet* as well as the medical benefits booklet applicable to *your* coverage handy in case *you* have any questions about *your* coverage.

Important: This is not an insured benefit *plan*. The benefits described in this *benefit booklet* or any rider or amendments hereto are funded by the *plan administrator* who is responsible for their payment. Anthem Blue Cross Life and Health Insurance Company provides administrative claims payment services only and does not assume any financial risk or obligation with respect to benefit claims.

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

COMPLAINT NOTICE

All complaints and disputes relating to benefits available under this *plan* must be resolved in accordance with the *plan's* grievance procedures. Grievances may be made by telephone (please call the *Member* Services Department named on *your* ID card). If *you* wish, the *Claims Administrator* will provide a Complaint Form which *you* may use to explain the matter.

Claims Administered by:

ANTHEM BLUE CROSS

on behalf of

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

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TYPES OF PROVIDERS

PLEASE READ THE FOLLOWING INFORMATION SO *YOU* WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDER *PRESCRIPTION DRUGS* MAY BE OBTAINED. THE MEANINGS OF WORDS AND PHRASES IN ITALICS ARE DESCRIBED IN THE SECTION OF THIS *BENEFIT BOOKLET* ENTITLED DEFINITIONS.

For Medical Related Coverage Details, Please Refer to *Your* Separate Medical *Plan* Benefits Booklet.

Participating and Non-Participating Pharmacies. "Participating Pharmacies" agree to charge only the *prescription drug maximum allowed amount* to fill the *prescription*. After you have met your Calendar Year Deductible, *You* pay only *your* co-payment amount.

"Non-Participating Pharmacies" have not agreed to the *prescription drug maximum allowed amount*. The amount that will be covered as *prescription drug covered expense* is significantly lower than what these providers customarily charge.

IN CERTAIN INSTANCES *PRESCRIPTION DRUGS* MAY BE COVERED UNDER THE TERMS OF THE SEPARATE MEDICAL *PLAN* AND PAID AND COORDINATED THROUGH THE PROVISIONS OF THAT *PLAN* AS OPPOSED TO THE *PHARMACY PLAN*.

SUMMARY OF BENEFITS

THE BENEFITS OF THIS *PLAN* ARE PROVIDED ONLY FOR *PRESCRIPTION DRUGS* WHICH ARE CONSIDERED TO BE *MEDICALLY NECESSARY*. THE FACT THAT A *PHYSICIAN* PRESCRIBES OR ORDERS A SERVICE OR *DRUG* DOES NOT, IN ITSELF, MEAN THAT THE SERVICE OR *DRUG* IS *MEDICALLY NECESSARY* OR MEAN THAT THE SERVICE IS COVERED UNDER THIS *PLAN*.

CONSULT THIS *BENEFIT BOOKLET* AS WELL AS *Your* Separate Medical *Plan* Benefits Booklet OR TELEPHONE THE NUMBER SHOWN ON *YOUR* IDENTIFICATION CARD IF *YOU* HAVE ANY QUESTIONS REGARDING WHETHER SERVICES OR *DRUGS* ARE COVERED.

THIS *PLAN* CONTAINS MANY IMPORTANT TERMS (SUCH AS "*MEDICALLY NECESSARY*" AND "*PRESCRIPTION DRUG MAXIMUM ALLOWED AMOUNT*") THAT ARE DEFINED IN THE DEFINITIONS SECTION. WHEN READING THROUGH THIS *BENEFIT BOOKLET*, CONSULT THE DEFINITIONS SECTION TO BE SURE THAT *YOU* UNDERSTAND THE MEANINGS OF THESE ITALICIZED WORDS.

For *your* convenience, this summary provides a brief outline of *your pharmacy* benefits. *You* need to refer to the entire *benefit booklet* for more complete information about the benefits, conditions, limitations and exclusions of *your plan*.

The benefits of this *plan* may be subject to the SUBROGATION AND REIMBURSEMENT section.

PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG CO-PAYMENTS. The following co-payments apply for each *prescription* after you have met your Medical Deductible under *Your* Separate Medical *Plan* Benefits Booklet:

Retail Pharmacies: The following co-payments apply for a 30-day supply of medication. **Note**: Specified *specialty drugs* must be obtained through the specialty *pharmacy* program. However, the first two month supply of a *specialty drug* may be obtained through a retail *pharmacy*, after which the *drug* is available only through the specialty *pharmacy* program unless an exception is made.

Please note, *prescription drugs* that are required to be covered by federal law under the "Preventive Care Services" benefit will be covered with no deductible, copayments or coinsurance when *you* use a *participating pharmacy*.

Participating Pharmacies

- *Tier 1 drugs*.....**20%**
- *Tier 2 drugs*.....**20%**
- *Tier 3 drugs*.....**20%**
- *Tier 4 drugs*.....**20%**

Please note that presentation of a *prescription* to a pharmacy or pharmacist does not constitute a claim for benefit coverage. If *you* present a *prescription* to a *participating pharmacy*, and the *participating pharmacy* indicates *your prescription* cannot be filled, or requires an additional Co-Payment, this is not considered an adverse claim decision. If *you* want the *prescription* filled, *you* will have to pay either the full cost, or the additional Co-Payment, for the *prescription drug.* If *you* believe *you* are entitled to some *plan* benefits in connection with the *prescription drug*, submit a claim for reimbursement to the *pharmacy benefits manager* as described below.

Non-Participating Pharmacies

- *Tier 1 drugs*.....**40%**
- *Tier 2 drugs*.....**40%**
- *Tier 3 drugs*.....**40%**
- *Tier 4 drugs*.....**40%**

Home Delivery Prescriptions: The following co-payments apply for a 90-day supply of medication.

- *Tier 1 drugs*.....**$20**
- *Tier 2 drugs*.....**$60**
- *Tier 3 drugs*.....**$100**
- *Tier 4 drugs*.....**$100**

Exception(s) to Prescription Drug Co-payments

- "Preventive *Prescription Drugs* and Other Items" covered under *YOUR PRESCRIPTION DRUG* BENEFITS ..... **No charge**
- The following *prescription drugs* are covered under *YOUR PRESCRIPTION DRUG* BENEFITS ..... **No charge**
  - Abilify Maintena
  - Abilify MyCite
  - Abilify Tablets
  - Dacogen
  - IV Busulfex
  - Inqovi
  - Jynarque
  - Samsca
  - Nuedexta
  - Rexulti
  - Lonsurf
  - Balversa
  - Kisqali
  - Kisqal & Femara

***Important Note About *Prescription Drug Covered Expense* and *Your* Co-Payment.**

The *prescription drug formulary* is a list of outpatient *prescription drugs* which may be particularly cost-effective, therapeutic choices. *Your* co-payment amount for *non-formulary drugs* is higher than for *formulary drugs*. Any *participating pharmacy* can assist *you* in purchasing a *formulary drug*. *You* may also get information about covered *formulary drugs* by calling the number on the back of *your* ID Card or going to the internet website www.anthem.com/ca.

***YOU* WILL BE REQUIRED TO PAY YOUR CO-PAYMENT AMOUNT TO THE *PARTICIPATING PHARMACY* AT THE TIME YOUR PRESCRIPTION IS FILLED.**

Note: If your *pharmacy's* retail price for a *drug* is less than the co-payment shown above, *you* will not be required to pay more than that retail price.

Preferred Generic Program

Prescription drugs will always be dispensed by a *pharmacist* as prescribed by your *physician*. Your *physician* may order a *drug* in a higher or lower *drug co-payment* tier for you. You may request your *physician* to prescribe a *drug* in a higher *drug co-payment* tier instead of a *drug* in a lower *co-payment* tier or you may request the *pharmacist* to give you a *drug* in a higher co-payment tier instead of a *drug* in a lower co-payment tier. Under this *plan*, if a *drug* is available in a lower *co-payment drug* tier, and it is not determined that a *drug* in a higher *co-payment drug* tier is *medically necessary* for you to have (see *PRESCRIPTION DRUG FORMULARY*: PRIOR AUTHORIZATION below), you will have to pay the *co-payment* for the lower tier *drug* plus the difference in cost between the *prescription drug maximum allowed amount* for the lower *co-payment drug* tier and the higher *co-payment drug* tier, but, not more than 50% of the average cost for the tier that the *drug* is in. If your *physician* specifies "dispense as written," in lieu of paying the co-payment for the lower tier *drug* plus the difference, as previously stated, you will pay just the applicable co-payment shown for the higher tier *drug* you get. For certain higher cost *generic drugs*, the *plan* may make an exception and not require you to pay the difference in cost between the *generic drug* and *brand name drug*.

PreventiveRx Program

The PreventiveRx Program allows *you* to obtain certain preventive medications included on the PreventiveRx Expanded List with payment of a co-payment. The PreventiveRx Plus *drug* list is a combination of *drugs* that have been identified as useful in preventing disease or illness. The *Pharmacy and Therapeutics Process* will periodically determine additions and deletions to the approved list. To obtain a list of the products available on this program call the number on the back of *your* ID Card or go to the *claims administrator's* internet website www.anthem.com.

Note: The PreventiveRx Program covers *drugs* in addition to those required by federal law under the "Preventive Prescription Drugs and Other Items" benefit. Any *drugs* covered under the "Preventive Prescription Drugs and Other Items" benefit will not be subject to the *Calendar Year* Deductible or a co-payment.

National 90 for Maintenance Drugs

You can get a 90-day supply of *maintenance drugs* from a *maintenance pharmacy*. A *maintenance drug* is a *drug you* take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If *you* are not sure the *prescription drug you* are taking is a *maintenance drug* or need to determine if *your pharmacy* is a *maintenance pharmacy,* please call Pharmacy Member Services at the number on the back of *your* Identification Card or check our website at www.anthem.com for more details.

YOUR PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG COVERED EXPENSE

Prescription drug covered expense is the maximum charge for each covered service or supply that will be accepted for each different type of *pharmacy*. It is not necessarily the amount a *pharmacy* bills for the service.

You may avoid higher out-of-pocket expenses by choosing a *participating pharmacy*, or by utilizing the home delivery program whenever possible. In addition, *you* may also reduce *your* costs by asking *your physician*, and *your* pharmacist, for the more cost-effective *generic* form of *prescription drugs*.

Prescription drug covered expense will always be the lesser of the billed charge or the *prescription drug maximum allowed amount*. Expense is incurred on the date *you* receive the *drug* for which the charge is made.

When *you* choose a *participating pharmacy*, the *pharmacy benefits manager* will subtract any expense which is not covered under *your prescription drug* benefits. The remainder is the amount of *prescription drug covered expense* for that claim. *You* will not be responsible for any amount in excess of the *prescription maximum allowed amount* for the covered services of a *participating pharmacy*.

***You* will always be responsible for expense incurred which is not covered under this *plan*.**

PRESCRIPTION DRUG CO-PAYMENTS

CO-PAYMENTS

After the *pharmacy benefits manager* determines *prescription drug covered expense*, they will subtract *your Prescription Drug* Co-Payment for each *prescription*.

If *your Prescription Drug* Co-Payment includes a percentage of *prescription drug covered expense*, then the *pharmacy benefits manager* will apply that percentage to such expense. This will determine the dollar amount of *your Prescription Drug* Co-Payment.

The *Prescription Drug* Co-Payments is set forth in the SUMMARY OF BENEFITS.

HOW TO USE YOUR PRESCRIPTION DRUG BENEFITS

When *You* Go to a Participating Pharmacy. To identify *you* as a *member* covered for *prescription drug* benefits, *you* will be issued an ID card. *You* must present this card to *participating pharmacies* when *you* have a *prescription* filled. Provided *you* have properly identified yourself as a *member*, a *participating pharmacy* will only charge *your* Co-Payment.

Generic drugs will be dispensed by *participating pharmacies* when the *prescription* indicates a *generic drug*. When a *brand name drug* is specified, but a *generic drug* equivalent exists, the *generic drug* will be substituted. *You* will have to pay an additional charge equal to the difference between the *brand name drug* and *generic drug*. *Brand name drugs* will be dispensed by *participating pharmacies* when the *prescription* specifies a *brand name* and states "dispense as written" or no *generic drug* equivalent exists. (see PREFERRED GENERIC PROGRAM above)

For information on how to locate a *participating pharmacy* in *your* area, call the number on the back of *your* ID Card.

Please note that presentation of a prescription to a *pharmacy* or pharmacist does not constitute a claim for benefit coverage. If *you* present a *prescription* to a *participating pharmacy*, and the *participating pharmacy* indicates *your prescription* cannot be filled, or requires an additional Co-Payment, this is not considered an adverse claim decision. If *you* want the *prescription* filled, *you* will have to pay either the full cost, or the additional Co-Payment, for the *prescription drug.* If *you* believe *you* are entitled to some *plan* benefits in connection with the *prescription drug*, submit a claim for reimbursement to the *pharmacy benefits manager* at the address shown below:

Prescription Drug Program
ATTN: Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872

Participating pharmacies usually have claims forms, but, if the *participating pharmacy* does not have claim forms, claim forms and *Member* Services are available by calling the number on the back of *your* ID Card. Mail *your* claim, with the appropriate portion completed by the pharmacist, to the *pharmacy benefits manager* within 90 days of the date of purchase. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed.

Important Note: If the *claims administrator* determines that *you* may be using *prescription drugs* in a harmful or abusive manner, or with harmful frequency, *your* selection of *participating pharmacies* may be limited. If this happens, the *plan* may require *you* to select a single *participating pharmacy* that will provide and coordinate all future *pharmacy* services.

Benefits will only be paid if *you* use the single *participating pharmacy*. The *claims administrator* will contact *you* if they determine that use of a single *participating pharmacy* is needed and give *you* options as to which *participating pharmacy you* may use. If *you* do not select one of the *participating pharmacies* that the *plan* offers within 31 days, the *claims administrator* will select a single *participating pharmacy* for *you*. If *you* disagree with the *claims administrator's* decision, *you* may file complaint as described in the COMPLAINT NOTICE.

In addition, if the *claims administrator* determines that *you* may be using *controlled substance prescription drugs* in a harmful or abusive manner, or with harmful frequency, *your* selection of *participating providers* for *controlled substance prescriptions* may be limited. If this happens, the *claims administrator* may require *you* to select a single *participating provider* that will provide and coordinate all *controlled substance prescriptions*. Benefits for *controlled substance prescriptions* will only be paid if *you* use the single *participating provider*. The *claims administrator* will contact *you* if it determines that use of a single *participating provider* is needed and give *you* options as to which *participating provider you* may use. If *you* do not select one of the *participating providers* that is offered within 31 days, the *claims administrator* will select a single *participating provider* for *you*. If *you* disagree with the *claims administrator's* decision, *you* may file complaint as described in the COMPLAINT NOTICE.

When *You* are Out of State. If *you* need to purchase a *prescription drug* out of the state of California, *you* may locate a *participating pharmacy* by calling the number on the back of *your* ID Card. If *you* cannot locate a *participating pharmacy*, *you* must pay for the *drug* and submit a claim to the *claims administrator*.

When *You* Order Your Prescription Through the Home Delivery Program. *You* can order *your prescription* through the home delivery *prescription drug* program. Not all medications are available through the home delivery *pharmacy*.

The *prescription* must state the *drug* name, dosage, directions for use, quantity, the *physician's* name and phone number, the patient's name and address, and be signed by a *physician*. *You* must submit it with the appropriate payment for the amount of the purchase, and a properly completed order form. *You* need only pay the cost of *your* Co-Payment.

Your first home delivery *prescription* must also include a completed Patient Profile questionnaire. The Patient Profile questionnaire can be obtained by calling the toll-free number on *your* ID card. *You* need only enclose the *prescription* or refill notice, and the appropriate payment for any subsequent home delivery prescriptions, or call the toll-free number. Co-payments can be paid by check, money order or credit card.

Order forms can be obtained by contacting the number on the back of *your* ID Card to request one. The form is also available on-line at www.anthem.com/ca.

When *You* Order Your Prescription Through Specialty Pharmacy Program. Certain specified *specialty drugs* must be obtained through the specialty *pharmacy* program unless *you* are given an exception from the specialty *pharmacy* program (see *PRESCRIPTION DRUG* CONDITIONS OF SERVICE). These specified *specialty drugs* that must be obtained through the Specialty *Pharmacy* Program are limited up to a 30-day supply. The Specialty *Pharmacy* Program will deliver *your* medication to *you* by mail or common carrier (*you* cannot pick up *your* medication at Anthem Blue Cross Life and Health).

The *prescription* for the *specialty drug* must state the *drug* name, dosage, directions for use, quantity, the *physician's* name and phone number, the patient's name and address, and be signed by a *physician*.

You or *your physician* may order *your specialty drug* by calling the number on the back of *your* ID card. When *you* call the Specialty *Pharmacy* Program, a Dedicated Care Coordinator will guide *you* through the process up to and including actual delivery of *your specialty drug* to *you*. (If *you* order *your specialty drug* by telephone, *you* will need to use a credit card or debit card to pay for it.) *You* may also submit *your specialty drug prescription* with the appropriate payment for the amount of the purchase (*you* can pay by check, money order, credit card or debit card), and a properly completed order form to the Specialty *Pharmacy* Program. *You* will only have to pay the cost of *your* Co-Payment.

The first time *you* get a *prescription* for a *specialty drug you* must also include a completed Intake Referral Form. The Intake Referral Form is to be completed by calling the toll-free number below. *You* need only enclose the *prescription* or refill notice, and the appropriate payment for any subsequent *specialty drug prescriptions*, or call the toll-free number. Co-payments can be made by check, money order, credit card or debit card.

You or *your physician* may obtain order forms or a list of *specialty drugs* that must be obtained through specialty *pharmacy* program by contacting *Member* Services at the number listed on *your* ID card or online at www.anthem.com/ca.

Specified *specialty drugs* must be obtained through the Specialty *Pharmacy* Program. When these specified *specialty drugs* are not obtained through the Specialty *Pharmacy* Program, and *you* do not have an exception, *you* will not receive any benefits for these *drugs* under this *plan*.

PRESCRIPTION DRUG UTILIZATION REVIEW

Your prescription drug benefits include utilization review of *prescription drug* usage for *your* health and safety. Certain *drugs* may require prior authorization. If there are patterns of over-utilization or misuse of *drugs*, the *claims administrator's* medical consultant will notify *your* personal *physician* and *your* pharmacist. The *claims administrator* reserves the right to limit benefits to prevent over-utilization of *drugs*.

PRESCRIPTION DRUG FORMULARY

The presence of a *drug* on the *plan's prescription drug formulary* list does not guarantee that *you* will be prescribed that *drug* by *your physician*. These medications, which include both generic and *brand name drugs*, are listed in the *prescription drug formulary*. The *formulary* is updated quarterly to ensure that the list includes *drugs* that are safe and effective. **Note:** The *formulary drugs* may change from time to time.

Some *drugs* may require prior authorization. If *you* have a question regarding whether a particular *drug* is on the *formulary drug* list or requires prior authorization please call the number on the back of *your* ID card. Information about the *drugs* on the *formulary drug* list is also available on the *claims administrator's* internet website www.anthem.com/ca.

Exception request for a *drug* not on the *prescription drug formulary* (non-formulary exceptions).

Your prescription drug benefit covers *drugs* listed in a *prescription drug formulary*. This *prescription drug formulary* contains a limited number of *prescription drugs*, and may be different than the *prescription drug formulary* for other Anthem products. **In cases where *your physician* prescribes a medication that is not on the *prescription drug formulary*, it may be necessary to obtain a non-formulary exception in order for the *prescription drug* to be a covered benefit. *Your physician* must complete a non-formulary exception form and return it to the *claims administrator*. *You* or *your physician* can get the form online at www.anthem.com or by calling the number listed on the back of *your* ID card.**

When the *claims administrator* receives a non-formulary exception request, they will make a coverage decision within a certain period of time, depending on whether exigent circumstances exist.

Exigent circumstances exist if *you* are suffering from a health condition that may seriously jeopardize *your* life, health, or ability to regain maximum function, or if *you* are undergoing a current course of treatment using a *drug* not covered by the *plan*. In this case, the *claims administrator* will make a coverage decision within 24 hours of receiving *your* request. If the

drug is approved, coverage of the *drug* will be provided for the duration of the exigency. If the *drug* coverage is denied, *you* have the right to request an external review.

When exigent circumstances do not exist, the *claims administrator* will make a coverage decision within 72 hours of receiving *your* request. If the *drug* is approved, coverage of the *drug* will be provided for the duration of the *prescription*, including refills. If the *drug* coverage is denied, *you* have the right to request an external review.

Requesting a non-formulary exception does not affect *your* right to submit an appeal.

Coverage of a *drug* approved as a result of *your* request or *your physician's* request for an exception will only be provided if *you* are a *member* enrolled under the *plan*.

Prior Authorization. *Physicians* must obtain prior authorization in order for *you* to get benefits for certain *prescription drugs*. At times, *your physician* will initiate a prior authorization on *your* behalf before *your pharmacy* fills *your* prescription. At other times, the *pharmacy* may make *you* or *your physician* aware that a prior authorization or other information is needed. In order to determine if the *prescription drug* is eligible for coverage, the following criteria has been established:

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

- Specific clinical criteria and/or recommendations made by state or federal agencies (including, but not limited to, requirements regarding age, test result requirements, presence of a specific condition or disease, quantity, dose and/or frequency of administration);
- Specific provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies) as recommended by the FDA;
- Use of a *prescription drug formulary* which is a list of FDA-approved *drugs* that have been reviewed and recommended for use based on their quality and cost effectiveness.

You or *your physician* can get the list of the *prescription drug* that require prior authorization by calling the phone number on the back of *your* ID card or check the *claims administrator's* website at www.anthem.com. 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 physician* may check with the *claims administrator* to verify

prescription drug coverage, to find out which *prescription drug* are covered under this section and if any *drug* edits apply.

In order for *you* to get a *drug* that requires prior authorization, *your physician* must send a written request to the *claims administrator* for the *drug* using the required uniform prior authorization request form. The request, for either prior authorization exceptions, can be facsimiled, mailed or submitted electronically to the *claims administrator*. If *your physician* needs a copy of the request form, he or she may call the *claims administrator* at the number on the back of *your* ID card to request one. The form is also available on-line at www.anthem.com/ca.

Upon receiving the completed uniform prior authorization request form, the *claims administrator* will review the request and respond within the following time periods:

- 72 hours for non-urgent requests, and
- 24 hours if exigent circumstances exist. Exigent circumstances exist if *you* are suffering from a health condition that may seriously jeopardize *your* life, health, or ability to regain maximum function, or if *you* are undergoing a current course of treatment using a *drug* not covered by the *plan.*

While the *claims administrator* is reviewing the request, a 72-hour *emergency* supply of medication may be dispensed to *you* if *your physician* or pharmacist determines that it is appropriate and *medically necessary*. *You* may have to pay the applicable co-payment shown in SUMMARY OF BENEFITS: *PRESCRIPTION DRUG* BENEFITS: *PRESCRIPTION DRUG* CO-PAYMENTS for the 72-hour supply of *your drug*. If the *plan* approves the request for the *drug* after *you* have received a 72-hour supply, *you* will receive the remainder of the 30-day supply of the *drug* with no additional co-payment.

If *you* have any questions regarding whether a *drug* in on the *prescription drug formulary*, or requires prior authorization, please call the number on the back of *your* ID card.

If the *claims administrator* denies a request for prior authorization of a *drug*, *you* or *your* prescribing *physician* may appeal the decision by calling the number on the back of *your* ID card.

Revoking or modifying a prior authorization. A prior authorization of benefits for *prescription drugs* may be revoked or modified prior to *your* receiving the *drugs* for reasons including but not limited to the following:

- *Your* coverage under this *plan* ends;
- The *plan* with the *plan administrator* terminates;

- *You* reach a benefit maximum that applies to *prescription drugs*, if the *plan* includes such a maximum;

- *Your prescription drug* benefits under the *plan* change so that *prescription drugs* are no longer covered or are covered in a different way.

A revocation or modification of a prior authorization of benefits for *prescription drugs* applies only to unfilled portions or remaining refills of the *prescription*, if any, and not to *drugs you* have already received.

New *drugs* and changes in the *prescription drugs* covered by the *plan*. The outpatient *prescription drugs* included on the list of *formulary drugs* covered by the *plan* is decided by the *Pharmacy and Therapeutics Process*, which is comprised of independent nurses, *physicians* and pharmacists. The *Pharmacy and Therapeutics Process* meets quarterly and decides on changes to make in the *formulary drug* list based on recommendations from the *claims administrator* and a review of relevant information, including current medical literature.

PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS

Your prescription drug benefits include certain preventive *drugs*, medications, and other items as listed below that may be covered under this *plan* as *preventive care services*. In order to be covered as a *preventive care service*, these items must be prescribed by a *physician* and obtained from a *participating pharmacy* or through the home delivery program. This includes items that can be obtained over the counter for which a *physician's prescription* is not required by law.

When these items are covered as *preventive care services*, no co-payment will apply.

- All FDA-approved contraceptives for women, including oral contraceptives, diaphragms, patches, and over-the-counter contraceptives. In order to be covered as a *preventive care service,* in addition to the requirements stated above, contraceptive *prescription drugs* must be *generic* oral contraceptives or *brand name drugs*.

- Vaccinations prescribed by a *physician* and obtained from a *participating pharmacy*.

- Tobacco cessation *drugs*, medications, and other items for *members* age 18 and older as recommended by the United States Preventive Services Task Force including:

  - *Prescription drugs* to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products.

- FDA-approved smoking cessation products including over-the-counter (OTC) nicotine gum, lozenges and patches when obtained with a *physician's* prescription.

- Aspirin to reduce the risk of heart attack or stroke, for men ages 45-79 and women ages 55-79.
- Aspirin after 12 weeks of gestation in pregnant women who are at high risk for preeclampsia.
- *Generic* low to moderate dose statins for *members* that are 40-75 years and have one or more risk factors for cardiovascular disease.
- Folic acid supplementation for women age 55 years and younger (folic acid supplement or a multivitamin).
- Medications for risk reduction of primary breast cancer in women (such as tamoxifen or raloxifene) for women who are at increased risk for breast cancer and at low risk for adverse medication effects.
- Bowel preparations when prescribed for a preventive colon screening.
- Fluoride supplements for children from birth through 6 years old (drops or tablets).
- Dental fluoride varnish to prevent tooth decay of primary teeth for children from birth to 5 years old.

PRESCRIPTION DRUG CONDITIONS OF SERVICE

To be covered, the *drug* or medication must satisfy all of the following requirements:

1. It must be prescribed by a licensed prescriber and be dispensed within one *year* of being prescribed, subject to federal and state laws. This requirement will not apply to covered vaccinations provided at a *participating pharmacy*.
2. It must be approved for general use by the Food and *Drug* Administration (FDA).
3. It must be for the direct care and treatment of *your* illness, injury or condition. Dietary supplements, health aids or *drug*s for cosmetic purposes are not included. However the following items are covered:
    a. Formulas prescribed by a *physician* for the treatment of phenylketonuria.

b. Vaccinations provided at a *participating pharmacy* as specified under PREVENTIVE *PRESCRIPTION DRUGS* AND OTHER ITEMS, subject to all terms of this *plan* that apply to those benefits.

c. Vitamins, supplements, and health aids as specified under PREVENTIVE *PRESCRIPTION DRUGS* AND OTHER ITEMS, subject to all terms of this *plan* that apply to those benefits.

4. It must be dispensed from a licensed retail *pharmacy*, through the home delivery program or through the specialty *pharmacy* program.

5. **If it is an approved *compound medication*, be dispensed by a *participating pharmacy*.** Call the number on the back of *your* ID card to find out where to take *your prescription* for an approved *compound medication* to be filled. (*You* can also find a *participating pharmacy* at www.anthem.com/ca.) **Some *compound medications* must be approved before *you* can get them (See *PRESCRIPTION DRUG FORMULARY*: PRIOR AUTHORIZATION). *You* will have to pay the full cost of the *compound medications you* get from a *pharmacy* that is not a *participating pharmacy*.**

6. **If it is a specified *specialty drug*, be obtained by using the specialty *pharmacy* program.** See the section HOW TO USE *YOUR PRESCRIPTION DRUG* BENEFITS: WHEN *YOU* ORDER *YOUR PRESCRIPTION* THROUGH SPECIALTY *PHARMACY* PROGRAM for how to get *your drugs* by using the specialty *pharmacy* program. ***You* will have to pay the full cost of any *specialty drugs you* get from a retail *pharmacy* that *you* should have obtained from the specialty *pharmacy* program. If *you* order a *specialty drug* that must be obtained using the specialty *pharmacy* program through the home delivery program, it will be forwarded to the specialty *pharmacy* program for processing and will be processed according to *specialty* program rules.**

   Exceptions to specialty *pharmacy* program. This requirement does not apply to:

   a. The first two month's supply of a specified *specialty drug* which is available through a participating retail *pharmacy*;

   b. *Drugs*, which due to medical necessity, must be obtained immediately;

   c. A *member* who is unable to pay for delivery of their medication (i.e., no credit card); or

   d. A *member* for whom, according to the Coordination of Benefit rules, this *plan* is not the primary *plan*.

How to obtain an exception to the specialty *pharmacy* program. If *you* believe that *you* should not be required to get *your* medication through the specialty *pharmacy* program, for any of the reasons listed above, except for d., *you* must complete an Exception to Specialty *Pharmacy* Program form to request an exception and send it to the *claims administrator*. The form can be faxed or mailed to the *claims administrator*. If *you* need a copy of the form, *you* may call the number on the back of *your* ID card to request one. *You* can also get the form on-line at www.anthem.com/ca. If the *claims administrator* has given *you* an exception, it will be good for a limited period of time based on the reason for the exception. When the exception period ends, if *you* believe that *you* should still not be required to get *your* medication through the specialty *pharmacy* program, *you* must again request an exception. If *your* request for an exception is denied, it will be in writing and will tell *you* why they did not approve the exception.

Urgent or *emergency* need of a *specialty drug* subject to the specialty *pharmacy* program. If *you* are out of a *specialty drug* which must be obtained through the specialty *pharmacy* program, the *claims administrator* will authorize an override of the specialty *pharmacy* program requirement for 72-hours, or until the next business day following a holiday or weekend, to allow *you* to get an *emergency* supply of medication if *your* doctor decides that it is appropriate and *medically necessary*. *You* may have to pay the applicable co-payment shown under SUMMARY OF BENEFITS: *PRESCRIPTION DRUG* BENEFITS: *PRESCRIPTION DRUG* CO-PAYMENTS for the 72-hour supply of *your drug*.

If *you* order *your specialty drug* through the specialty *pharmacy* program and it does not arrive, if *your physician* decides that it is *medically necessary* for *you* to have the *specialty drug* immediately, the *claims administrator* will authorize an override of the specialty *pharmacy* program requirement for 30-day supply or less, to allow *you* to get an *emergency* supply of medication from a *participating pharmacy* near *you*. A Dedicated Care Coordinator from the specialty *pharmacy* program will coordinate the exception and *you* will not be required to make an additional co-payment.

7. It must not be used while *you* are confined in a *hospital*, *skilled nursing facility,* rest home, sanitarium, convalescent *hospital*, or similar facility. Also, it must not be dispensed in or administered by a *hospital*, *skilled nursing facility,* rest home, sanitarium, convalescent *hospital*, or similar facility. Other *drugs* that may be prescribed by *your physician* while *you* are confined in a rest home, sanitarium, convalescent *hospital* or similar facility, may be purchased at a *pharmacy* by the *member*, or a friend, relative or care giver on *your* behalf, and are covered under this *prescription drug* benefit.

8. For a retail *pharmacy* or specialty *pharmacy* program, the *prescription* must not exceed a 30-day supply.

   Prescription drugs federally-classified as Schedule II which are FDA-approved for the treatment of attention deficit disorder must not exceed a 60-day supply. If the *physician* prescribes a 60-day supply for *drugs* classified as Schedule II for the treatment of attention deficit disorders, the *member* has to pay double the amount of co-payment for retail *pharmacies.* If the *drugs* are obtained through the home delivery program, the co-payment will remain the same as for any other *prescription drug.*

   FDA-approved smoking cessation products and over-the-counter nicotine replacement products are limited as specified under PREVENTIVE *PRESCRIPTION DRUGS* AND OTHER ITEMS.

9. Certain *drugs* have specific quantity supply limits based on the analysis of *prescription* dispensing trends and the Food and Drug Administration dosing recommendations.

10. Acne products limited to age 34 years and younger.

11. For the home delivery program, the *prescription* must not exceed a 90-day supply.

12. The *drug* will be covered under YOUR PRESCRIPTION DRUG BENEFITS only if it is not covered under another benefit of *your plan*.

13. *Drugs* for the treatment of impotence and/or sexual dysfunction are limited to six tablets/units for a 30-day period and are available at retail *pharmacies* and eighteen tablets/units for a 90-day period are available at home delivery.

14. It must be prescribed by a licensed *physician* with an active Drug Enforcement Administration (DEA) license, if the *drug* is considered a *controlled substance*.

PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED

1. Outpatient *drugs* and medications which the law restricts to sale by *prescription*, except as specifically stated in this section. Formulas prescribed by a *physician* for the treatment of phenylketonuria. These formulas are subject to the co-payment for *brand name drugs*.

2. Insulin.

3. Continuous glucose monitoring systems, including monitors designed to assist the visually impaired.

4. Syringes when dispensed for use with insulin and other self-injectable *drugs* or medications.

5. *Drugs* with Food and *Drug* Administration (FDA) labeling for self-administration.

6. AIDS vaccine (when approved by the federal Food and *Drug* Administration and that is recommended by the US Public Health Service).

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

8. Diabetic supplies (i.e. test strips and lancets).

9. Inhaler spacers and peak flow meters for the treatment of pediatric asthma. These items are subject to the co-payment for *brand name drugs*.

10. *Prescription drugs*, vaccinations (including administration), vitamins, supplements, and certain over-the-counter items as specified under PREVENTIVE *PRESCRIPTION DRUGS* AND OTHER ITEMS, subject to all terms of this *plan* that apply to those benefits.

11. *Drugs* used primarily for the purpose of treating *infertility*.

12. Travel immunizations

13. Glucometers

14. *Prescription drugs* for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.

15. Anorexiants and *drugs* used for weight loss except when used to treat morbid obesity (e.g., diet pills and appetite suppressants).

PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED

In addition to the exclusions and limitations listed under YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS NOT COVERED, *prescription drug* benefits are not provided for or in connection with the following:

1. Hypodermic syringes and/or needles except when dispensed for use with insulin and other self-injectable *drugs* or medications. While not covered under this *prescription drug* benefit, these items are covered under the "Home Health Care," "*Hospice* Care," "Infusion Therapy or Home Infusion Therapy," and "Diabetes" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

2. *Drugs* and medications used to induce spontaneous and non-spontaneous abortions. While not covered under this *prescription drug* benefit, FDA approved medications that may only be dispensed by or under direct supervision of a *physician*, such as *drugs* and medications used to induce non-spontaneous abortions, are covered as specifically stated in the "*Prescription Drug* for Abortion" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to the benefit.

3. *Drugs* and medications dispensed or administered in an outpatient setting; including, but not limited to, outpatient *hospital* facilities and *physicians'* offices. While not covered under this *prescription drug* benefit, these services are covered as specified under the "*Hospital*," "Home Health Care," "*Hospice* Care," and "Infusion Therapy or Home Infusion Therapy" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

4. Professional charges in connection with administering, injecting or dispensing of *drugs*. While not covered under this *prescription drug* benefit, these services are covered as specified under the "Professional Services" and "Infusion Therapy or Home Infusion Therapy" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

5. *Drugs* and medications which may be obtained without a *physician's* written *prescription*, except insulin or niacin for cholesterol reduction.

   Note: Vitamins, supplements, and certain over-the-counter items as specified under PREVENTIVE *PRESCRIPTION DRUGS* AND OTHER ITEMS are covered under this *plan* only when obtained with a *physician's*

prescription, subject to all terms of this *plan* that apply to those benefits.

6. *Drugs* and medications dispensed by or while *you* are confined in a *hospital*, *skilled nursing facility,* rest home, sanitarium, convalescent *hospital*, or similar facility While not covered under this *prescription drug* benefit, such *drugs* are covered as specified under the "*Hospital*", "*Skilled Nursing Facility*", and "*Hospice* Care", provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits. While *you* are confined in a rest home, sanitarium, convalescent *hospital* or similar facility, *drugs* and medications supplied and administered by *your physician* are covered as specified under the "Professional Services" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to the benefit. Other *drugs* that may be prescribed by *your physician* while *you* are confined in a rest home, sanitarium, convalescent *hospital* or similar facility, may be purchased at a *pharmacy* by the *member*, or a friend, relative or care giver on *your* behalf, and are covered under this *prescription drug* benefit.

7. Durable medical equipment, devices, appliances and supplies, even if prescribed by a *physician*. While not covered under this *prescription drug* benefit, these items are covered as specified under the "Durable Medical Equipment", "Hearing Aid Services", and "Diabetes" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

8. Services or supplies for which *you* are not charged.

9. Oxygen. While not covered under this *prescription drug* benefit, oxygen is covered as specified under the "*Hospital*", "*Skilled Nursing Facility*", "Home Health Care" and "*Hospice* Care" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

10. Cosmetics and health or beauty aids. However, health aids that are *medically necessary* and meet the requirements for durable medical equipment as specified under the "Durable Medical Equipment" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), are covered, subject to all terms of this *plan* that apply to that benefit.

11. *Drugs* labeled "Caution, Limited by Federal Law to Investigational Use" or Non-FDA approved investigational *drugs*. Any *drugs* or medications prescribed for *experimental* indications. If *you* are denied a *drug* because the *claims administrator* determines that the *drug* is *experimental* or *investigative*, *you* may ask that the denial be reviewed.

12. Any expense incurred for a *drug* or medication in excess of: *prescription drug maximum allowed amount*.

13. *Drugs* which have not been approved for general use by the Food and *Drug* Administration. This does not apply to *drugs* that are *medically necessary* for a covered condition.

14. *Drugs* used primarily for cosmetic purposes (e.g., Retin-A for wrinkles). However, this will not apply to the use of this type of *drug* for *medically necessary* treatment of a medical condition other than one that is cosmetic.

15. *Drugs* obtained outside of the United States unless they are furnished in connection with *urgent care* or an *emergency*.

16. Allergy desensitization products or allergy serum. While not covered under this *prescription drug* benefit, such *drugs* are covered as specified under the "*Hospital*", "*Skilled Nursing Facility*", and "Professional Services" provisions of YOUR MEDICAL *PLAN*. BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits. PLEASE REVIEW YOUR MEDICAL *PLAN* BOOKLET FOR ADDITIONAL INFORMATION.

17. Infusion *drugs*, except *drugs* that are self-administered subcutaneously. While not covered under this *prescription drug* benefit, infusion *drugs* are covered as specified under the "Professional Services" and "Infusion Therapy or Home Infusion Therapy" provisions of YOUR MEDICAL *PLAN*. BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits. PLEASE REVIEW YOUR MEDICAL *PLAN* BOOKLET FOR ADDITIONAL INFORMATION.

18. Herbal supplements, nutritional and dietary supplements, except as described in this *plan* or what must covered by 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.

    However, formulas prescribed by a *physician* for the treatment of phenylketonuria that are obtained from a *pharmacy* are covered as specified under *PRESCRIPTION DRUG* SERVICES AND SUPPLIES THAT ARE COVERED. Special food products that are not available from a

pharmacy are covered as specified under the "Phenylketonuria (PKU)" provision of YOUR MEDICAL *PLAN*. PLEASE REVIEW YOUR MEDICAL *PLAN* BOOKLET FOR ADDITIONAL INFORMATION, subject to all terms of this *plan* that apply to the benefit. Also, vitamins, supplements, and certain over-the-counter items as specified under PREVENTIVE *PRESCRIPTION DRUGS* AND OTHER ITEMS are covered under this *plan* only when obtained with a *physician's prescription*, subject to all terms of this *plan* that apply to those benefits.

19. *Prescription drugs* with a non-*prescription* (over-the-counter) chemical and dose equivalent except insulin, even if written as a *prescription*. This does not apply if an over-the-counter equivalent was tried and was ineffective.

20. Onychomycosis (toenail fungus) *drugs* except to treat *members* who are immuno-compromised or diabetic.

21. *Prescription drugs* that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material, thus treating a disease or abnormal medical condition.

22. Compound ingredients that are not FDA-approved , or do not require a *prescription* to dispense, and the *compound medication* is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.

23. *Specialty drugs* that must be obtained from the specialty *pharmacy* program, but, which are obtained from a retail *pharmacy* or through the home delivery program. Unless *you* qualify for an exception, these *drugs* are not covered by this *plan* (please see YOUR *PRESCRIPTION DRUG* BENEFITS: *PRESCRIPTION DRUG* CONDITIONS OF SERVICE). ***You* will have to pay the full cost of the *specialty drugs you* get from a retail *pharmacy* that *you* should have obtained from the specialty *pharmacy* program**.

    If *you* order a *specialty drug* through the home delivery program, it will be forwarded to the specialty *pharmacy* program for processing and will be processed according to specialty *pharmacy* program rules.

24. *Drugs* that do not need a prescription by federal law (including *drugs* that need a prescription by state law, but not by federal law), except for injectable insulin or other *drugs* provided in the Preventive Care paragraph of the YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED section. This exclusion does not apply to over-the-counter *drugs* that we must cover under state law, or federal law when

recommended by the U.S. Preventive Services Task Force, and prescribed by a *physician*.

25. **Clinical Trial Non-Covered Services.** Any *investigative 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-*investigative* treatments.

26. **Growth Hormone Treatment.** Any treatment, device, *drug*, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

27. **Hyperhidrosis Treatment.** *Prescription drugs* related to the medical and surgical treatment of excessive sweating (hyperhidrosis).

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

GENERAL PLAN EXCLUSIONS

No payment will be made under this *plan* for expenses incurred for or in connection with any of the items below. (The titles given to these exclusions and limitations are for ease of reference only; they are not meant to be an integral part of the exclusions and limitations and do not modify their meaning.)

Not Medically Necessary. Services or supplies that are not *medically necessary,* as defined.

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

Services Received Outside of the United States. Services rendered by providers outside the United States, unless the services are for an *emergency* or *urgent care*.

Incarceration. For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

Not Covered. Services received before *your effective date* or after *your* coverage ends.

Excess Amounts. Any amounts in excess of *maximum allowed amounts* or any Medical Benefit Maximum.

Work-Related. Any injury, condition or disease arising out of employment for which benefits or payments are covered by any workers' compensation law or similar law. If the *plan* provides benefits for such injuries, conditions or diseases the *claims administrator* shall be entitled to establish a lien or other recovery under applicable law.

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

Family Members. Services prescribed, ordered, referred by or given by a *member* of *your* immediate family, including *your spouse*, *child*, brother, sister, parent, in-law or self.

Voluntary Payment. Services for which *you* have no legal obligation to pay. Services for which no charge is made in the absence of insurance coverage or other health *plan* coverage.

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

SUBROGATION AND REIMBURSEMENT

These Subrogation and Reimbursement provisions apply when the Plan pays benefits as a result of injuries or illnesses You sustained, and You have a right to a Recovery or have received a Recovery from any source.

Definitions

As used in these Subrogation and Reimbursement provisions, "You" or "Your" includes anyone on whose behalf the plan pays benefits. These Subrogation and Reimbursement provisions apply to all current or former plan participants and plan beneficiaries. The provisions also apply to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the Plan. The Plan's rights under these provisions shall also apply to the personal representative or administrator of Your estate, Your heirs or beneficiaries, minors, and legally incompetent or disabled persons. If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to these Subrogation and Reimbursement provisions. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, or because of the death of the covered person, that Recovery shall be subject to this provision, regardless of how any Recovery is allocated or characterized.

As used in these Subrogation and Reimbursement provisions, "Recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, workers' compensation insurance or fund, premises medical payments coverage, restitution, or "no-fault" or personal injury protection insurance and/or automobile medical payments coverage, or any other first or third party insurance coverage, whether by lawsuit, settlement or otherwise. Regardless of how You or Your representative or any agreements allocate or characterize the money You receive as a Recovery, it shall be subject to these provisions.

Subrogation

Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to, or stand in the place of, all of Your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan has the right to recover payments it makes on Your behalf from any party or insurer responsible for compensating You for Your illnesses or injuries. The Plan has the right to take whatever legal action it sees fit against any person, party, or entity to recover the benefits paid under the Plan. The Plan may assert a claim or file suit in Your name and take appropriate action to assert its subrogation claim, with or without Your consent. The Plan is not required to pay You part of any recovery it may obtain, even if it files suit in Your name.

Reimbursement

If You receive any payment as a result of an injury, illness or condition, You agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of Your recovery. If You obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on Your behalf, the Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on Your behalf. You must promptly reimburse the Plan from any Recovery to the extent of benefits the Plan paid on Your behalf regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.

Secondary to Other Coverage

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

Assignment

In order to secure the Plan's rights under these Subrogation and Reimbursement Provisions, You agree to assign to the Plan any benefits or claims or rights of recovery You have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim You may have regardless of whether You choose to pursue the claim.

Applicability to All Settlements and Judgments

Notwithstanding any allocation or designation of Your Recovery made in any settlement agreement, judgment, verdict, release, or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery You make. Furthermore, the Plan's rights under these Subrogation and Reimbursement provisions will not be reduced due to Your own negligence. The terms of these Subrogation and Reimbursement provisions shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the terms of any settlement, judgment, or verdict pertaining to Your Recovery identify the medical benefits the Plan provided or purport to allocate any portion of such Recovery to payment of expenses other than medical expenses. The Plan is entitled to recover from any Recovery, even those designated as being for pain and suffering, non-economic damages, and/or general damages only.

Constructive Trust

By accepting benefits from the Plan, You agree that if You receive any payment as a result of an injury, illness or condition, You will serve as a constructive trustee over those funds. You and Your legal representative must hold in trust for the Plan the full amount of the Recovery to be paid to the Plan immediately upon receipt. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Plan. Any Recovery You obtain must not be dissipated or disbursed until such time as the Plan has been repaid in accordance with these Subrogation and Reimbursement provisions.

Lien Rights

The Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of Your illness, injury or condition upon any Recovery related to treatment for any illness, injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds from Your Recovery including, but not limited to, you, your representative or agent, and/or any other source possessing funds from Your Recovery. You and Your legal representative acknowledge that the portion of the Recovery to which the Plan's equitable lien applies is a Plan asset. The Plan shall be entitled to equitable relief, including without limitation restitution, the imposition of a constructive trust or an injunction, to the extent necessary to enforce the Plan's lien and/or to obtain (or preclude the transfer, dissipation or disbursement of) such portion of any Recovery in which the Plan may have a right or interest.

First-Priority Claim

By accepting benefits from the Plan, You acknowledge the Plan's rights under these Subrogation and Reimbursement provisions are a first priority claim and are to be repaid to the Plan before You receive any Recovery for your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any Recovery, even if such payment to the Plan will result in a Recovery which is insufficient to make You whole or to compensate You in part or in whole for the losses, injuries, or illnesses You sustained. The "made-whole" rule does not apply. To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by You, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to Your claim, Your attorney fees, other expenses or costs. The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs You incur. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Cooperation

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

- You must promptly notify the Plan of how, when and where an accident or incident resulting in personal injury or illness to You occurred, all information regarding the parties involved and any other information requested by the Plan.
- You must notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to Your injury, illness or condition.
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- You and your agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other

forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation.

- You recognize that to the extent that the Plan paid or will pay benefits under a capitated agreement, the value of those benefits for purposes of these provisions will be the reasonable value of those payments or the actual paid amount, whichever is higher.
- You must not do anything to prejudice the Plan's rights under these Subrogation and Reimbursement provisions. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to You.
- You must promptly notify the Plan if You retain an attorney or if a lawsuit is filed on Your behalf.
- You must immediately notify the Plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its rights under these Subrogation and Reimbursement provisions, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

If You fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of Your Recovery whichever is less, from any future benefit under the Plan if:

1. The amount the Plan paid on Your behalf is not repaid or otherwise recovered by the Plan; or
2. You fail to cooperate.

In the event You fail to disclose the amount of Your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.

The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of Your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments

on Your behalf. In such a circumstance, it may then be Your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse You.

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

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

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

Discretion

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

HOW COVERAGE BEGINS AND ENDS

HOW COVERAGE BEGINS

ELIGIBLE STATUS

1. **Subscribers.** For specific information about *your* employer's eligibility rules for coverage, please contact *your* Human Resources or Benefits Department. Please note that *you* must enroll in the medical *plan* in order to be eligible for coverage in this *plan.*

2. **Dependents.** The following are eligible to enroll as *dependents:* (a) Either the *subscriber's spouse* or *domestic partner;* and (b) A *child*.

Definition of Dependent

1. **Spouse** is the *subscriber's spouse* as recognized under state or federal law. This includes same sex spouses when legally married in a state that recognizes same sex marriages. *Spouse* does not include any person who is: (a) covered as a *subscriber*; or (b) in active service in the armed forces.

2. **Domestic partner** is the *subscriber's domestic partner* under a legally registered and valid domestic partnership. *Domestic partner* does not include any person who is: (a) covered as a *subscriber*; or (b) in active service in the armed forces.

   For a domestic partnership, other than one that is legally registered and valid, in order for the *subscriber* to include their *domestic partner* as a *dependent*, the *subscriber* and *domestic partner* must meet the following requirements:

   a. Both persons have a common residence.

   b. Neither person is married to someone else nor a *member* of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.

   c. The two persons are not related by blood in a way that would prevent them from being married to each other in California, or if they reside in another state or commonwealth, that state or commonwealth.

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

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

f. Both partners must provide the *plan administrator* with a signed, notarized, affidavit certifying they meet all of the requirements set forth in 2.a through 2.e above, inclusive.

As used above, "have a common residence" means that both *domestic partners* share the same residence. It is not necessary that the legal right to possess the common residence be in both of their names. Two people have a common residence even if one or both have additional residences. *Domestic partners* do not cease to have a common residence if one leaves the common residence but intends to return.

3. **Child** is the *subscriber*'s or *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, subject to the following:

   a. The *child* must be covered under the Otsuka *plan* prior to turning age 26, unless: (i) is a new hire, (ii) the *subscriber* who experiences a QLE can demonstrate that the disabled dependent was covered under a group health plan immediately prior to the QLE date, (iii) During OE can demonstrate that the disabled dependent was covered under a group health plan immediately prior to the coverage start date (1/1), and (iv) If the *subscriber* meets the above requirements, the Health Plan carrier will perform a medical evaluation of the disabled status and provide a decision (approval/denial) status.

   b. The unmarried *child* is 26 years of age, or older and: (i) is permanently disabled, (ii) is chiefly dependent on the *subscriber, spouse or domestic partner* for support and maintenance*,* and (iii) is incapable of self-sustaining employment due to a physical or mental condition. A *physician* must certify in writing that the *child* is incapable of self-sustaining employment due to a physical or mental condition due to a permanently disabled status. *We* must receive the certification, at no expense to *us*, within 60-days of the date the *subscriber* receives *our* request. *We* may request proof of continuing dependency and that a physical or mental condition still exists, but not more often than once each *year* after the initial certification. This exception will last until the *child* is no longer chiefly dependent on the *subscriber, spouse* or *domestic partner* for support and maintenance due to a continuing physical or mental condition. A *child* is considered chiefly dependent for support and maintenance if he or she qualifies as a *dependent* for federal income tax purposes.

c. A *child* who is in the process of being adopted is considered a legally adopted *child* if the *plan administrator* receives legal evidence of both: (i) the intent to adopt; and (ii) that the *subscriber, spouse* or *domestic partner* have either: (a) the right to control the health care of the *child*; or (b) assumed a legal obligation for full or partial financial responsibility for the *child* in anticipation of the *child's* adoption.

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

d. A *child* for whom the *subscriber, spouse* or *domestic partner* is a legal guardian is considered eligible on the date of the court decree (the "eligibility date"). The *plan administrator* must receive legal evidence of the decree.

ELIGIBILITY DATE

1. For *subscribers, you* become eligible for coverage in accordance with rules established by *your* employer. For specific information about *your* employer's eligibility rules for coverage, please contact *your* Human Resources or Benefits Department.

2. For *dependents, you* become eligible for coverage on the later of: (a) the date the *subscriber* becomes eligible for coverage; or, (b) the date *you* meet the *dependent* definition.

   If, after *you* become covered under this *plan*, *you* cease to be eligible due to termination of employment, and *you* return to an eligible status based on *your* employer's eligibility rules, *you* will become eligible to re-enroll for coverage on the first day of the month following the date *you* return.

ENROLLMENT

To enroll as a *subscriber,* or to enroll *dependents,* the *subscriber* must properly file an application. An application is considered properly filed, only if it is personally signed, dated, and given to the *plan administrator* within 31 days from *your* eligibility date. If any of these steps are not followed, *your* coverage may be denied.

EFFECTIVE DATE

Your effective date of coverage is subject to the timely payment of required monthly contributions. The date *you* become covered is determined as follows:

1. **Timely Enrollment:** If *you* enroll for coverage before, on, or within 31 days after *your* eligibility date, then *your* coverage will begin as follows: (a) for *subscribers,* on *your* eligibility date; and (b) for *dependents,* on the later of (i) the date the *subscriber's* coverage begins, or (ii) the first day of the month after the *dependent* becomes eligible. If *you* become eligible before the *plan* takes effect, coverage begins on the *effective date* of the *plan,* provided the enrollment application is on time and in order.

2. **Late Enrollment:** If *you* enroll more than 31 days after *your* eligibility date, *you* must wait until the next Open Enrollment Period to enroll unless there is a special event before that time that would allow *your* enrollment.

3. **Disenrollment:** If *you* voluntarily choose to disenroll from coverage under this *plan*, *you* will be eligible to reapply for coverage as set forth in the "Enrollment" provision above, during the next Open Enrollment period (see OPEN ENROLLMENT PERIOD).

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) for any *child* born to the *subscriber, spouse* or *domestic partne*r, eligibility coverage will begin at birth if the *child* is properly and timely enrolled. The *subscriber,* or *spouse* or *domestic partner* if subscriber is unavailable, must enroll the newborn *child* within 31 days (or such other time as indicated in your employer's life event chart). If a *child* is not properly and timely enrolled any claims related to the *child* will be denied. The *plan administrator* will extend coverage for the newborn *child* retro-active to the *child's* date of birth, so long as the enrollment is timely received; and (2) any *child* being adopted by the *subscriber, spouse* or *domestic partner* will be enrolled from the date on which either: (a) the adoptive *child's* birth parent, or other appropriate legal authority, signs a written document granting the *subscriber, spouse* or *domestic partner* the right to control the health care of the *child* (in the absence of a written document, other evidence of the *subscriber's, spouse's* or *domestic partner's* right to control the health care of the *child* may be used)*;* or (b) the *subscriber, spouse* or *domestic partner* assumed a legal obligation for full or partial financial responsibility for the *child* in

anticipation of the *child's* adoption so long as the enrollment is timely received. In either case mentioned above, the *child* must be properly enrolled in the Plan within 31 days (or such other time as indicated in your employer's life event chart) in order to receive coverage. The "written document" referred to above includes, but is not limited to, a health facility minor release report, a medical authorization form, or relinquishment form.

Special Enrollment Periods

You may enroll without waiting for the *plan administrator's* next open enrollment period if *you* are otherwise eligible under any one of the circumstances set forth below (some changes are subject to certain consistency requirements):

1. *You* have met all of the following requirements:

    a. *You* were covered as an individual or *dependent* under either:

        i. Another employer group health *plan* or health insurance coverage, including coverage under a COBRA continuation; or

        ii. A state Medicaid *plan* or under a state *child* health insurance program (SCHIP), including the Healthy Families Program or the Access for Infants and Mothers (AIM) Program.

    b. *You* certified in writing at the time *you* became eligible for coverage under this *plan* that *you* were declining coverage under this *plan* or disenrolling because *you* were covered under another health *plan* as stated above and *you* were given written notice that if *you* choose to enroll later, *you* may be required to wait until the *plan administrator's* next open enrollment period to do so.

    c. *Your* coverage under the other health *plan* wherein *you* were covered as an individual or *dependent* ended as follows:

        i. If the other health *plan* was another employer group health *plan* or health insurance coverage, including coverage under a COBRA continuation, coverage ended because *you* lost eligibility under the other *plan* through no fault of *your* own, *your* coverage under a COBRA continuation was exhausted, or employer contributions toward coverage under the other *plan* terminated. *You* must properly file an application with the *plan administrator* within 31 days after the date *your* coverage ends or the date employer contributions toward coverage under the other *plan* terminate.

            Loss of eligibility for coverage under an employer group health *plan* or health insurance includes loss of eligibility due to termination of employment or change in employment status,

reduction in the number of hours worked, loss of *dependent* status under the terms of the *plan*, termination of the other *plan*, legal separation, divorce, death of the person through whom *you* were covered, and any loss of eligibility for coverage after a period of time that is measured by reference to any of the foregoing.

ii. If the other health *plan* was a state Medicaid *plan* or a state *child* health insurance program (SCHIP), including the Healthy Families Program or the Access for Infants and Mothers (AIM) Program, coverage ended because *you* lost eligibility under the program. *You* must properly file an application with the *plan administrator* within 60 days after the date *your* coverage ended.

2. A court has ordered coverage be provided for a *spouse, domestic partner* or *dependent child* under *your* employee health *plan* and an application is filed within 31 days from the date the court order is issued.

3. The *claims administrator* does not have a written statement from the *plan administrator* stating that prior to declining coverage or disenrolling, *you* received and signed acknowledgment of a written notice specifying that if *you* do not enroll for coverage within 31 days after *your* eligibility date, or if *you* disenroll, and later file an enrollment application, *your* coverage may not begin until the first day of the month following the end of the *plan administrator's* next open enrollment period.

4. *You* have a change in family status through either marriage or domestic partnership, or the birth, adoption, or placement for adoption of a *child*:

   a. If *you* are enrolling following marriage or domestic partnership, *you* and *your* new *spouse* or *domestic partner* must enroll within 31 days of the date of marriage or domestic partnership. *Your* new *spouse* or *domestic partner's* children may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above.

   b. If *you* are enrolling following the birth, adoption, or placement for adoption of a *child*, *your spouse* (if *you* are already married) or *domestic partner*, who is eligible but not enrolled, may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above. Application must be made within 31 days of the birth or date of adoption or placement for adoption.

5. *You* meet or exceed a lifetime limit on all benefits under another health *plan*. Application must be made within 31 days of the date a claim or a portion of a claim is denied due to *your* meeting or exceeding the lifetime limit on all benefits under the other *plan*.

6. *You* become eligible for assistance, with respect to the cost of coverage under the employer's group *plan*, under a state Medicaid or SCHIP health *plan*, including any waiver or demonstration project conducted under or in relation to these plans. *You* must properly file an application with the *plan administrator* within 60 days after the date *you* are determined to be eligible for this assistance.

7. *You* are an employee who is a reservist as defined by state or federal law, who terminated coverage as a result of being ordered to military service as defined under state or federal law, and apply for reinstatement of coverage following reemployment with *your* employer. *Your* coverage will be reinstated without any waiting period. The coverage of any *dependents* whose coverage was also terminated will also be reinstated. For *dependents*, this applies only to *dependents* who were covered under the *plan* and whose coverage terminated when the employee's coverage terminated. Other *dependents* who were not covered may not enroll at this time unless they qualify under another of the circumstances listed above.

Effective date of coverage. For enrollments during a special enrollment period as described above, coverage will be effective on the first day of the month following the date *you* file the enrollment application, except as specified below:

1. If a court has ordered that coverage be provided for a *dependent child*, coverage will become effective for that *child* on the earlier of (a) the first day of the month following the date *you* file the enrollment application or (b) within 30 days after a copy of the court order is received or of a request from the district attorney, either parent or the person having custody of the *child*, or the employer.

2. For enrollments following the birth, adoption, or placement for adoption of a *child*, coverage will be effective as of the date of birth, adoption, or placement for adoption.

3. For reservists and their *dependents* applying for reinstatement of coverage following reemployment with the employer, coverage will be effective as of the date of reemployment.

OPEN ENROLLMENT PERIOD

There is an open enrollment period once each *year*. During that time, an individual who meets the eligibility requirements as a *subscriber* under this *plan* may enroll. A *subscriber* may also enroll any eligible *dependents* at that time. Persons eligible to enroll as *dependents* may enroll only under the *subscriber's plan*.

For anyone so enrolling, coverage under this *plan* will begin on the first day of the month following the end of the Open Enrollment Period. Coverage under the former *plan* ends when coverage under this *plan* begins.

HOW COVERAGE ENDS

Your coverage ends without notice as provided below:

1. If the *plan* terminates, *your* coverage ends at the same time. This *plan* may be canceled or changed without notice to *you*.

2. If the *plan* no longer provides coverage for the class of *members* to which *you* belong, *your* coverage ends on the *effective date* of that change. If this *plan* is amended to delete coverage for *dependents,* a *dependent*'s coverage ends on the *effective date* of that change.

3. Coverage for *dependents* ends when *subscriber's* coverage ends.

4. Coverage ends at the end of the period for which the required monthly contribution has been paid on *your* behalf when the required monthly contribution for the next period is not paid.

5. If *you* voluntarily cancel coverage at any time, coverage ends on the due date for the required monthly contribution coinciding with or following the date of voluntary cancellation which *you* provide to *us*.

6. If *you* no longer meet the requirements set forth in the "Eligible Status" provision of HOW COVERAGE BEGINS, *your* coverage ends as of the due date for the required monthly contribution coinciding with or following the date *you* cease to meet such requirements.

   Exceptions to item 6:

   a. **Leave of Absence.** If *you* are a *subscriber* and the required monthly contributions are paid, *your* coverage may continue for up to six months during an approved temporary leave of absence. This time period may be extended if required by law.

   b. **Handicapped Children:** If a *child* reaches the age limits shown in the "Eligible Status" provision of this section, the *child* will continue to qualify as a *dependent* if he or she is (i) covered under this *plan,* (ii) still chiefly dependent on the *subscriber*, *spouse* or

domestic partner for support and maintenance, and (iii) incapable of self-sustaining employment due to a physical or mental condition due to a permanently disabled status. 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. *We* 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 proof of the *child's* physical or mental condition within 60-days of the date the *subscriber* receives *our* request. If *we* do not complete *our* 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 *our* determination. When a period of two years has passed, *we* 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.

Note: If a marriage or domestic partnership terminates, the *subscriber* must give or send to the *plan administrator* written notice of the termination within 60 days of such termination. Coverage for a former *spouse* or *domestic partner*, and their *dependent children*, if any, ends according to the "Eligible Status" provisions. Failure to provide written notice to the *plan administrator* will not delay or prevent termination of the marriage or domestic partnership. If the *subscriber* notifies the *plan administrator* in writing to cancel coverage for a former *spouse* or *domestic partner* and the *children* of the *spouse* or *domestic partner*, if any, immediately upon termination of the *subscriber's* marriage or domestic partnership, such notice will be considered compliance with the requirements of this provision.

You may be entitled to continued benefits under terms which are specified elsewhere under CONTINUATION OF COVERAGE.

CONTINUATION OF COVERAGE

Applicable To *Your* Separate Medical *Plan* Benefit Booklet.

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

DEFINITIONS

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

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

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

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

1. **For Subscribers and Dependents:**

    a. The *subscribers* termination of employment, for any reason other than gross misconduct; or

    b. Loss of coverage under an employer's health *plan* due to a reduction in the *subscriber's* work hours.

2. **For Retired Subscribers and their Dependents.** Cancellation or a substantial reduction of retiree benefits under the *plan* due to the *plan's* filing for Chapter 11 bankruptcy, provided that:

    a. The *plan* expressly includes coverage for retirees; and

b. Such cancellation or reduction of benefits occurs within one *year* before or after the *plan's* filing for bankruptcy.

3. **For Dependents:**

   a. The death of the *subscriber;*

   b. The *spouse's* divorce or legal separation from the *subscriber;*

   c. The end of a *domestic partner's* partnership with the *subscriber;*

   d. The end of a *child's* status as a *dependent child,* as defined by the *plan;* or

   e. The *subscriber's* entitlement to Medicare.

ELIGIBILITY FOR COBRA CONTINUATION

A *subscriber* or *dependent* may choose to continue coverage under the *plan* if his or her coverage would otherwise end due to a Qualifying Event.

TERMS OF COBRA CONTINUATION

Notice. The *plan administrator* will notify either the *subscriber* or *dependent* of the right to continue coverage under COBRA, as provided below:

1. For Qualifying Events 1, or 2, the *plan administrator* or the applicable COBRA administrator will notify the *subscriber* of the right to continue coverage.

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

3. *You* must inform the *plan administrator* in writing within 60 days of Qualifying Events 3(b), 3(c), or 3(d) above, if *you* wish to continue coverage. The *plan administrator* or COBRA administrator, if applicable, in turn, will give *you* official notice of the COBRA continuation right. See *your* general COBRA notice for additional information about this process.

If *you* or *your dependent* choose to continue coverage *you* or *your dependent* must notify the *plan administrator* within 60 days of the date of receipt of the notice of *your* COBRA continuation right. The COBRA continuation coverage may be chosen for all affected qualified beneficiaries within a family, or only for selected qualified beneficiaries.

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

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

Additional Dependents. A *spouse, domestic partner* or *child* acquired during the COBRA continuation period is eligible to be enrolled as a *dependent*. The standard enrollment provisions of the *plan* apply to enrollees during the COBRA continuation period.

Cost of Coverage. The *plan administrator* may require that *you* pay the entire cost of *your* COBRA continuation coverage. This cost, called the "required monthly contribution", must be timely remitted to the *plan administrator* each month during the COBRA continuation period in order to maintain the coverage in force. The initial COBRA payment is due within 45 days of the COBRA election and must include the amount for the months of coverage through the payment date. Thereafter, the COBRA premium is due on the first of the month (subject to a 30-day grace period).

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

1. A *spouse* whose COBRA continuation began due to divorce, separation or death of the *subscriber;*

2. A *domestic partner* whose COBRA continuation began due to the end of the domestic partnership or death of the *subscriber;*

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

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

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

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

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

For *dependents* properly enrolled during the COBRA continuation, coverage begins according to the enrollment provisions of the *plan*.

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

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

*For a *member* whose COBRA continuation coverage began under a *prior plan,* this term will be dated from the time of the Qualifying Event under that *prior plan*.

Subject to the *plan* remaining in effect, a retired employee whose COBRA continuation coverage began due to Qualifying Event 2 may be covered for the remainder of his or her life; that person's covered *dependents* may continue coverage for 36 months after the *subscriber's* death. However,

coverage could terminate prior to such time for either *subscriber* or *dependent* in accordance with items 4, 5 or 6 above.

Other Coverage Options Besides COBRA Continuation Coverage. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for *you* and *your* family through the Health Insurance Marketplace, Medicaid, or other group health *plan* coverage options (such as a *spouse's plan*) through the conditions listed under the SPECIAL ENROLLMENT PERIODS provision. Some of these options may cost less than COBRA continuation coverage. *You* can learn more about many of these options at www.healthcare.gov.

EXTENSION OF CONTINUATION DURING TOTAL DISABILITY

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

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

1. Satisfy the legal requirements for being totally and permanently disabled under the Social Security Act; and
2. Be determined and certified to be so disabled by the Social Security Administration prior to the end of the 18-month COBRA period.

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

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

Cost of Coverage. For the 19th through 29th months that the total disability continues, the cost for the extended continuation coverage must

be remitted to *us*. This cost (called the "required monthly contribution") shall be subject to the following conditions:

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

2. The cost for extended continuation coverage must be remitted each month during the period of extended continuation coverage. Timely payment of the required monthly contribution must be received in order to maintain the extended continuation coverage in force.

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

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

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

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

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

3. The date the *plan* terminates;

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

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

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

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

GENERAL PROVISIONS

Terms of Coverage

1. In order for *you* to be entitled to benefits under the *plan,* both the *plan* and *your* coverage under the *plan* must be in effect on the date the expense giving rise to a claim for benefits is incurred.

2. The benefits to which *you* may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date *you* receive the service or supply for which the charge is made.

3. The *plan* is subject to amendment, modification or termination according to the provisions of the *plan* without *your* consent or concurrence.

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

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

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

Medical Necessity. The benefits of this *plan* are provided only for services which the *claims administrator* determines to be *medically necessary*. The services must be ordered by the attending *physician* for the direct care and treatment of a covered condition. They must be standard medical practice where received for the condition being treated and must be legal in the United States. The process used to authorize or deny health care services under this *plan* is available to *you* upon request.

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

Benefits Not Transferable. Only the *member* is entitled to receive benefits under this *plan*. The right to benefits cannot be transferred.

Notice of Claim. After *you* get covered services, the *claims administrator* must receive written notice of *your* claim in order for benefits to be paid.

- *Participating providers* will submit claims for *you*. They are responsible for ensuring that claims have the information we need to determine benefits. If the claim does not include enough information, we will ask them for more details, and they will be required to supply those details within certain timeframes.

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

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

Non-participating provider claims must be submitted within 180 days after the date of service. In certain cases, state or federal law may allow additional time to file a claim, if *you* could not reasonably file within the 180-day period. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask *you* for more details and inform *you* of the time by which we need to receive that information. Once we receive the required information, we will process the claim according to the terms of *your plan*.

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

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

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

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

Under certain circumstances, if the *claims administrator* pays *your* healthcare provider amounts that are *your* responsibility, such as co-payments or co-insurance, the *claims administrator* may collect such amounts directly from *you*. *You* agree that the *claims administrator* has the right to recover such amounts from *you*.

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

The *claims administrator* has established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses, and whether to settle or compromise recovery amounts. The *claims administrator* will not pursue recoveries for overpayments if it determines that the cost of collection likely will exceed the overpayment amount. The *claims administrator* may not provide *you* with notice of overpayments made by the *plan* or *you* if the recovery method makes providing such notice administratively burdensome.

The *claims administrator* reserves the right to deduct or offset, including cross plan offsetting on *participating provider* claims and on *non-participating providers* claims where the *non-participating providers* agrees to cross plan offsetting, any amounts paid in error from any pending or future claim.

Legal Actions. No attempt to recover on the *plan* through legal or equity action may be made until at least 60 days after the written proof of loss has been furnished as required by this *plan*. No such action may be

started later than three years from the time written proof of loss is required to be furnished. If *you* bring a civil action under Section 502(a) of ERISA, *you* must bring it within one year of the grievance or appeal decision.

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

Prepayment Fees. The *plan administrator* may require that *you* contribute all or part of the costs of these required monthly contributions. Please consult *your plan administrator* for details.

Renewal Provisions. The *plan* is subject to renewal at certain intervals. The required monthly contribution or other terms of the *plan* may be changed from time to time.

Protecting *Your* Privacy

Where to find *our* Notice of Privacy Practices.

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

We may collect, use and share *your* Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy Rule:
For payment: *We* use and share PHI to manage *your* account or benefits; or to pay claims for health care *you* get through *your plan*.

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

- *We* keep information about *your* premium and deductible payments.
- *We* may give information to a doctor's office to confirm *your* benefits.
- *We* may share explanation of benefits (EOB) with the subscriber of *your plan* for payment purposes.

- *We* may share PHI with *your* health care provider so that the provider may treat *you*.
- *We* may use PHI to review the quality of care and services *you* get.
- *We* may use PHI to provide *you* with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.
- *We* may also use and share PHI directly or indirectly with or through health information exchanges for payment, health care operations and treatment. If *you* do not want *your* PHI to be shared for payment, health care operations, or treatment purposes in health information exchanges, please visit https://www.anthem.com/ca/privacy for more information.

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

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

BINDING ARBITRATION

Note: If *you* are enrolled in a *plan* provided by *your* employer that is subject to ERISA, any dispute involving an adverse benefit decision must be resolved under ERISA's claims procedure rules, and is not subject to mandatory binding arbitration. *You* may pursue voluntary binding arbitration after *you* have completed an appeal under ERISA. If *you* have any other dispute which does not involve an adverse benefit decision, this BINDING ARBITRATION provision applies.

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

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

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

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

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

The arbitration is begun by the *member* making written demand on the *plan administrator*. 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.

DEFINITIONS

The meanings of key terms used in this *benefit booklet* are shown below. Whenever any of the key terms shown below appear, it will appear in italicized letters. When any of the terms below are italicized in this *benefit booklet*, *you* should refer to this section.

Benefit Booklet (benefit booklet) is this written description of the benefits provided under the *plan*.

Biosimilar (Biosimilars) is a type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product.

Brand name prescription drugs (brand name drugs) are *prescription drugs* that are classified as *brand name drugs* or the *pharmacy benefit manager* has classified as *brand name drugs* through use of an independent proprietary industry database.

Child meets the *plan's* eligibility requirements for children as outlined under HOW COVERAGE BEGINS AND ENDS.

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

Compound Medication (Compound Drug) is a mixture of ingredients within a *compound drug* when a commercially available dosage form of a *medically necessary* medication is not available, ingredients of the compound *drug* are FDA-approved in the form in which they are used in the *compound medication*, require a *prescription* to dispense and are not essentially the same as an FDA-approved product from a *drug* manufacturer. Non-FDA approved non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.

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

Dependent meets the *plan's* eligibility requirements for *dependents* as outlined under HOW COVERAGE BEGINS AND ENDS.

Domestic partner meets the *plan's* eligibility requirements for *domestic partners* as outlined under HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE BEGINS.

Drug (prescription drug) is a substance, that under the Federal Food, Drug & Cosmetic Act, must bear a message on their original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

- Compound ingredients within a *compound drug*, when the ingredients are FDA-approved in the form in which they are used in the *compound drug*, require a prescription to dispense and are not essentially the same as an FDA-approved product from a drug manufacturer.
- Insulin, diabetic supplies, and syringes.

Effective date is the date *your* coverage begins under this *plan*.

Experimental procedures are those that are mainly limited to laboratory and/or animal research.

Formulary drug is a *drug* listed on the *prescription drug formulary*.

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

Hospital is a facility which provides diagnosis, treatment and care of persons who need acute inpatient *hospital* care under the supervision of *physicians*. It must be licensed as a general acute care *hospital* according to state and local laws. It must also be registered as a general *hospital* by the American *Hospital* Association and meet accreditation standards of The Joint Commission (TJC).

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

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

Maintenance medications or maintenance drugs are *drugs you* take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If *you* are not sure the *prescription drug you* are taking is a *maintenance medication* or need to

determine if *your pharmacy* is a *maintenance pharmacy,* please call Member Services at the number on the back of *your* ID card or check our website at www.anthem.com for more details.

Maintenance Pharmacy is a *participating pharmacy* that is contracted with our *pharmacy benefit manager* to dispense a 90-day supply of *maintenance drugs*.

Medically necessary procedures, supplies equipment or services are those the *claims administrator* determines to be:

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease;
3. Provided for the diagnosis or direct care and treatment of the medical condition;
4. Within standards of good medical practice within the organized medical community;
5. Not primarily for *your* convenience, or for the convenience of *your physician* or another provider;
6. Not more costly than an equivalent service, including 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 in regard to the diagnosis or treatment of the patient's illness, injury, or condition; and
7. The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:
    a. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for *you* with the particular medical condition being treated than other possible alternatives; and
    b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable.

Member is the *subscriber* or *dependent*. A *member* may enroll under only one health *plan* provided by the *plan administrator*, or any of its affiliates.

Multi-source brand name drugs are drugs with at least one generic substitute.

Participating pharmacy is a *pharmacy* which has a *Participating Pharmacy* Agreement in effect with the *pharmacy benefit manager* at the time services are rendered. Call *your* local *pharmacy* to determine whether it is a *participating pharmacy* or call the toll-free *Member* Services telephone number.

Pharmacy means a licensed retail *pharmacy*.

Pharmacy and Therapeutics Process is a process in which health care professionals including nurses, pharmacists, and *physicians* determine the clinical appropriateness of *drugs* and promote access to quality medications. The process also reviews *drugs* to determine the most cost effective use of benefits and advise on programs to help improve care. The programs include, but are not limited to, *drug* utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and *drug* profiling initiatives.

Pharmacy Benefits Manager (PBM) a company that manages *pharmacy* benefits on the *claims administrator's* behalf. The c*laims administrator's* PBM has a nationwide network of *retail pharmacies*, a *home delivery pharmacy*, and clinical services that include *prescription drug* list management.

The management and other services the PBM provides include, but are not limited to, managing a network of *retail pharmacies* and operating a mail service *pharmacy*. The PBM, in consultation with the c*laims administrator*, also provides services to promote and assist *members* in the appropriate use of *pharmacy* benefits, such as review for possible excessive use, proper dosage, *drug* interactions or *drug*/pregnancy concerns.

Physician means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or

2. A provider who is licensed to practice where the care is provided, is rendering a service within the scope of that license and such license is required to render that service, and is providing a service for which benefits are specified in this booklet.

Plan is the set of benefits described in this *benefit booklet* and in the amendments to this *benefit booklet*, if any. These benefits are subject to the terms and conditions of the *plan.* If changes are made to the *plan*, an amendment or revised *benefit booklet* should be issued to each *subscriber* affected by the change. (The word "*plan*" here does not mean the same as "*plan*" as used in ERISA.)

Plan administrator refers to Otsuka America, Inc., the entity which is responsible for the administration of the *plan,* or its delegate.

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

Prescription drug covered expense is the expense *you* incur for a covered *prescription drug*, but not more than the *prescription drug maximum allowed amount*. Expense is incurred on the date *you* receive the service or supply.

Prescription drug formulary (formulary) is a list which the *claims administrator* has developed of outpatient *prescription drugs* which may be cost-effective, therapeutic choices. Any *participating pharmacy* can assist *you* in purchasing *drugs* listed on the formulary. *You* may also get information about covered *formulary drugs* by calling the number on the back of *your* ID card or going to the internet website anthem.com/ca.

Prescription drug maximum allowed amount is the maximum amount the *claims administrator* will allow for any *drug*. The amount is determined by the *claims administrator* using *prescription drug* cost information provided to them by the *pharmacy benefits manager*. The amount is subject to change. *You* may determine the *prescription drug* maximum allowed amount of a particular *drug* by calling the number on the back of *your* ID card.

Prescription drug tiers are used to classify *drugs* for the purpose of setting their *co-payment*. The *claims administrator* will decide which *drugs* should be in each tier based on clinical decisions made by the *Pharmacy and Therapeutics Process*. The *claims administrator* retains the right at its discretion to determine coverage for dosage formulation in terms of covered dosage administration methods (for example, by mouth, injection, topical or inhaled) and may cover one form of administration and may exclude or place other forms of administration in another tier (if it is *medically necessary* for *you* to get a *drug* in an administrative form that is excluded *you* will need to get written prior authorization (see *PRESCRIPTION DRUG FORMULARY*: PRIOR AUTHORIZATION above) to get that administrative form of the *drug*). This is an explanation of what *drugs* each tier includes:

Tier 1 Drugs are those that have the lowest co-payment. This tier contains low cost preferred *drugs* that may be *generic*, *single source brand name*

drugs, biosimilars, interchangeable biologic products or *multi-source brand name drugs*.

Tier 2 Drugs are those that have higher co-payments than Tier 1 *Drugs*, but, lower than Tier 3 *Drugs*. This tier may contain *preferred drugs* that may be *generic, single source brand name drugs, biosimilars, interchangeable biologic products* or *multi-source brand name drugs*.

Tier 3 Drugs are those that have the higher co-payments than Tier 2 *Drugs*, but, lower than Tier 4 *Drugs*. This tier may contain higher cost preferred *drugs* and non-*preferred drugs* that may be *generic*, *single source brand name drugs, biosimilars, interchangeable biologic products* or *multi-source brand name drugs*.

Tier 4 Drugs are those that have the higher co-payments than Tier 3 *Drugs*. This tier may contain higher cost *preferred drugs* and non-*preferred drugs* that may be *generic*, *single source brand name drugs, biosimilars*, *interchangeable biologic products* or *multi-source brand name drugs*.

Prior plan is a *plan* sponsored by *us* which was replaced by this *plan* within 60 days. *You* are considered covered under the *prior plan* if *you*: (1) were covered under the *prior plan* on the date that *plan* terminated; (2) properly enrolled for coverage within 31 days of this *plan's Effective Date*; and (3) had coverage terminate solely due to the *prior plan's* termination.

Single source brand name drugs are *drugs* with no generic substitute.

Specialty drugs are typically high-cost, injectable, infused, oral or inhaled medications that generally require close supervision and monitoring of their effect on the patient by a medical professional. Certain specified *specialty drugs* may require special handling, such as temperature controlled packaging and overnight delivery, and therefore, certain specified *specialty drugs* will be required to be obtained through the specialty *pharmacy* program, unless *you* qualify for an exception.

Spouse meets the *plan's* eligibility requirements for spouses as outlined under HOW COVERAGE BEGINS AND ENDS.

Subscriber is the person who, by meeting the *plan's* eligibility requirements for employees, is allowed to choose membership under this *plan* for himself or herself and his or her eligible *dependents*. Such requirements are outlined in HOW COVERAGE BEGINS AND ENDS. A person may enroll as a *subscriber* under only one health *plan* provided by the *plan administrator*, or any of its affiliates.

Totally disabled *dependent* is a *dependent* who is unable to perform all activities usual for persons of that age.

Totally disabled subscriber is a *subscriber* who, because of illness or injury, is unable to work for income in any job for which he/she is qualified or for which they become qualified by training or experience, and who are in fact unemployed.

Urgent care is the services received for a sudden, serious, or unexpected illness, injury or condition, other than one which is life threatening, which requires immediate care for the relief of severe pain or diagnosis and treatment of such condition.

We (us, our) refers to Otsuka America, Inc..

Year or **calendar year** is a 12 month period starting January 1 at 12:01 a.m. Pacific Standard Time.

You (your) refers to the *subscriber* and *dependents* who are enrolled for benefits under this *plan*.

YOUR RIGHT TO APPEALS

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

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

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

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

The procedure the *claims administrator* will follow will satisfy following the minimum requirements for a full and fair review under applicable federal regulations.

Notice of Adverse Benefit Determination

If *your* claim is denied, the *claims administrator's* notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific *plan* provision(s) on which the *claims administrator*'s determination is based;
- a description of any additional material or information needed to perfect *your* claim;
- an ex*plan*ation of why the additional material or information is needed;
- a description of the *plan's* review procedures and the time limits that apply to them, including a statement of *your* right to bring a civil action under ERISA (if applicable) within one year of the appeal decision if *you* submit an appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about *your* right to request a copy of it free of charge, along with a discussion of the claims denial decision; and

- information about the scientific or clinical judgment for any determination based on medical necessity or *experimental* treatment, or about *your* right to request this explanation free of charge, along with a discussion of the claims denial decision; and

- information regarding *your* potential right to an External Appeal pursuant to federal law.

For claims involving urgent/concurrent care:

- the *claims administrator*'s notice will also include a description of the applicable urgent/concurrent review process; and

- the *claims administrator* may notify *you* or *your* authorized representative within 72 hours orally and then furnish a written notification.

Appeals

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

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

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

- the identity of the claimant;

- the date (s) of the prescription service;

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

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

Anthem Blue Cross Life and Health Insurance Company
ATTN: Appeals
P.O. Box 54159, Los Angeles, CA 90054

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

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

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the *plan*, applied consistently for similarly-situated claimants; or
- is a statement of the *plan*'s policy or guidance about the treatment or benefit relative to *your* diagnosis.

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

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

How Your Appeal will be Decided

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

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

Notification of the Outcome of the Appeal

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

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

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

Appeal Denial

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

Voluntary Second Level Appeals

If *you* are dissatisfied with the *plan*'s mandatory first level appeal decision, a voluntary second level appeal may be available. If *you* would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal. *You* are not required to complete a voluntary

second level appeal prior to submitting a request for an independent External Review.

External Review

If the outcome of the mandatory first level appeal is adverse to *you* and it was based on medical judgment, or if it pertained to a rescission of coverage, *you* may be eligible for an independent External Review pursuant to federal law.

You must submit *your* request for External Review to the *claims administrator* within four (4) months of the notice of *your* final internal adverse determination.

A request for an External Review must be in writing unless the *claims administrator* determines that it is not reasonable to require a written statement. *You* do not have to re-send the information that *you* submitted for internal appeal. However, *you* are encouraged to submit any additional information that *you* think is important for review.

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

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

All other requests for External Review should be submitted in writing unless the *claims administrator* determines that it is not reasonable to require a written statement. Such requests should be submitted by *you* or *your* authorized representative to:

Anthem Blue Cross Life and Health Insurance Company
ATTN: Appeals
P.O. Box 54159, Los Angeles, CA 90054

***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 state laws or ERISA (if applicable).

You may be afforded an additional voluntary review of an adverse External Review, adverse Voluntary Second Level review, or other final appeal decision of a benefits claim by making a written claim to the Benefits Review Committee. This voluntary appeal is in addition to *your* right to file a lawsuit as described below. If *you* want to take advantage of this additional review *you* may send *your* written appeal to the Benefits Review Committee in care of Otsuka America, Inc.

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.

FOR YOUR INFORMATION

ANTHEM BLUE CROSS WEBSITE

Information specific to *your* benefits and claims history are available by calling the 800 number on *your* ID card. Anthem Blue Cross Life and Health is an affiliate of Anthem Blue Cross. *You* may use Anthem Blue Cross's website to access benefit information, claims payment status, benefit maximum status, *participating providers* or to order an ID card. Simply log on to www.anthem.com/ca, select "*Member*", and click the "Register" button on *your* first visit to establish a User ID and Password to access the personalized and secure MemberAccess Website. Once registered, simply click the "Login" button and enter *your* User ID and Password to access the MemberAccess Website.

IDENTITY PROTECTION SERVICES

The *claims administrator* has made identity protection services available to *members*. To learn more about these services, please visit https://anthemcares.allclearid.com/.

LANGUAGE ASSISTANCE PROGRAM

Anthem Blue Cross Life and Health introduced its Language Assistance Program to provide certain written translation and oral interpretation services to California *members* with limited English proficiency.

The Language Assistance Program makes it possible for *you* to access oral interpretation services and certain written materials vital to understanding *your* health coverage at no additional cost to *you*.

Written materials available for translation include grievance and appeal letters, consent forms, claim denial letters, and explanations of benefits. These materials are available in the following languages:

- Spanish
- Chinese
- Vietnamese
- Korean
- Tagalog

Oral interpretation services are available in additional languages.

Requesting a written or oral translation is easy. Just contact *Member* Services by calling the phone number on *your* ID card to update *your* language preference to receive future translated documents or to request interpretation assistance. Anthem Blue Cross Life and Health also sends/receives TDD/TTY messages at **866-333-4823** or by using the National Relay Service through **711.**

For more information about the Language Assistance Program visit www.anthem.com/ca.

ADDITIONAL INFORMATION

This "Additional Information" section of the Booklet was prepared by *your* employer. The entire Booklet, including this Section, is the Summary Plan Description ("SPD") for the prescription benefits described in the booklet under the *plan* named below. In the event of a conflict between the terms of the *prescription drug* booklet and this additional information, the *prescription drug* booklet document will control.

Name of Plan: Otsuka America, Inc. Health and Welfare *Plan*

Plan Sponsor: Otsuka America, Inc.

Employer Identification Number: 91-1461045

Plan Number: 510

Type of Plan: The *plan* described in the booklet is a component *plan* under the Otsuka America, Inc. Health and Welfare *Plan*. It is a group health *plan* providing *pharmacy* benefits.

Type of Administration and *Claims Administrators*: The *plan* is administered by a third party administrator. The third party administrator and *claims administrator* for prescription claims is:

Anthem Blue Cross Life and Health Insurance Company
ATTN: Appeals
P.O. Box 54159, Los Angeles, CA 90054

Plan Administrator:

Otsuka America, Inc. Health and Welfare Committee
One Embarcadero Center, Suite 2020
San Francisco, CA 94111
Attn: OAI Benefits

The *Plan administrator* has the responsibility, and the full power and authority, to determine in its sole discretion, all questions concerning the construction and interpretation of the *Plan* and its administration, including, but not by way of limitation, the determination of the rights or eligibility of *members* and their benefits. The *Plan administrator* has delegated its rights with respect to claims administration to the *claims administrator* to the extent set forth in the booklet.

Agent for Service of Legal Process:

Otsuka America, Inc.
One Embarcadero Center, Suite 2020
San Francisco, CA 94111
ATTN: VP Aministration

Plan Year: January 1 - December 31

Plan Funding: The *plan* is self-insured and benefit disbursements are made from the general assets of the *Plan* Sponsor and its subsidiaries.

Amendment and Termination: The *Plan* Sponsor reserves the right to amend or terminate the *plan* at any time, for any reason, or for no reason, with or without notice to *you*.

ERISA Rights

As a participant in the group benefit *plan you* are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all *plan* participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the *Plan Administrator's* office and at other specified locations, such as worksites, all documents governing the *Plan*, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) that is filed by the *Plan* with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the *Plan Administrator*, copies of documents governing the operation of the *Plan*, including any insurance contracts, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the *Plan's* annual financial report. The *Plan administrator* is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, *your spouse*, or *your dependents* if there is a loss of coverage under the *Plan* as a result of a qualifying event. *You* or *your dependents* may have to pay for such coverage. Review this summary plan description and the documents governing the *Plan* for the rules governing *your* COBRA continuation coverage rights.

Receive a copy of the procedures used by the *Plan* for determining a qualified medical *child* support order (QMCSO).

Prudent Actions by Plan Fiduciaries

In addition to creating rights for *plan* participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit *plan*. The people who operate *your Plan*, called "fiduciaries" of the *Plan*, have a duty to do so prudently and in *your* interest and that of other *plan* participants and beneficiaries. No one, including *your* employer, or any other person, may fire *you* or otherwise discriminate against *you* in any way to prevent *you* from obtaining a welfare benefit or exercising *your* rights under ERISA.

Enforce Your Rights

If *your* claim for a welfare benefit is denied or ignored, in whole or in part, *you* have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps *you* can take to enforce the above rights. For instance, if *you* request materials from the *Plan* and do not receive them within 30 days *you* may file suit in a federal court. In such a case, the court may require the *Plan administrator* to provide the materials and pay up to $110 a day until *you* receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If *you* have a claim for benefits which is denied or ignored, in whole or in part, *you* may file suit in a state or federal court. In addition, if *you* disagree with the *Plan's* decision or lack thereof concerning the status of a medical *child* support order, *you* may file suit in a federal court.

If it should happen that *plan* fiduciaries misuse the *Plan's* money or if *you* are discriminated against for asserting *your* rights, *you* may seek assistance from the U.S. Department of Labor or *you* may file suit in a federal court. The court will decide who should pay court costs and legal fees. If *you* are successful, the court may order the person *you* have sued to pay these costs and fees. If *you* lose, the court may order *you* to pay these costs and fees, for example, if it finds *your* claim is frivolous.

Assistance with Your Questions

If *you* have any questions about *your Plan*, *you* should contact the *Plan Administrator*.

If *you* have any questions about this statement or about *your* rights under ERISA, *you* should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in *your* telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You may also obtain certain publications about *your* rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

IMPORTANT NOTICES

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by the Family and Medical Leave Act of 1993 (FMLA). If *your* employer grants *you* an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be determined by *your* employer.

If *your* employer grants *you* an approved FMLA leave in accordance with FMLA, *you* may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for *you* and *your* eligible *dependents*.

At the time *you* request the leave, *you* must agree to make any contributions required by *your* employer to continue coverage.

If any coverage *your* employer allows *you* to continue has reduction rules applicable by reason of age or retirement, the coverage will be subject to such rules while *you* are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date *you* are required to make any contribution and *you* fail to do so.
- The date *your* employer determines *your* approved FMLA leave is terminated.

- The date the coverage involved discontinues as to *your* eligible class. However, coverage for health expenses may be available to *you* under another *plan* sponsored by *your* employer.

Any coverage being continued for a *dependent* will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because *your* approved FMLA leave is deemed terminated by *your* employer, *you* may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though *your* employment terminated, other than for gross misconduct, on such date. If this *plan* provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined *dependent*), *you* (or *your* eligible *dependents*) may be eligible for such continuation on the date *your* employer determines *your* approved FMLA leave is terminated or the date of the event for which the continuation is available.

If *you* acquire a new *dependent* while *your* coverage is continued during an approved FMLA leave, the *dependent* will be eligible for the continued coverage on the same terms as would be applicable if *you* were actively at work, not on an approved FMLA leave.

If *you* return to work for *your* employer following the date *your* employer determines the approved FMLA leave is terminated, *your* coverage under this *Plan* will be in force as though *you* had continued in active employment rather than going on an approved FMLA leave provided *you* make request for such coverage within 31 days of the date *your* employer determines the approved FMLA leave to be terminated. If *you* do not make such request within 31 days, coverage will again be effective under this *plan* only if and when this *plan* gives its written consent.

If any coverage being continued terminates because *your* employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though *your* employment had terminated on the date *your* employer determines the approved FMLA leave is terminated.

Get help in your language

Curious to know what all this says? 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, documents are made 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)**

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك
للمساعدة(TTY/TDD: 711).

Armenian
Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

Hindi
आपके पास यह जानकारी और मदद अपनी भाषा में मुफ़्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें।(TTY/TDD: 711)

Hmong
Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Khmer
អ្នកមានសិទ្ធិក្នុងការទទួលព័ត៌មាននេះ
និងទទួលជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើប័ណ្ណ ID
របស់អ្នកដើម្បីទទួលជំនួយ។(TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Punjabi
ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ।(TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng *Member* Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Thai
ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ(TTY/TDD: 711)

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

It's important that *you* are treated fairly

That's why the *claims administrator* follows federal civil right laws in *our* health programs and activities. The *claims administrator* doesn't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, free aids and services are offered. For people whose primary language isn't English, free language assistance services through interpreters and other written languages are offered. Interested in these services? Call the *Member* Services number on *your* ID card for help (TTY/TDD: 711). If *you* think the *claims administrator* 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 Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or *you* can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html 030509.0001:29144875.129144875.2