



USC EPO PLUS PLAN



Self-Insured Plan
Effective January 1, 2023

FOREWORD

The plan described on the following pages provides benefits for a wide range of services and supplies for medical care. Your medical benefit plan is a self-funded program provided by the University of Southern California (the "University"). Benefits are administered by the University with HealthComp, Anthem Blue Cross, and Navitus Health Solutions, each providing certain administrative services.

The USC Group Health Plan provides self-insured medical benefits under the USC EPO Plus Plan. This booklet constitutes the portion of the plan document that describes the USC EPO Plus Plan.

The University of Southern California reserves the right to amend or terminate the USC EPO Plus Plan (the "Plan") at any time or terminate any benefit under the Plan. The Plan is intended to comply with all applicable laws (including, but not limited to, the Federal Cares Act) and shall be automatically amended to any extent necessary to maintain such compliance.

Plan Administrator's Decision Final. The administration of the Plan shall be under the supervision of the Plan Administrator, which is the University and the University's delegate, USC Health Plans (hereafter, collectively, the "Plan Administrator"). To the fullest extent permitted by law, the Plan Administrator shall have the discretion to determine all matters relating to eligibility, coverage and benefits under the Plan, and the Plan Administrator shall have the discretion to determine all matters relating to the interpretation and operation of the Plan. Any determination by the Plan Administrator shall be final and binding, in the absence of clear and convincing evidence that the Plan Administrator acted arbitrarily and capriciously.

THIS BOOKLET, TOGETHER WITH THE INFORMATION CONTAINED ON THE USC EMPLOYEE GATEWAY WEBSITE, employees.usc.edu/epoplus, RELATING TO THE PLAN CONSTITUTES THE SUMMARY PLAN DESCRIPTION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, (*ERISA*). IMPORTANT *ERISA* INFORMATION AND A STATEMENT OF YOUR *ERISA* RIGHTS CAN BE FOUND AT THE USC EMPLOYEE GATEWAY WEBSITE AT employees.usc.edu/epoplus.

IMPORTANT NOTE: The Plan is subject to the provisions of the federal "No Surprises Act" (NSA) which is described in the notice at the end of this booklet. Notwithstanding anything in this summary plan description to the contrary, payment under the Plan shall be in accordance with the NSA when it is applicable to the claim in question.

| IMPORTANT CONTACTS | | |
|------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------|
| Prior Authorizations | Anthem Blue Cross | (800) 274-7767 |
| Plan Coverage Questions | HealthComp | (855) SC-PLANS (855) 727-5267 honline.healthcomp.com/usc |
| Claim Questions | HealthComp | (855) SC-PLANS (855) 727-5267 honline.healthcomp.com/usc |
| Find a Participating EPO Plus Network Provider | EPO Plus Network Provider: Keck Medicine of USC | (833) KECK-USC (833-532-5872) keckmedicine.org |
| | EPO Plus Network Provider: All Other Providers | (855) SC-PLANS (855-727-5267) honline.healthcomp.com/usc |
| | Contracted Pharmacies: Navitus Health Solutions | (855) 673-6504 navitus.com |
| For help scheduling an appointment with a Keck Medicine provider | Keck Medicine of USC | (833) KECK-USC (833-532-5872) |
| Prescription/Pharmacy Questions | Navitus Health Solutions | (855) 673-6504 navitus.com |
| Keck Medicine at UPC | Keck Medicine of USC – UPC Clinic | (833) KECK-USC (833-532-5872) |

You can also visit the USC EPO Plus Plan’s website for other important information and links:

employees.usc.edu/epoplus

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PROVISIONS APPLYING TO THE EPO PLUS PLAN

IMPORTANT NOTE ABOUT YOUR EPO PLUS MEDICAL PLAN

YOUR EPO PLUS MEDICAL PLAN CONTAINS A PRIOR AUTHORIZATION PROGRAM, AS DESCRIBED ON PAGES 19-20.

Failure to follow the Prior Authorization Program **may** result in a reduction or denial of benefits, which may mean a greater expense to you.

TO ARRANGE FOR A PRIOR AUTHORIZATION, PLEASE CONTACT ANTHEM BLUE CROSS AT (800) 274-7767.

USC's Exclusive Provider Organization Program

The USC EPO Plus Network Providers are comprised of Keck Medicine of USC Physicians, Keck Hospital of USC, USC Arcadia Hospital, USC Norris Cancer Hospital, USC Verdugo Hills Hospital and all other selected strategic providers within the six Southern California counties. Subscribers who reside anywhere in California and covered dependents who reside in Southern California, with a Plan ID number prefix of U7S, must access these Network Providers.

Covered dependents who reside in Northern California or any U.S. state outside of California, with a Plan ID number prefix of U6C, have access to Anthem Prudent Buyer/BlueCard providers and the Network Providers within the six Southern California counties.

Except for Emergency Services and Urgent Care Services, the Plan provides no coverage for services from providers who are not EPO Plus Network Providers. Those providers are referred to as Non-Network Providers.

If you seek treatment at a Network facility (e.g., hospital or outpatient surgery center) and a Non-Network Provider (e.g., a Non-Network Physician, anesthesiologist, radiologist, respiratory therapist) participates in your treatment, the Non-Network Provider's claim will be paid at 90% of billed charges.

USC, as the EPO Plan Sponsor and Plan Administrator, is not responsible for the quality and extent of care you may receive at any of the Network Hospitals or from any specific Network Provider. It is important that you request information on proposed medical treatment directly from the Hospital and your Physician.

Designating a Primary Care Physician (PCP)

While you are not required to designate a Primary Care Physician (PCP), your Network non-specialty Physician office visit copayments will be reduced after you do designate one, from \$20 to \$10 per physician office visit.

You must have designated a PCP before your visit in order for the \$10 reduction in your office visit copay to apply. To designate a Primary Care Physician for you and each of your covered dependents, register at hconline.healthcomp.com/usc.

Your PCP designation must also remain in effect in order for all future PCP office visits to receive the \$10 reduction. You may change your PCP designation at any time. Changes made on or before the 15th day of the month will be effective on the first day of the following month.

For services received from Non-Network Providers, you are responsible for all charges, except for Emergency Services and Urgent Care Services.

PROVISIONS APPLYING TO THE EPO PLUS PLAN — Continued

The Deductible

The Plan has a Calendar Year deductible that will apply to Eligible Expenses which do not have a flat dollar copay. You must meet your annual deductible before the Plan will pay Benefits. The deductible is waived for Medically Necessary screening and testing of COVID-19 (coronavirus) and preventive services. The Calendar Year deductible does apply (count toward) to your annual medical out-of-pocket limit.

Individual

The individual Calendar Year deductible is the first \$100 of Eligible Expenses.

Family

Each individual deductible incurred (met) is applied to the family deductible. The family deductible does not have to be met before Plan Benefits are paid for a single Covered Person in a family. The family Calendar Year deductible is met collectively when three or more Covered Persons in a family have Eligible Expenses where the deductible applies (not counting more than the individual deductible for any one person). Once your family deductible is met, the Plan will pay Benefits for all members in the family, regardless of whether each member has met their individual deductible.

| | Annual Deductible |
|---------------------------------------|--------------------------|
| Individual | \$100 |
| Family (3 or more persons) | \$300 |

Carryover of Expenses Year-to-Year

There is no carryover of expense from one year to another. Limits on Benefits start anew each January 1.

Out-Of-Pocket Limits

The USC EPO Plus Plan limits your expenses each year. Once a Covered Person has met the out-of-pocket maximum(s) in one Calendar Year, the percentage covered by the Plan increases for that year.

The annual medical out-of-pocket maximum is \$1,000 per person or a maximum of three individuals within a family (\$1,000 x 3 people).

The out-of-pocket prescription Copay/Coinsurance maximums for the Plan are \$2,000 maximum for an individual and \$4,000 maximum for a Family (2 or more persons). This is a separate out-of-pocket maximum from the Plan's medical out-of-pocket maximum in a Calendar Year. This means that after a single person meets the prescription out-of-pocket maximum of \$2,000 in a Calendar Year, he/she will be covered at 100% for covered prescriptions filled at Network pharmacies for the remainder of the Calendar Year. For an employee covering one or more dependents, when the Covered Persons cumulatively reach the \$4,000 prescription out-of-pocket maximum, all covered members of the family will be covered at 100% for covered prescriptions filled at Network pharmacies for the remainder of the Calendar Year.

PROVISIONS APPLYING TO THE EPO PLUS PLAN — Continued

This does not imply coverage in excess of limits expressed elsewhere.

| | <u>Network Providers</u> | <u>Non-Network Providers</u> |
|------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|-------------------------------|
| Medical Out-of-Pocket Limits (Per Calendar Year) | \$1,000 - Individual maximum \$3,000 - Family (maximum of 3 or more persons) Thereafter, coverage increases to 100% | Not Covered |
| Prescription Out-of-Pocket Limits (Per Calendar Year) | <u>Network Pharmacies</u> | <u>Non-Network Pharmacies</u> |
| | \$2,000 - Individual maximum \$4,000 - Maximum for two or more individuals within a family | Not Covered |

Continuity Of Covered Care

In the event a Covered Person is a continuing care patient receiving a covered course of treatment from a Network Provider or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the provider's failure to meet applicable quality standards or for fraud, the Covered Person shall have the following rights to continuation of covered care.

The Plan shall use reasonable efforts to notify the Covered Person that the provider's contractual relationship with the Plan has terminated, and that the Covered Person has rights to elect continued transitional care from the provider. If the Covered Person elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred as determined by the plan administrator in its discretion, beginning on the date the Plan's notice of termination is provided and ending 90 days later or when the Covered Person ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means a Covered Person who:

- (1) is undergoing a course of treatment for a serious and complex condition from a specific provider,
- (2) is undergoing a course of institutional or Inpatient care from a specific provider,
- (3) is scheduled to undergo non-elective surgery from a specific provider, including receipt of postoperative care with respect to the surgery,
- (4) is pregnant and undergoing a course of treatment for the pregnancy from a specific provider, or
- (5) is or was determined to be terminally ill and is receiving treatment for such illness from a specific provider.

Note that during continuation, Plan benefits will be processed as if the termination had not occurred, however, the Provider may be free to pursue the Covered Person for any amounts above the Plan's benefit amount to the extent permitted by law.

DEFINITIONS FOR THE PURPOSE OF THE EPO PLUS PLAN

BENEFICIARY/COVERED PERSON

means a person who is entitled to Covered Services and who, on the date health care services are rendered, has satisfied the eligibility requirements of the Plan and who has elected to be covered by the Plan.

BENEFITS

means the dollar amount payable for a Covered Service after the application of Deductible/Coinsurance/Copayments under the Plan, subject to all of the terms and conditions of the Plan.

BRAND NAME DRUG

means a single-source and/or multisource non-generic prescription drug as determined by using MediSpan indicators in accordance with the drug classification requirements of USC's Prescription Drug Program Agreement with Navitus.

BUSINESS DAY

means a weekday that is not a recognized holiday between the hours of 8:30 a.m. to 5:00 p.m.

CALENDAR YEAR

means the period of time from any January 1st through the following December 31st. When a person first enrolls in the EPO Plus Plan, his/her first Calendar Year begins on the Effective Date of his/her enrollment and ends on the coinciding or following December 31st.

CERTIFIED IDR ENTITY

is an entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

COINSURANCE

means the portion of the Eligible Expense for which the Covered Person has a financial responsibility, usually according to a fixed percentage. The percentage of covered expenses that you pay is your coinsurance.

COPAYMENT

means the fixed dollar amount which must be paid directly by the Covered Person to the provider. (See page 53, "Patient Responsibility For Payment".)

COSMETIC SURGERY

means surgery performed mainly to change a person's appearance (including, but not limited to, "cosmetic surgery" as defined under Section 213(d)(9)(B) of the Internal Revenue Code). It includes surgery performed to treat mental, psychoneurotic and personality disorders through change in appearance.

COVERED SERVICES

means all Medically Necessary Physician services and health care services and supplies that are provided by or at the direction of a Physician, and for which Benefits are expressly available under the Plan, subject to the exclusions and limitations set forth herein.

CUSTODIAL CARE

means services which are intended to help a Covered Person meet the activities of daily living, whether he/she is disabled or not. "Activities of daily living" include but are not limited to:

| | | |
|-----------------------------|-----------------------------|------------------|
| Judgment/Cognitive Function | Transfer from bed or toilet | Sitting/Standing |
| Writing/Reading | Reaching | Ambulation |
| Communications | Shopping | Climbing stairs |
| Bathing | Cooking/Cleaning | Grasping |
| Eating | Bowel and bladder control | Laundry |
| Toileting | Managing money | Lifting |
| Dressing | Using public transportation | Pushing/Pulling |
| Using a telephone | Driving a motor vehicle | |

DEFINITIONS FOR THE PURPOSE OF THE EPO PLUS PLAN — Continued

DOCTOR/PHYSICIAN

means a person licensed under the laws of the state in which he/she practices medicine within the scope of his/her license.

DURABLE MEDICAL EQUIPMENT

means that equipment is (1) able to withstand repeated use, (2) primarily and customarily used to serve a medical purpose, and (3) not generally useful to a person in the absence of illness or injury. Examples include: wheelchair, walker, bed, bedside commode, crutches, apnea monitor, blood glucose machine and nebulizer.

ELIGIBLE EXPENSES/CHARGES

means those charges or expenses for Covered Services, subject to the terms and limitations of the Plan. For example, reimbursement for Eligible Expenses of Non-Network Providers is limited to the lower of the applicable reimbursement percentage of Usual, Customary and Reasonable Charges (UCR) or the Qualifying Payment Amount. For Non-Network charges subject to the No Surprises Act, reimbursement of Eligible Expenses may be the amount deemed payable by a Certified IDR Entity to the extent permitted by the No Surprises Act.

For Network Providers, reimbursement of Eligible Expense is limited to the applicable reimbursement percentage of the reimbursement provided under the terms of the Network Provider's applicable contractual arrangement.

EMERGENCY

means a situation requiring Emergency Services.

EMERGENCY MEDICAL CONDITION

means the treatment given in a Hospital's emergency room to evaluate and treat medical conditions of recent onset and severity - including (but not limited to) severe pain - that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness or injury is of such a nature that failure to get immediate medical care could result in:

1. placing the person's health in serious jeopardy, or
2. serious impairment to bodily function, or
3. serious dysfunction of a body part or organ, or
4. serious jeopardy to the health of the fetus (in the case of a pregnant woman).

EMERGENCY SERVICES

means, with respect to an Emergency Medical Condition, the following:

1. an appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment (as are required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to an Emergency Medical Condition, Emergency Services shall also include an item or service provided by a Non-Network Provider (regardless of the department of the Hospital in which items or services are furnished) after the Covered Person is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the provider determines

DEFINITIONS FOR THE PURPOSE OF THE EPO PLUS PLAN — Continued

that the Covered Person is in a condition to, and in fact does, give informed consent to the provider to be treated as a Non-Network Provider.

Emergency Services include pre-stabilization services that are provided after a patient is moved out of the emergency department and admitted to a Hospital, as well as any additional services rendered after a patient is stabilization as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which other Emergency Services are furnished. These services include those provided at an Independent Freestanding Emergency Department, as well as a Hospital emergency department. A decision of what constitutes Emergency Services will not be defined solely on the basis of the diagnosis but rather will be a determination that takes into account the reasonableness of each situation as defined by a prudent layperson.

EXPERIMENTAL OR INVESTIGATIONAL

means any treatment, service or supply that is:

1. not universally accepted by informed health care professionals in the United States as safe, appropriate, and more effective than medically accepted alternatives, or
2. not likely to restore health and extend life as determined by the Plan Administrator in its discretion, or
3. not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use, or
4. subject to federal laws requiring Institutional Review Board review and approval for the proposed use, or
5. the subject of ongoing FDA regulated Phase I, II, or III clinical trial, except where federal law requires coverage under the USC EPO Plus Plan for any treatment, service or supply in connection with an approved clinical trial, or
6. not conclusively demonstrated to Plan Administrator's satisfaction to be safe, cost effective, likely to restore health and extend life and more effective than medically accepted alternatives.

However, the following are **not** considered experimental or investigational:

Transplantation

Any human solid organ or bone marrow/stem cell transplant provided that:

- a) the condition is life-threatening; and
- b) such transplant for that condition is the subject of an ongoing Phase III clinical trial or is otherwise not experimental or investigational as provided above with respect to legally-required coverage for services and supplies in connection with an approved clinical trial; and
- c) such transplant for that condition follows a written protocol that has been reviewed and approved by an institutional review board, federal agency or other such organization recognized by medical specialists who have appropriate expertise; and
- d) the Covered Person is a suitable candidate for the transplant under the medical protocols used by Anthem Blue Cross and approved from time to time by the Plan Administrator; and
- e) the transplant is more effective than medically-accepted alternatives and likely to restore health and extend life, as determined by the Plan Administrator, in its discretion.

Drugs

Any drug or biologic which has been approved by the Food and Drug Administration (FDA), provided that it:

1. conforms to FDA approved use guidelines; **or**
2. conforms to usage listed in a Recognized National Compendia.

DEFINITIONS FOR THE PURPOSE OF THE EPO PLUS PLAN — Continued

Medical Devices

Any medical device provided that it:

1. has been approved by the FDA; **and**
2. conforms to FDA approved use guidelines.

FAMILY UNIT

means an employee and his/her covered dependents.

GENERALLY ACCEPTED BY THE MEDICAL COMMUNITY IN THE UNITED STATES

means that the clinical efficacy of the treatment has been documented in credible, published medical literature which demonstrates that the results of the treatment have been measured for a 5 year period or other period generally regarded as valid.

GENERIC DRUG

means a single and/or multi-source non-brand prescription drug, whether identified by its chemical, proprietary or nonproprietary name, as determined by using MediSpan indicators in accordance with the drug classification requirements of USC's Prescription Drug Program Agreement with Navitus.

HOME HEALTH CARE AGENCY

means any of the following: (1) a home health agency licensed by the state of operation, or (2) a home health agency as defined under Medicare, or (3) an organization which is certified by the patient's Physician as an appropriate provider of home health services, has a full-time administrator, keeps medical records and has at least one Registered Nurse (R.N.) or one's services available.

HOME HEALTH CARE PLAN

means a written program for care and treatment in the patient's home and certification that continued inpatient confinement in a Hospital or nursing facility would be required if the home care were not provided.

HOSPICE SERVICES

means those services provided by a licensed or certified provider of care to a terminally ill person to (1) reduce or abate pain or other symptoms of mental or physical distress, and (2) meet the special needs arising out of the stresses of the terminal illness, dying and bereavement.

HOSPICE TEAM

means a team of professionals and volunteer workers which includes at least: a Physician; a registered nurse; and could include the following: a social worker, a clergyman/counselor; volunteers; a clinical psychologist; physiotherapist; and occupational therapist.

HOSPITAL

means an institution licensed as a hospital by the appropriate state and local authorities and approved by The Joint Commission.

IMMUNIZATION

means a procedure to render an individual resistant to infection or disease.

INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT

is a health care facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services.

DEFINITIONS FOR THE PURPOSE OF THE EPO PLUS PLAN — Continued

INPATIENT CONFINEMENT

means that a Covered Person is duly admitted by a Physician and is registered as a bed patient in a Hospital or Skilled Nursing Facility (SNF).

MEDICALLY NECESSARY

means services are Covered Services that are necessary and appropriate for treatment of a Covered Person's illness or injury according to generally accepted standards of medical practice.

A service or supply is Medically Necessary only when it meets all of the following requirements:

1. it must be legal, ordered by a Physician, safe, cost effective and appropriate in treating the condition for which it is ordered;
2. it must not be considered experimental or investigational;
3. it must be the proper quantity, frequency and duration for treatment of the condition for which it is ordered;
4. it must not be redundant when it is combined with other services and supplies that are used to treat the condition for which it is ordered;
5. it must not be custodial;
6. its purpose must be to restore health and extend life and must, in the judgment of the EPO Plus Plan Administrator, be likely to accomplish that purpose; and
7. for any type of bariatric surgery or procedure, in addition to meeting all of the above requirements, such surgery or procedure must satisfy Anthem Blue Cross' Medical Policy requirements and must also have prior authorization from Anthem Blue Cross. For more information about those Medical Policy requirements, you may contact Anthem Blue Cross directly.

As indicated above, to be Medically Necessary, a procedure must, in the judgment of the Plan Administrator, be likely to accomplish its intended purpose of restoring health and extending life.

MENTAL DISORDER

means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or which under applicable law would be considered a Mental Disorder.

NETWORK SERVICE AREA

generally means the six counties in Southern California: Los Angeles, Ventura, Orange, San Bernardino, Riverside and San Diego, except as otherwise determined by the EPO Plus Plan Administrator from time to time. This applies to all Subscribers and covered dependents with a Plan ID number prefix of U7S.

Covered dependents with a Plan ID number prefix of U6C, the Network Service Area generally means the United States of America.

NETWORK PROVIDER/PARTICIPATING NETWORK PROVIDER

means health care providers listed on the Keck Medicine of USC website available at keckmedicine.org, Keck Hospital of USC, USC Arcadia Hospital, USC Norris Cancer Hospital, USC Verdugo Hills Hospital and all other selected strategic providers within the six Southern California counties listed at hconline.healthcomp.com/usc. These Network Providers apply to Subscribers and covered dependents with a Plan ID number prefix of U7S.

Covered dependents who reside in Northern California and any U.S. state outside of California, with a Plan ID prefix of U6C, Network Provider/Participating Network Provider generally means the Anthem Prudent Buyer/BlueCard providers and the Network Providers within the six Southern California counties listed at keckmedicine.org and hconline.healthcomp.com/usc.

DEFINITIONS FOR THE PURPOSE OF THE EPO PLUS PLAN — Continued

NO SURPRISES ACT (NSA)

is the Title I of the Consolidated Appropriations Act of 2021 or any provision or section thereof and which may be amended from time to time.

NON-NETWORK PROVIDER

means any Physician, Hospital or ancillary provider who does not have an agreement with the USC EPO Plus Plan to participate as a Network Provider with the Plan.

PARTICIPATING HEALTH CARE FACILITY

is a Hospital, ambulatory surgical center, or other provider as required by law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

PLAN

means the USC EPO Plus Plan.

PREVENTIVE CARE

means health screening and immunizations at designated intervals depending upon age, including any recommended preventive services that the Plan is required to cover under the Patient Protection and Affordable Care Act (“PPACA” or the “Affordable Care Act”).

PRIMARY CARE PHYSICIAN (PCP)

Primary Care Physicians (PCP) consist of Network Providers who are general and family practitioners, internists, pediatricians and OB/GYNs. All Covered Persons are urged to designate a PCP to receive the lowest office visit copay when seen by a Network PCP after making that designation. Each covered member may designate a different PCP and you may change your PCP designation any month, provided you make the election in the HealthComp System (HOnline) prior to the 15th of the preceding month. To designate or change a PCP, access the HealthComp System at honline.healthcomp.com/usc.

QUALIFYING PAYMENT AMOUNT

means, in accordance with, and subject to, the No Surprises Act, the median of the contracted rates recognized by the Plan for the same or a similar item or service provided by a provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

RECOGNIZED NATIONAL COMPENDIA

means the American Hospital Formulary Service, the American Medical Association Drug Evaluations or the U.S. Pharmacopoeia Drug Information of the Health Care Professional.

REMISSION

means a halt in the progression of a terminal disease or an actual reduction in the extent to which the disease has already progressed.

RESIDENTIAL TREATMENT CENTER

means an institution that meets all of the following requirements:

- Has an on-site, licensed medical **or** chemical dependency providers 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Patients are admitted by a Physician.
- Has access to necessary medical services 24 hours per day/7 days a week.

DEFINITIONS FOR THE PURPOSE OF THE EPO PLUS PLAN — Continued

- If the member requires detoxification services, must have the availability of on-site medical treatment 24 hours per day/7 days a week. The treatment must be actively supervised by an attending Physician.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-level health professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a psychiatrist or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Its services are managed by a licensed provider who, while not needing to be individually contracted, needs to:
 - Meet the Provider Network's credentialing criteria as an individual practitioner, and
 - Function under the direction/supervision of a licensed psychiatrist (Medical Director).
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a wilderness treatment program or any such related or similar program, school and/or education service.
- Is able to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally.
- Provides 24-hours per day/7 days a week supervision by a Physician with evidence of close and frequent observation.

SKILLED NURSING FACILITY

means a licensed institution that (1) provides 24-hour care by one or more professional nurses, (2) is under full-time supervision of a Physician, (3) keeps medical records as required by the licensing body, and (4) is not an institution, or part of one, used mainly as a rest facility or a facility for the aged.

SMOKING CESSATION PROGRAM

means a structured outpatient program of not greater than 12 weeks, designed to provide behavior modification tools to assist a Covered Person in ceasing tobacco use.

SURGERY CENTER

means a freestanding ambulatory surgical facility that:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Makes charges for its services.
- Is directed by a staff of Physicians, at least one of whom is on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery that requires general or spinal anesthesia is performed, and during the recovery period.
- Extends surgical staff privileges to Physicians who practice surgery in an area hospital and to dentists who perform oral surgery.
- Has at least two operating rooms and one recovery room.
- Provides or arranges with a medical facility in the area for diagnostic X-ray and laboratory services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by an RN.
- Is equipped and has staff trained to handle medical emergencies.
- Must have a Physician trained in CPR, a defibrillator, a tracheotomy set and a blood volume expander.
-

DEFINITIONS FOR THE PURPOSE OF THE EPO PLUS PLAN — Continued

- Has a written agreement with an area hospital for the immediate emergency transfer of patients. Written procedures for such a transfer must be displayed, and the staff must be aware of them.
- Provides an ongoing quality assurance program that includes reviews by Physicians who do not own or direct the facility.
- Keeps a medical record for each patient.

SURGICAL PROCEDURES

means only: cutting, suturing, correction of a fracture, reduction of a dislocation, electrocauterization, tapping (paracentesis, arthrocentesis), amniocentesis, administration of artificial pneumothorax, laparoscopic and arthroscopic procedures, or injection of sclerosing solution.

TELEHEALTH SERVICES

Telehealth is the use of electronic information and telecommunication technologies to support long distance clinical care when you and your provider are not in the same place at the same time. Your provider must use an interactive audio and video telecommunications system that permits real-time communication between you and your provider. Telehealth providers can include Physicians, nurse practitioners, Physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, therapists (including licensed speech pathologist, physical therapists and occupational therapists), registered dietitians, and nutrition professionals. Examples of covered telemedicine visits include:

- General health care, like wellness visits
- Prescriptions for medicine
- Dermatology (skin care)
- Mental health counseling
- Therapies, includes speech, physical and occupational therapy
- Urgent care conditions, such as sinusitis, back pain, urinary tract infections, common rashes, etc.

TERMINALLY ILL PERSON

means a Covered Person whose life expectancy is six months or less, as certified by the primary attending Physician.

URGENT CARE PROVIDER

This is a freestanding medical facility that:

- Provides unscheduled medical services to treat an urgent condition if the person's physician is not reasonably available,
- Routinely provides ongoing unscheduled medical services for more than eight consecutive hours,
- Charges for services,
- Is licensed and certified as required by state or federal law or regulation,
- Keeps a medical record for each patient,
- Provides an ongoing quality assurance program, including reviews by physicians other than those who own or run the facility,
- Is run by a staff of physicians, with one physician on call at all times, and
- Has a full-time administrator who is a physician.

An urgent care provider may also be a Physician's office if it has contracted with the Claims Administrator to provide urgent care and is, with the Claims Administrator's consent, included in its provider directory as a Network Urgent Care Provider.

A Hospital emergency room or outpatient department is not considered to be an Urgent Care Provider.

DEFINITIONS FOR THE PURPOSE OF THE EPO PLUS PLAN — Continued

URGENT CONDITION

This is a sudden illness, injury or condition that:

- Is severe enough to require prompt medical attention to avoid serious health problems,
- Includes a condition that could cause a person severe pain that cannot be managed without urgent care or treatment,
- Does not require the level of care provided in a Hospital emergency room, and
- Requires immediate outpatient medical care that cannot be postponed until the person's physician becomes reason.

WEEKDAY

means a day of the week other than a Saturday, Sunday or legal holiday.

ELIGIBILITY AND ENROLLMENT

Eligible Employees - To be eligible, an Employee must reside in the Network Service Area (California) and be eligible under the criteria below.

50% Full Time Eligibility

All benefits-eligible employees of the University who are scheduled to work at least 50% of full time (or work such 50% of full-time) are eligible for participation in the University's health coverage program, except those covered by a collective bargaining agreement which does not provide for their participation in the University's health coverage programs that applies to non-union represented employees.

Look-Back Period Eligibility

In addition to eligibility under the above, USC ("the University") will also determine the benefits eligibility of certain employees by looking back at a defined period of twelve consecutive calendar months (the Look-Back Period), to determine whether during that measurement period the employee averaged at least 30 hours of service per week. If the employee were determined to be a full-time employee (as defined by the Affordable Care Act or "ACA") during the Look-Back measurement period, then the employee would be treated as a full-time employee during a subsequent "stability period", regardless of the employee's number of hours of service during the stability period, so long as he or she remained an employee of the University. For an employee determined to be a full-time employee during the measurement period, the stability period would be a period of twelve consecutive calendar months that follows the measurement period and any related Administrative Period.

Measurement Periods

The University's Standard Measurement Period will run from October 15th through October 14th (followed by an Administrative Period of October 15th to December 31st). This period will determine eligibility for January 1st open enrollment for a stability period beginning on that January 1st and ending on the following December 31st. In other words, the stability period for ongoing employees is the Plan Year (January 1st-December 31st).

The Initial Measurement Period for new variable, part-time or seasonal employees will start with the hire date, and will span a twelve month period followed by no more than a permitted Administrative Period and thereafter, a twelve month initial stability period.

Eligible Dependents

Eligible dependents are your legally married spouse residing in the Network Service Area or your Registered Domestic Partner residing in the Network Service Area, and your children less than 26 years of age (your children age 26 or older may be eligible if they qualify as a disabled dependent child under the requirements of the Plan as described below). New spouses must be enrolled within 30 days of the date of marriage. A copy of the marriage certificate must be submitted at the time of enrollment. Children are eligible from birth but must be enrolled within 90 days of birth. A copy of the birth certificate must be submitted at the time of enrollment.

Under the Plan a "child" does not include grandchildren or other relatives (such as nieces, nephews, aunts, uncles, brothers, sisters, etc.) and such persons are not eligible dependents under the Plan. Rather, "child" is limited to your natural children, stepchildren and children legally placed for adoption. A "dependent child" whose parents are divorced or legally separated is treated as a dependent of both parents for purposes of group health plan coverage under Section 105(b) of the Code.

Disabled dependents who are age 26 or older may be eligible for coverage if they qualify as your disabled dependent child. A disabled dependent child is someone who is 26 years of age or older who is totally and permanently disabled and incapable of self-support. At time of enrollment you must submit proof of disabled status from a Physician who will certify the dependent child's total and permanent disability and incapacity for self-support. If the dependent child is currently enrolled in the Plan and then reaches the limiting age of 26, you must submit proof of disabled status 30 days before their 26th birthday in order to continue coverage. Otherwise, the dependent child will be terminated at the end of the month of their 26th birthday. The Plan will require proof of continued disabled status from time to time.

ELIGIBILITY AND ENROLLMENT — Continued

Enrolling New Dependents

Enrollment is not automatic. It requires an affirmative action (i.e., enrollment through the Workday Employee Self Service system adding your dependent(s)) within 30 days of the event (90 days for newborns).

If you do not apply for coverage within 30 days after the dependent(s) becomes eligible, you will be required to wait until the next annual open enrollment period to enroll your dependent(s). This means that your dependent(s) will not be eligible for health care benefits until January 1 of the following year. Certain Special Enrollment Rules apply, as outlined below.

Change in Family Status

Once you are enrolled in a medical plan, it is necessary that you notify the HR Service Center promptly if your family situation changes. HR Service Center needs to know about birth or adoption, marriage or divorce, the death of your spouse or dependent or someone becoming eligible for Medicare. This will help establish when a dependent becomes eligible for coverage or when a dependent is no longer eligible. Status changes must be initiated through the Workday Employee Self Service system.

Special Enrollment Rules

The Health Insurance Portability and Accountability Act of 1996 provides additional enrollment opportunities for employees who initially waive coverage then subsequently experience a status change. See the USC Employee Gateway website at employees.usc.edu for additional information. Please contact the HR Service Center at (213) 821-8100 within 30 days of such status change to discuss the effect on your benefits. You will be required to provide documentation of the status change.

Eligible dependents who have other health coverage but subsequently lose that coverage, either because their COBRA coverage is exhausted or because they cease to be eligible for the other coverage, may be enrolled in the employee's health plan within thirty (30) days of the loss of coverage. Documentation of other coverage and reason for loss, along with documentation of the dependent's relationship to the employee must be provided. Enrollment in the employee's health plan is not permitted if the dependent's loss of coverage is due to failure to pay required premiums on a timely basis. You or your covered dependent may lose coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in conjunction with the Plan). Such loss of eligibility may be disclosed by a health plan to the USC Benefits department as disenrollment for cause. A disenrollment of dependent or employee for cause from one USC health plan will result in loss of eligibility for enrollment in any other USC health plan.

Right to Receive and Release Information

As a condition of enrollment in this health plan and condition precedent to the provision of Benefits under this health plan, the USC EPO Plus Plan, its agents, independent contractors and Participating Providers, in accordance with applicable law, shall be entitled to release to, or obtain from, any person, organization or government agency, any information and records, including patient records of Beneficiaries, which the Plan requires or is obligated to provide pursuant to legal process, Federal, State or Local law in the administration of this health plan. The Plan shall have the right to review any information and records including patient records of Beneficiaries pursuant to payment of a claim.

PRIOR AUTHORIZATION PROGRAM

This is a pre-service review program which means that you must contact Anthem Blue Cross before receiving certain treatment and incurring expenses.

Failure to follow the Prior Authorization Program, as described in this booklet, may result in a reduction or denial of benefits, which may mean a greater expense to you.

Only services and supplies which are Medically Necessary will be covered as Eligible Expenses. For services and supplies found not to be Medically Necessary **no Benefits will be paid under the Plan.** Anthem Blue Cross will make a determination of Medical Necessity for services and supplies listed on the following page.

To the extent permitted by law, cosmetic procedures are not covered under the Plan, unless considered Medically Necessary and approved through Prior Authorization, as determined by Anthem Blue Cross.

Non-Emergency Inpatient Admission

Including but not limited to Hospital admissions, elective inpatient surgeries, Skilled Nursing Facility Care and inpatient Hospice Care.

You or your Physician must request a review by Anthem Blue Cross for Medical Necessity. The request must meet these criteria:

- a. It must be made by phone call to Anthem Blue Cross at (800) 274-7767 from you or your Physician on a weekday at least three (3) business days before the confinement starts.
- b. It must include the facts required by Anthem Blue Cross for the review. If the request does not include all such facts, Anthem Blue Cross has the right to ask you or your Provider for them. The request for Medical Necessity review will not be considered complete unless Anthem Blue Cross receives the requested information by the end of the second weekday after Anthem Blue Cross asks.

If the above criteria are met, Anthem Blue Cross will inform the provider and the facility of the number of days of Inpatient Confinement that Anthem Blue Cross approved as needed for care of the patient's condition. This will be confirmed by written notice sent to you, the provider and the facility.

Emergency Hospital Admission

The rules for non-Emergency admission apply, except that:

- a. The request for Anthem Blue Cross' determination of Medical Necessity must be made by phoning (800) 274-7767 within 48 hours after the Hospital confinement starts.
- b. The phone call may be made by the patient's provider, the Hospital, the patient or a member of the patient's family.

Extension of Length of Inpatient Confinement

It may be possible to extend the number of days of Inpatient Confinement that Anthem Blue Cross had approved. You or the patient must arrange for the patient's provider to request such an extension by phoning Anthem Blue Cross at (800) 274-7767 before the previously approved length of stay is over.

When the request is made, Anthem Blue Cross will make a new determination of Medical Necessity on the basis of information given by the provider. The provider will be informed as to how many more days, if any, that Anthem Blue Cross approves. This will be confirmed by written notice sent to you, the provider and the facility.

Outpatient Services And Supplies

You or your provider must request Anthem Blue Cross' determination of Medical Necessity for prescribed outpatient invasive procedures and certain designated services and supplies. The request must meet these criteria:

PRIOR AUTHORIZATION PROGRAM — Continued

- Requests must be made by phone call to Anthem Blue Cross at (800) 274-7767 from either you, your provider or your care/service provider (e.g., physical therapist) on a weekday at least three (3) business days before you undergo the prescribed invasive procedure or obtain the prescribed service or supply.
- The request must include the facts required by Anthem Blue Cross for the review. If the request does not include all such facts, Anthem Blue Cross has the right to ask you or your provider for them. The request for determination of Medical Necessity will not be considered complete unless Anthem Blue Cross receives the requested information by the end of the second weekday following their request.

If the above criteria are met, Anthem Blue Cross will inform you, the prescribing provider and the care/service provider of the result of the review. This will be confirmed by written notice sent to you, the prescribing provider and the care/service provider.

Outpatient services and supplies and mental health treatment which require prior authorization by Anthem Blue Cross for Medical Necessity include:

- **Ambulance – Ground/Air/Water (in a non-medical emergency)**
Reasonable base charge, mileage and non-reusable supplies of a licensed air ambulance company used to transport a Covered Person in a non-medical emergency. The Prior Authorization Program will make every effort to obtain an agreed upon maximum of billed charges with the air/water ambulance company prior to authorizing.
- **Outpatient Surgical procedures**
(Refer to page 15 for an example of what can be considered a surgical procedure)
- **Durable Medical Equipment, Prosthetics and Orthotics**
purchase price or rental cost exceeding \$2,000
- **Home Health Care services**
including home infusion therapy exceeding 10 visits
- **Hyperbaric Oxygen Therapy**
- **In-home Uterine Monitoring**
- **Physical and Occupational Therapy visits**
after twenty 20 visits in one Calendar Year regardless of body treatment area (i.e., the annual limitation applies even if body treatment area is different)
- **All Cochlear Implants**
- **All Bariatric Surgeries** (No Benefits will be payable if prior authorization for Hospital Admission is not done by Anthem Blue Cross)
- **Mental Health**
Partial hospitalization and Residential treatment center
- **Temporomandibular Joint Dysfunction treatment**
when treatment is rendered by providers other than the USC Dental School, Faculty Practice providers

A prior authorization made by Anthem Blue Cross does not guarantee either payment of Benefits or the amount of Benefits. Eligibility for, and payment of, Benefits are subject to all of the terms of the coverage.

Effect On Eligible Expenses When A Request For Prior Authorization Is Not Made On Time

If a request for a prior authorization is not made in compliance with the procedures and time limits stated above, coverage for all treatment, services and confinement listed in this section may be reduced or denied.

Similarly, if an extension of Inpatient Confinement request is not made in compliance with the procedures above, coverage for all treatment, services and confinement listed in this section may be reduced or denied.

Note: It is your responsibility to ensure that a request for prior authorization is made on time.

COVERED SERVICES

The medical Benefit applies to the following Eligible Expenses for services and supplies furnished to you or your covered dependents for the treatment of injuries and sicknesses. Such **services and supplies must be Medically Necessary** and furnished in conjunction with the treatment of an injury or sickness incurred while you or your dependents are covered under the Plan. Regardless of any provision or statement, a service or supply will NOT be covered unless it is Medically Necessary and also satisfies all other conditions and requirements of the Plan. Expenses are considered to be incurred on the date the service or supply is given or received. **All expenses are subject to the applicable exclusions or limitations, deductibles, Copayments, Coinsurance, maximums and prior authorization provisions.**

Acupuncture

See “Chiropractic / Acupuncture” services.

Ambulance Services / Emergency Medical Transportation

Emergency transportation by professional ambulance service (ground) is covered when Medically Necessary and required for an Emergency Medical Condition. Ambulance services are covered only when it is not medically appropriate to transport the Covered Person by ordinary public or private vehicle.

The use of air and water ambulance services is covered when it is considered Medically Necessary and when all of the following criteria are met:

1. The ambulance must have the necessary equipment and supplies to address the needs of the individual; and
2. The individual’s condition must be such that any form of transportation other than by ambulance would be medically contraindicated; and
3. The individual’s condition is such that the time needed to transport by land poses a threat to the individual’s survival or seriously endangers the individual’s health; or the individual’s location is such that accessibility is only feasible by air or water transportation; and
4. The individual is transported to the nearest Hospital with appropriate facilities for treatment; and
5. There is a medical condition that is life threatening, including, but not limited to, the following:
 - Intracranial bleeding; or
 - Cardiogenic shock; or
 - Major burns requiring immediate treatment in a Burn Center; or
 - Conditions requiring immediate treatment in a Hyperbaric Oxygen Unit; or
 - Multiple severe injuries; or
 - Transplants; or
 - Limb-threatening trauma; or
 - High risk pregnancy; or
 - Acute myocardial infarction; if this would enable the individual to receive a more timely medically necessary intervention (such as percutaneous transluminal coronary angioplasty [PTCA] or fibrinolytic therapy).

The use of air and water ambulance services to transport an individual from one Hospital to another requires that:

- The above criteria must be met, and
- The first Hospital does not have the required services and facilities to treat the individual.

The use of air and water ambulance services for *deceased* individuals is considered Medically Necessary when the above criteria are met and when either of the following is present:

1. The individual was pronounced dead while in route or upon arrival at the Hospital or final destination; or
2. The individual was pronounced dead by a legally authorized individual (Physician or medical examiner) after the ambulance call was made, but prior to pick-up. In these circumstances the response to call is considered Medically Necessary.

COVERED SERVICES — Continued

However, where ground ambulance service would have sufficed, payment will be based on the amount payable to ground ambulance if such transportation would have been less costly.

Transportation, whether by ground ambulance or air/water ambulance, will only be covered to the nearest Hospital with appropriate facilities.

Non-Emergency (Scheduled) Ambulance Services

Ground, air and water ambulance services are also covered, when Medically Necessary, to transfer a Covered Person from one facility to another. All non-Emergency scheduled ambulance service is subject to Prior Authorization.

The charge must not exceed the recognized charge, as determined by the Claims Administrator, in its discretion.

| | |
|--------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| Ground Ambulance Services (Emergency) | Plan pays 100% |
| Air/Water Ambulance Services (Emergency) | Plan pays 100% |
| Ground/Air/Water Ambulance Services (Non-Emergency) Requires Prior Authorization | Plan pays 100% of the rate agreed upon during prior authorization. |

Bariatric Surgery

The Plan covers inpatient or outpatient services for bariatric surgery and repair only when performed at a Center of Medical Excellence in California.

For any type of bariatric surgery or procedure, in addition to meeting all of the requirements as outlined in the definition of Medically Necessary on page 12, such surgery or procedure must satisfy Anthem Blue Cross' Medical Policy requirements and must also have prior authorization from Anthem Blue Cross. For more information about those Medical Policy requirements, you may contact Anthem Blue Cross directly.

Repeat surgical procedures for revision or conversion to another surgical procedure (that is also considered medically necessary within this document) for inadequate weight loss, (that is, unrelated to a surgical complication of a prior procedure) are considered Medically Necessary when **ALL** the following criteria are met:

1. The individual continues to meet all the medical necessity criteria for bariatric surgery; and
2. There is documentation of compliance with the previously prescribed postoperative dietary and exercise program; and
3. 2 years following the original surgery, weight loss is less than 50% of pre-operative excess body weight and weight remains at least 30% over ideal body weight (taken from standard tables for adult weight ranges based on height, body frame, gender and age, an example is available from the National Heart Lung and Blood Institute (NHLBI) at: http://www.nhlbi.nih.gov/guidelines/obesity/bmi_tbl.htm).

COVERED SERVICES — Continue

| Bariatric Surgery | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|
| All Hospital admissions are subject to the Prior Authorization Program. No Benefits will be payable if prior authorization for Hospital admission is not done by Anthem Blue Cross. | |
| Inpatient Room and Board | Plan pays 100% after you pay a \$100 Copay per admission |
| Outpatient Surgery Facility | Plan pays 100% after you pay a \$200 Copay per admission |
| Surgeon, Assistant Surgeon, Anesthesiologist | Plan pays 90% after deductible You pay 10% after deductible |
| Imaging, Tests, Lab Work | Plan pays 90% after deductible You pay 10% after deductible |

The Plan does not cover bariatric surgery when done for cosmetic reasons.

Breast Pumps

Rental or purchase of a breast pump is covered at 100% of contracted rate, through a DME Network Provider or purchase through a Non-Network Provider is covered up to \$700 of billed charges. Coverage excludes any additional fees such as credit card fees, layaway fees, etc. Any breast pump purchased or rented through a Non-Network Provider will require you to pay upfront and submit a claim form for reimbursement, along with the original receipt, identifying product purchased as a breast pump.

Breast pumps are limited to one (1) per Calendar Year, unless the Plan receives written medical necessity justification from your Physician.

| | Network Provider | Non-Network Provider |
|-----------------------------|-------------------------------------------|-----------------------------------------|
| Breast Pump | Limited to one (1) pump per Calendar Year | |
| | Plan pays 100% | Plan pays up to \$700 of billed charges |
| Breast Pump Supplies | Plan pays 100% | Plan pays up to \$700 of billed charges |

Chiropractic / Acupuncture Services

The maximum combined Benefit per Calendar Year for chiropractic and acupuncture services is limited to a maximum of 40 visits in a Calendar Year. Chiropractic and acupuncture services do not require prior authorization and do not require a Physician prescription.

| | |
|--------------------------------------------|----------------------------------------------------------------|
| Chiropractic / Acupuncture Services | Plan pays 90% after deductible You pay 10% after deductible |
|--------------------------------------------|----------------------------------------------------------------|

Cochlear Implants

Cochlear implants are covered **with prior authorization** by Anthem Blue Cross.

COVERED SERVICES — Continued

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|-----------------------------------------------------|----------------------------------------------------------------|
| Cochlear Implants Physician Office Visits | Plan pays 100% after you pay a \$20 Copay per visit |
| Cochlear Implants | Plan pays 90% after deductible You pay 10% after deductible |
| Surgeon, Assistant Surgeon, Anesthesiologist | Plan pays 90% after deductible You pay 10% after deductible |
| Outpatient Surgery Facility | Plan pays 100% after you pay a \$200 Copay per admission |

Dental Coverage

The Plan does not cover services or X-ray examinations in connection with mouth conditions due to periodontal disease or any condition (other than a malignant tumor) involving teeth, surrounding tissue or structure, the alveolar process or the gingival tissue. However, the Plan does cover the following treatment at 90% after deductible:

- a. Temporomandibular Joint Dysfunction treatment, when determined in advance by Anthem Blue Cross that treatment is Medically Necessary. (No prior authorization required when services are being provided by a USC Faculty Practice Oral Health Center provider.)
- b. Treatment for accidental injury to the teeth: covered up to one (1) year after the accident. The Plan will provide coverage only when the individual's dental insurance maximum is reached. The Plan will not cover the dental insurance deductible or the dental coinsurance payments. Eligible Expenses include, but are not limited to: treatment by a Physician, dentist, or oral surgeon of injuries to natural teeth including replacement of such teeth, and related X-rays. The charges for these services will be considered to be Eligible Charges under the Plan, but paying after payment by your dental insurance, if any.

| | |
|--------------------------------------------|----------------------------------------------------------------|
| Temporomandibular Joint Dysfunction | Plan pays 90% after deductible You pay 10% after deductible |
| Accidental Dental Treatment | Plan pays 90% after deductible You pay 10% after deductible |

Diabetic Equipment and Supplies

The Plan covers the following equipment and supplies under the medical benefits:

- Blood glucose monitors
- Insulin pumps and insulin pump supplies

| | |
|----------------------------------------|----------------------------------------------------------------|
| Diabetic Equipment and Supplies | Plan pays 90% after deductible You pay 10% after deductible |
|----------------------------------------|----------------------------------------------------------------|

The following diabetic supplies are covered by the **Prescription Drug Program**:

- Blood glucose monitors
- Pump cartridges and supplies

COVERED SERVICES — Continued

- Test strips and solutions for blood glucose monitors
- Syringes and lancets
- Medications for treatment of diabetes

Disposable Medical Supplies

The Plan covers supplies needed to operate or use covered Durable Medical Equipment, prosthetics or orthotics.

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|------------------------------------|----------------------------------------------------------------|
| Disposable Medical Supplies | Plan pays 90% after deductible You pay 10% after deductible |
|------------------------------------|----------------------------------------------------------------|

Durable Medical Equipment, Prosthetic and Orthotic Devices

Durable Medical Equipment (DME), prosthetic and orthotic devices are covered by the Plan when Medically Necessary and prescribed by a Physician.

DME includes medical equipment and supplies which are of no further use when medical needs end, for the exclusive use of the patient, not primarily for comfort or hygiene, not for environmental control or for exercise and manufactured specifically for medical use (e.g., wheelchairs, crutches, traction equipment, blood glucose machines, etc.).

Where two or more alternative devices are appropriate to treat a Covered Person's condition, the most cost effective device will be covered as determined by Anthem Blue Cross, in its discretion, at the time of rental/purchase. The Plan shall have no obligation to replace that device while it remains functional despite normal wear and tear, notwithstanding any subsequent improvements in the design of the product.

Wheelchairs provided as a covered service under this Plan are limited to standard wheelchairs. However, the Plan will provide coverage for a motorized wheelchair if it is determined by Anthem Blue Cross that it is Medically Necessary and a standard wheelchair would not meet the basic functional requirements. Additionally, if a Covered Person wishes to have a non-standard wheelchair that is not Medically Necessary, this Plan will apply the amount of money it would have had to pay for a standard wheelchair to the coverage for the non-standard wheelchair. The Covered Person would then be fully responsible for the difference remaining on the non-standard wheelchair.

External orthotic and external prosthetic devices are limited to those devices that are affixed to the body externally and which are ordered by a Physician to support a defect of form or function of a permanently inoperative or malfunctioning body part (e.g., occlusal splint and communication devices such as voice boxes, but not including such un-affixed devices as voice-activated computers, etc.).

The Plan covers external prosthetics when Medically Necessary, including:

- Artificial limbs or eyes, when FDA approved and not considered Experimental or Investigational,
- Breast prostheses following a mastectomy,
- Cranial cold cap, and
- Wigs prescribed by a Physician as a prosthetic for hair loss due to injury, disease, or treatment of a disease, up to \$1,000 per Covered Person, within a 24-month period.

Repairs of prosthetic devices are covered when the repair will cost less than the cost of replacing the device.

The Plan covers internal prosthetics, including (but not limited to) the following, when Medically Necessary and surgically implanted:

Electronic heart pacemakers, intraocular lenses and joints, and

- Post-operative breast prostheses following a mastectomy. See Reconstructive Surgery and Women's Health Rights for more information.

DME, prosthetic and orthotic devices with a purchase price or rental cost exceeding \$2,000 must have prior authorization by Anthem Blue Cross. Rental charges which exceed the reasonable purchase price of the equipment

COVERED SERVICES — Continued

are not covered. If purchase is required, the Beneficiary will be notified. After notification, the Plan will discontinue rental authorization.

The Benefit level for DME, prosthetic and orthotic devices will be based on Medical Necessity. This Plan does not apply the allowable cost of covered devices toward services and supplies that are not covered devices.

Convenience, luxury items and features are not covered.

| | |
|------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|
| Prescribed Durable Medical Equipment, Prosthetic and Orthotic Devices | Plan pays 90% after deductible You pay 10% after deductible |
| Wigs | Plan pays 90% after deductible, up to \$1,000 within a 24-month period You pay 10% after deductible |

Emergency Services

For services to be considered Emergency Services, they must fall within the definition of “Emergency Medical Condition” set forth on page 9 and be rendered in a Hospital.

If you seek services at an Emergency Department and **are not** admitted as inpatient, services will be considered Outpatient Emergency Services and a \$150 Copayment will apply.

If you are admitted as an inpatient directly from the Hospital’s Emergency Department, the \$150 Outpatient Emergency Department Copayment will be waived and the inpatient Hospital Copay will apply.

| | |
|-------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Outpatient Emergency Department Services Hospital | Plan pays 100% after you pay a \$150 Copay per visit (Copay waived if admitted directly to Hospital) (If not admitted to the Hospital, the Copay is waived ONLY for Medically Necessary screening and testing of COVID-19 (coronavirus)) |
| Physician | Plan pays 100% |
| Inpatient Emergency Services Room and Board | Plan pays 100% after you pay a \$100 Copay per admission |
| Physician | Plan pays 90%* after deductible You pay 10% after deductible (*Plan pays 100% ONLY for Medically Necessary screening and testing of COVID-19 (coronavirus)) |

Gender Affirming Services

The Plan covers inpatient or outpatient charges submitted by a Hospital or a physician for Medically Necessary gender affirming surgery and fulfillment of prerequisites to qualify for the surgery. Prior Authorization by Anthem Blue Cross for gender affirming surgery is required.

To the extent permitted by law, cosmetic procedures are not covered under the Plan, unless considered Medically Necessary and approved through Prior Authorization, as determined by Anthem Blue Cross.

COVERED SERVICES — Continued

| Gender Affirming Services | |
|-------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|
| Facial feminization or facial masculinization surgery is subject to a lifetime maximum benefit of \$20,000. | |
| Inpatient Room and Board | Plan pays 100% after you pay a \$100 Copay per admission |
| Outpatient Surgery Facility | Plan pays 100% after you pay a \$200 Copay per admission |
| Physician | Plan pays 90% after deductible You pay 10% after deductible |
| Imaging, Tests and Lab Work | Plan pays 90% after deductible You pay 10% after deductible |

For Covered Persons diagnosed with gender dysphoria, it is the intention of this Plan to comply with all applicable requirements of coverage regarding non-discrimination. As outlined in the Forward, Coverage and Benefits are not affected by the sex, sexual orientation, or gender identification of the member. To the extent any provision of the Plan conflicts with those requirements, the Plan shall be automatically amended to so comply. Benefits are covered at the same Benefit levels as other similar services in accordance with, and to the extent required by, applicable law.

The IRS has not ruled on whether, or to what extent, these services qualify as nontaxable medical care. The employee will be solely liable for the payment of all taxes in connection with the receipt of such surgery if taxable, without any contribution or financial assistance from USC or the Plan. Consult your own tax advisor at your own expense if you have questions about such taxation.

Hearing Aids

The following hearing aid services are covered, up to a maximum of \$2,000 every 36 months, when provided by or purchased as a result of a written prescription from an otolaryngologist or a licensed audiologist:

- Hearing aids (monaural or binaural) including ear mold(s), the hearing aid instrument, batteries, cords and other ancillary equipment.
- Visits for fitting, counseling, adjustments and repairs for a one-year period after receiving the covered hearing aid.

Benefits will not be provided for charges for a hearing aid which exceeds the specifications prescribed for the correction of hearing loss, or for more than the maximum Benefit.

COVERED SERVICES — Continued

| | | |
|---------------------|------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| Hearing Aids | Network Provider | Non-Network Provider |
| | Maximum Benefit of \$2,000 every 36 months for one or both ears; dollar Benefit is not per ear | |
| | Plan pays 90% You pay 10% | Plan Pays 90% of billed charges You pay remainder of charges |

Home Health Care

Home Health Care coverage provides Benefits for Eligible Charges for care furnished by a Home Health Care Agency or visiting nurse association.

Any treatment plan in excess of ten (10) visits must be submitted in writing for prior authorization by Anthem Blue Cross.

Medically Necessary skilled care furnished by a Home Health Agency or visiting nurse association is covered, up to **one hundred (100) visits per Calendar Year**.

Covered Services include full-time, part-time or intermittent skilled nursing services provided by a registered nurse or licensed vocational nurse or licensed occupational therapist, physical therapist or speech therapist in the home. (Speech Therapy is subject to the limitations provided in the Benefit description for Speech Therapy described on pages 43-44.)

Covered Services must be:

1. prescribed by the patient's Physician;
2. for skilled care only and not for custodial care, and;
3. for the continued treatment of an injury or illness.

A visit of four (4) hours or less by any one individual provider, shall be considered as one Home Health visit.

Skilled nursing visits, including skilled nursing visits in association with home infusion services, in excess of ten (10) visits in a Calendar Year must have prior authorization by Anthem Blue Cross. These visits are included under the Home Health Care Benefit and limited to a total combined Benefit of one hundred (100) visits per Calendar Year.

| | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|
| Home Health Care including Home Infusion Therapy | Plan pays 90% after deductible You pay 10% after deductible |
| Any treatment plan in excess of ten (10) visits must be submitted in writing for prior authorization by Anthem Blue Cross. The Plan covers up to one hundred (100) visits per person per Calendar Year. | |

Home Infusion Therapy

The following are Covered Services and supplies when provided by a home infusion therapy provider in your home for the intravenous administration of your total daily nutritional intake or fluid requirements, medication related to illness or injury, chemotherapy, antibiotic therapy, aerosol therapy, tocolytic therapy, intravenous hydration, or pain management.

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

Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications;

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

COVERED SERVICES — Continued

Rental and purchase charges for Durable Medical Equipment (as defined above); maintenance and repair charges for such equipment;

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

Hospice Care

The Hospice Benefit coverage pays for charges incurred for a terminally ill person while in a Hospice Care Program.

The Benefits will be paid if the Hospice Services or the Hospice stay is:

1. provided while the terminally ill person is a Covered Person;
2. ordered by the supervising Physician as part of the Hospice Care Program;
3. charged for by the Hospice Care Program; and
4. provided within 6 months of the terminally ill person's entry or re-entry (after a remission period) in the Hospice Care Program.

All periods of care in a Hospice Care Program will be considered related and to have occurred in the one period of care unless separated by at least 3 consecutive months.

Exclusions Under the Hospice Care Benefit

The following charges are not covered:

1. Charges incurred during a remission period. This applies if, during remission, the terminally ill person is discharged from the Hospice Care Program.
2. Charges for services provided by yourself, spouse, or a child, brother, sister, or parent of yourself or spouse.
3. Charges for funeral arrangements.
4. Charges for pastoral counseling.
5. Charges for financial or legal counseling, including estate planning and the drafting of a will.

Extension of Benefits

Under certain circumstances, Hospice Care Benefits will be available for 30 days after the termination of coverage if a Covered Person is participating in a Hospice Care Program at the time the coverage ends. This extension of Benefits will apply only to Hospice Care Program expenses. Extension of Benefits requires Prior Authorization by Anthem Blue Cross.

| | |
|---------------------|----------------|
| Hospice Care | Plan pays 100% |
|---------------------|----------------|

Hospital Services

Subject to all the provisions of the Plan (including, but not limited to the Prior Authorization Program), the Plan covers Medically Necessary charges made by a Hospital for room and board and other Hospital services and supplies when you are confined as an Inpatient. The level of such coverage is described on the following table. Eligible Expenses for Medically Necessary room and board charges are subject to a maximum daily limit equal to the Hospital's standard semi-private room rate.

If confinement in a private room in a Hospital for a reason other than Medically Necessary isolation of the patient, the Eligible Expenses for room and board are subject to a daily limit equal to the Hospital's standard semi-private room rate.

Remind your health care provider that prior authorization is required for all Hospital admissions.

COVERED SERVICES — Continued

| | |
|------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Hospital Services Inpatient Room and Board | Plan pays 100% after you pay a \$100 Copay per admission |
| Physician Visits | Plan pays 90%* after deductible You pay 10% after deductible (*Plan pays 100% ONLY for Medically Necessary screening and testing of COVID-19 (coronavirus)) |
| Imaging, Tests and Lab Work | Plan pays 90%* after deductible You pay 10% after deductible (*Plan pays 100% ONLY for Medically Necessary screening and testing of COVID-19 (coronavirus)) |

Infertility Services

Expenses in connection with diagnostic testing to determine a diagnosis of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis are Covered Services that are not subject to the infertility lifetime maximum Benefits. Services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency) are Covered Services that do apply to the infertility lifetime maximum Benefits.

The following medical services are covered, up to a lifetime maximum Benefit of \$10,000:

1. Office visits
2. Reconstructive surgery, except for sterilization reversal
3. Artificial insemination
4. In-vitro fertilization
5. Cryopreservation

| Infertility Services | |
|--------------------------------------------------------------------------|----------------------------------------------------------------|
| \$10,000 lifetime medical maximum | |
| Physician Office Visit | Plan pays 100% after you pay a \$20 Copay per visit |
| Outpatient Facility | Plan pays 100% after you pay a \$200 Copay per admission |
| Inpatient Room and Board | Plan pays 100% after you pay a \$100 Copay per admission |
| Physician Services (at Outpatient & Inpatient Facilities) | Plan pays 90% after deductible You pay 10% after deductible |
| Imaging, Tests and Lab Work | Plan pays 90% after deductible You pay 10% after deductible |

COVERED SERVICES — Continued

Covered services for the treatment of infertility will exclude elective sterilization reversal, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), over-the-counter products, the purchase of donor sperm and any charges for the storage of donor sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to, fees for laboratory tests or any other service for infertility not specifically stated above.

Prescription drugs under Navitus formulary are covered, up to the lifetime maximum Benefit of \$15,000.

| Infertility Prescription Drugs | |
|---------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| \$15,000 lifetime prescription drug maximum | |
| Retail Copay (up to a 30-day supply) | Navitus Network Pharmacy |
| | Generic: \$5 Copay Brand (no Generic available): \$25 Copay Brand (with Generic available): \$70 Copay Specialty Drug (Brand): \$125 Copay |
| Mail Order Copay | Mail Order Same Copays as Retail, for each 30-day supply |

As a result of the lifetime maximums, a Covered Person receiving these services may incur significant personal financial expense to the provider (whether Network or Non-Network) that the Plan will not cover. Expenses in excess of the lifetime maximums will also not count toward the Plan's annual out-of-pocket maximums, regardless of whether the services are provided by a Network or Non-Network Provider. Therefore, before receiving services, it may be advisable to obtain information from the provider as to the specific cost of the services in order to estimate personal financial liability. If a provider - Network or Non-Network - agrees with the Covered Person to accept the lifetime maximum as payment in full or to a reduction in personal financial liability, that agreement will not affect coverage for these services under the terms of the Plan.

Infusion Therapy

The Plan covers Medically Necessary charges for the following outpatient infusion therapy services and supplies:

- Pharmaceuticals administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy
- Professional services
- Chemotherapy
- Dialysis
- Drug therapy (includes antibiotic and antivirals)

| | |
|-------------------------|----------------------------------------------------------------|
| Infusion Therapy | Plan pays 90% after deductible You pay 10% after deductible |
|-------------------------|----------------------------------------------------------------|

Laboratory Services

The Plan covers Medically Necessary laboratory services and pathology tests to diagnose an illness or injury.

COVERED SERVICES — Continued

| | |
|----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Laboratory Services | Plan pays 90%* after deductible You pay 10% after deductible (*Plan pays 100% ONLY for Medically Necessary screening and testing of COVID-19 (coronavirus)) |
|----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Breast and Ovarian Cancer (BRCA) Testing

BRCA testing is molecular susceptibility testing for breast and ovarian cancer. BRCA testing is considered Medically Necessary for women who are in high risk categories.

Maternity Care

Maternity care is covered as any other medical condition and as required by law. Coverage includes:

- Normal pregnancy and
- Complications of pregnancy.

The Plan covers prenatal, delivery and postnatal maternity care. For inpatient care of the mother and newborn child, benefits will be payable for a minimum of:

- 48 hours after a vaginal delivery, and
- 96 hours after a cesarean section.

Prior authorization from Anthem Blue Cross is required only for in-home uterine monitoring.

| | |
|----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| Maternity Care | Plan pays 100% after you pay a \$20 Copay per visit (Copay is reduced to \$10 per visit if you have designated a Primary Care Physician) |
| Physician Office Visits | |
| Physician Delivery | Plan pays 90% after deductible You pay 10% after deductible |
| Anesthesiologists, Surgical Assistants | Plan pays 90% after deductible You pay 10% after deductible |
| Hospital Room and Board | Plan pays 100% after you pay a \$100 Copay per admission |

Mental Health And Substance Abuse Program

Prior authorization is not required for outpatient visits.

Inpatient admissions, partial hospitalization and residential treatment center require prior authorization, to the extent permitted by law. Refer to the Prior Authorization Program on pages 19-20.

Inpatient Care

The Plan covers Hospital inpatient (residential) services when your condition requires Medically Necessary services that are available only in an inpatient setting. Coverage includes:

- Room and board charges, up to the facility's semi-private room rate and
- Other necessary services and supplies.

Treatment Facility

The Plan covers inpatient care in a treatment facility such as an acute inpatient facility or a residential treatment center.

COVERED SERVICES — Continued

Partial Hospitalization/Confinement

The Plan covers charges made by a Hospital or psychiatric Hospital/facility for partial confinement treatment through a day care or night care treatment program. Care is covered only if the condition requires treatment that is available only in a partial confinement treatment setting or if you would need inpatient care if you were not participating in this type of program.

Outpatient Treatment

The Plan also covers Medically Necessary treatment of substance abuse and/or mental disorders on an outpatient basis.

| | |
|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|
| Mental Health and Substance Abuse | Plan pays 100% after you pay a \$20 Copay per visit (Copay is reduced to \$10 per visit if you have designated a Primary Care Physician) |
| Physician Visits - Outpatient | |
| Physician Visits - Inpatient | Plan pays 90% after deductible You pay 10% after deductible |
| Inpatient Room and Board | Plan pays 100% after you pay a \$100 Copay per admission |
| Partial Hospitalization | Plan pays 90% after deductible You pay 10% after deductible |
| Residential Treatment | Plan pays 100% after you pay a \$100 Copay per admission |
| Outpatient Facility | Plan pays 100% after you pay a \$200 Copay per admission |

Nutritional Services

Nutrition evaluation and counseling are covered, when prescribed by a Physician, for medical management of:

- A documented organic disease (high cholesterol, diabetes, allergies and hypertension)
- Anorexia nervosa or Bulimia nervosa

All other services for the purpose of diet control and weight reduction are not covered, except as required by law or otherwise provided under the Plan.

| | |
|-----------------------------|----------------------------------------------------------------|
| Nutritional Services | Plan pays 90% after deductible You pay 10% after deductible |
|-----------------------------|----------------------------------------------------------------|

Outpatient Surgery – Hospital-Based or Freestanding Facility

Outpatient surgical procedures require prior authorization by Anthem Blue Cross.

The Plan covers outpatient surgery in:

- A surgery center or
- The outpatient department of a hospital.

The Plan covers the following outpatient surgery expenses:

- Services and supplies provided by the Hospital, surgery center or office-based surgical facility on the day of the procedure and
- The operating Physician's services for performing the procedure, related pre- and post-operative care and the administration of anesthesia.

COVERED SERVICES — Continued

The Plan does **not** cover the services of a Physician who renders technical assistance to the operating Physician.

| | |
|-------------------------------------------------|----------------------------------------------------------------|
| Outpatient Surgery Expenses Physician | Plan pays 90% after deductible You pay 10% after deductible |
| Facility | Plan pays 100% after you pay a \$200 Copay per admission |
| Imaging, Tests and Lab Work | Plan pays 90% after deductible You pay 10% after deductible |

Physical And Occupational Therapies

Benefits for a Physical or Occupational therapist's services will be payable at the rate of 100% after a \$20 Copay per visit.

Twenty (20) visits per Calendar Year are allowed for each, physical and occupational therapy (not combined) without prior authorization. Regardless of body treatment area, physical or occupational therapy services in excess of twenty (20) visits per Calendar Year require review and prior authorization by Anthem Blue Cross. Call (800) 274-7767 for information. No payment will be made for visits in excess of twenty (20) within a Calendar Year without prior authorization.

| | |
|------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physical and Occupational Therapy | Regardless of body treatment area, physical or occupational therapy services in excess of twenty (20) visits per Calendar Year require review and prior authorization by Anthem Blue Cross. |
| Outpatient Visit | Plan pays 100% after you pay a \$20 Copay per visit |
| Inpatient Visit | Plan pays 90% after deductible You pay 10% after deductible |

Physician Visits

Physician visits, when Medically Necessary, will be covered as follows:

| | |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Primary Care Physician* Visit | Plan pays 100% after you pay a \$20 Copay per visit (Copay is reduced to \$10 per visit if you have designated a Primary Care Physician) (Copay waived ONLY for Medically Necessary screening and testing of COVID-19 (coronavirus)) |
| Specialist Physician Visit | Plan pays 100% after you pay a \$20 Copay per visit (Copay waived ONLY for Medically Necessary screening and testing of COVID-19 (coronavirus)) |

* Includes General and Family Practitioners, Internists, Pediatricians, and Obstetricians and Gynecologists

COVERED SERVICES — Continued

Prescription Drug Program

This Plan provides Benefits for certain drugs prescribed by a Physician for an injury or illness and dispensed by a pharmacy, or other entity licensed to dispense prescription drugs.

- The amount of the drug which may be dispensed per prescription or refill must be in quantities normally prescribed and limited to a one month supply.
- Prescriptions requiring greater amounts must be completed on a refill basis, except those listed under the **maintenance drug** section herein.

The Plan pays the charge in excess of the Copayment for each covered prescription or refill, filled by a Network pharmacy.

Note: The Plan does *not* cover deductibles, copayments, or coinsurance amounts due under any other prescription drug plan. For example, if you are covered under a spouse's plan, this Plan does *not* cover your prescription drug copayments under your spouse's plan.

Formulary

The EPO Plus Prescription Drug Program is a formulary-based prescription drug benefits program that includes generic drugs and a defined list of brand name drugs that have been chosen for formulary coverage based on their reported medical effectiveness, positive results, and value. The drugs on the formulary were selected to give you the highest level of coverage under your prescription drug benefit.

In addition, the formulary is reviewed monthly to add or remove drugs which have cost-effective options available. To determine drug coverage and obtain a cost estimate for a selected medication, visit navitus.com and register as a "Member" to view the formulary drug list specific to your coverage.

Specialty Medication

Certain specialty medications are required to be filled through the Navitus SpecialtyRx network, which includes Keck Medicine of USC Specialty Pharmacy and Lumicera Health Services. These specialty pharmacies can assist you and your Physician in getting your prescription on file and dispensing your medication. Contact Keck Medicine of USC Specialty Pharmacy at (855) 885-2600 or Lumicera Health Services at (855) 847-3553 to get started.

Mail Order

For your convenience, mail order service is available through Costco Mail Order Pharmacy. The same Copay applies – mail order and retail pharmacy. For drugs dispensed in excess of a one month's supply, multiple Copayments will be charged. Allow up to 14 days for delivery from the date Costco Mail Order Pharmacy receives your order. For more information about mail order or to register online for mail order service, please visit pharmacy.costco.com or call Costco Mail Order Pharmacy at (800) 607-6861.

Prescription Drug Copayment

The retail Copayment for each prescription drug filled at a Network pharmacy for each 30-day supply is:

COVERED SERVICES — Continued

| Navitus Network Pharmacy | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| Retail Pharmacy ➤ Generic ➤ Brand (no Generic available) ➤ Brand (with Generic available) ➤ Specialty Drug (Brand) | Up to a 30-day supply \$5 Copay \$25 Copay \$70 Copay \$125 Copay |
| Mail Order – Costco Mail Order Pharmacy | Same Copay as Retail, for each 30-day supply |
| Prescription Out-of-Pocket Limits (Per Calendar Year) | \$2,000 - Individual maximum \$4,000 - Maximum for two or more individuals within a family |
| Drugs that are in the Maintenance Medication categories listed below, can be filled up to a 90-day supply, either at Retail or through Mail Order. Multiple Copay amounts apply to each 30-day supply. | |

Maintenance Medications

Certain maintenance medications may be dispensed in a larger than 30 day supply as long as the Physician prescribes it. Categories of drugs which may be dispensed in up to a three (3) month supply include:

| | | |
|---------------------|--------------------------------|-------------------------|
| Antiarthritics | Blood glucose test-tapes | Oral contraceptives |
| Antiasthmatics | Cardiac drugs | Oral hypoglycemics |
| Antiparkinson drugs | Cholesterol and lipid lowering | Prenatal vitamins |
| Anticlotting drugs | agents | Thyroid suppressants or |
| Antidepressants | Diuretics | replacements |
| Antiepileptic drugs | Insulin | |
| Antihypertensives | Long term replacement hormones | |

You can receive up to a 90 day supply of the above medications if your Physician has written the prescription for a 90 day supply. These medications can be obtained through retail or mail order. You will pay a three (3) month Copayment cost at either retail or mail order.

Prescription Drug Prior Authorization

Your prescription drug program provides coverage for some drugs only if they are prescribed for certain uses. For this reason, some medications must receive prior authorization before they can be covered under your benefit Plan. If the prescribed medication must have prior authorization, your pharmacist will inform you. You will need to have your Physician's office contact Navitus at (855) 673-6504 to request a prior authorization form. The Physician must then fax the filled out form back to Navitus for their review. It typically takes two (2) business days to review the form if all requested information is submitted by the Physician. Otherwise, the review will take longer.

Exception to Coverage Authorization

Your prescription drug program provides your Physician and you the ability to request an exception to formulary exclusions, clinical prior authorization denials and quantity limitations that have been determined by your Plan. To request an exception to coverage, you will need to have your Physician's office contact Navitus at (866) 333-2757 to request an Exception to Coverage Form. The Physician must then fax the filled out form back to Navitus for their review. It typically takes two (2) business days to review the form if all requested information is submitted by the Physician. Otherwise, the review will take longer.

The Physician will be notified when the review process is completed. If your medication is not approved for Plan coverage, you will have to pay the full cost of the medication.

COVERED SERVICES — Continued

The Physician will be notified when the review process is completed. If your medication is not approved for Plan coverage, you will have to pay the full cost of the medication.

Outpatient Prescription Drug Exclusions

The Prescription Drug Coverage *does not* cover:

1. Drugs dispensed by a Hospital, nursing home, clinic, ambulatory surgical center or other institution.
2. Administration of a drug.
3. Drugs related to the treatment of non-covered services.
4. Any refill of a prescription in excess of the number specified by the Physician or for any refill dispensed after one year from the date of the Physician's original order.
5. Over-the-counter (OTC) products, except as required by law.
6. Allergy and biological sera.
7. Workers' Compensation prescriptions.
8. Experimental or Investigational drugs.
9. Drugs which are used for cosmetic purposes only (e.g., Minoxidil, topical preparations, Retin-A for wrinkles and hair replacement, Eldoquin, Eldoquin-Forte, Eldopaque, etc.).
10. Blood, blood products or blood plasma.
11. A non-prescription patent or proprietary medicine, or medication not requiring a prescription.
12. Professional charges in connection with administering, injecting or dispensing of drugs.
13. Drugs or medications, dispensed or administered in an outpatient setting, including but not limited to outpatient Hospital facilities and Physician's offices.
14. Services or supplies for which you are not charged.
15. Any drug or medication not generally considered acceptable as a form of treatment for a given diagnosis.
16. Any expense for a drug or medication incurred in excess of the Covered Expense.
17. Any prescription drug used for non-FDA approved indications (e.g., Progesterone suppositories used for PMS is not an FDA-approved indication, etc.).
18. Cosmetics, dietary supplements and health or beauty aids.
19. Minerals.
20. Appetite suppressants, diet and weight loss medications, except as required by law.
21. Scopolamine patches used for the prevention of travel sickness.
22. Any prescription vitamin (other than prenatal vitamins and folic acid), including fluoride products (except oral fluoride for children less than 6 years of age).
23. Anorexients.
24. More than a 30 day supply of a medication, except when the Physician prescribes and the Plan judges it to be Medically Necessary under the circumstances. Convenience is not a Medical Necessity. Multiple Copayments will be charged for each 30 day supply of medication.
25. Replacement of lost, stolen, spilled or damaged medication.
26. Any drug or medication excluded from coverage under USC's Prescription Drug Program Agreement with Navitus.
27. Any drug or medication requiring prior authorization where prior authorization was not properly obtained.

Prescription Drug Expense Claims

Prescription drug expense claims should be submitted to Navitus **within 60 days of the fill** if the Plan was not charged at the time of your medication fill. Prescription drug claim forms may be downloaded at navitus.com. Select the "Members" option on the toolbar at the top of the page. Under "Claims/Authorization", select "Filing a Claim". You will find the "Direct Member Reimbursement" form within this section. Each drug receipt must show the Patient's full

COVERED SERVICES — Continued

name, **prescription number** and **name of medication** and the **charge for each item** and **date purchased (no reimbursement will be made for claims submitted more than 60 days after fill)**. Drug store cash register receipts or labels from containers are not acceptable.

Where to Send a Prescription Drug Claim

Send the completed Direct Member Reimbursement form and all your original pharmacy prescription receipts, not the cash register receipt, to:

Navitus Health Solutions, LLC ♦ P.O. Box 999 ♦ Appleton, WI 54912-0999

You can also fax your form and documents to (920) 735-5315.

Preventive Care

The Plan covers, as Preventive Care, any recommended preventive services the Plan is required to cover under the Affordable Care Act (ACA). Eligible preventive care services include:

- Evidence-based recommended items or services of the United States Preventive Services Task Force (USPSTF) with a rating of "A" or "B";
- Immunizations recommended from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC); and
- Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, adolescents and women.

Note: Recommended ages and populations vary for the services listed above. Refer to the charts in this section for more detailed information about eligible preventive care services. Services identified as Preventive Care are covered at 100% for the first Preventive Care service in a Calendar Year. **If the same service is Medically Necessary following the first Preventive Care service in a Calendar Year, normal Plan benefit coverage will apply to those repeated services, except as otherwise required by the ACA.**

Pre-employment physicals and work-related/travel immunizations are excluded.

| Preventive Care | |
|--------------------------------------------------|----------------|
| Physician Office Visit | Plan pays 100% |
| Preventive Care Screenings | Plan pays 100% |
| Outpatient Facility (if required with screening) | Plan pays 100% |
| Immunizations | Plan pays 100% |

| Covered Preventive Services for Adults | Special Notes |
|------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|
| Abdominal Aortic Aneurysm screening | A one-time screening for abdominal aortic aneurysm (AAA) by ultrasonography who have ever smoked. |
| Anemia Screening | Screening for iron deficiency anemia in asymptomatic pregnant women. |
| Alcohol Misuse screening and counseling | Screening and behavioral counseling interventions to reduce alcohol misuse by adults, in primary care settings. |

COVERED SERVICES — Continued

| Covered Preventive Services for Adults | Special Notes |
|---------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Bacteriuria Urinary Tract or Other Infection screening | Screening for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks gestation or at the first prenatal visit, if later. |
| Blood Pressure screening | Screening for high blood pressure in adults aged 18 and older. |
| BRCA counseling and testing | Genetic counseling and testing for BRCA for persons whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes. |
| Breast Cancer Chemoprevention counseling | Counseling for persons at high risk for breast cancer and at low risk for adverse effects of chemoprevention. Clinicians should inform patients of the potential benefits and harms of chemoprevention. |
| Breast Cancer Mammography screenings | Mammography screening for persons with or without clinical breast examination (CBE). |
| Breast Feeding interventions | Interventions during pregnancy and after birth to promote and support breastfeeding. |
| Cervical Cancer screening | Screening for cervical cancer in persons who have been sexually active. |
| Chlamydia Infection screening | Screening for chlamydial infection. |
| Cholesterol screening | Screening for lipid disorders. |
| Colorectal Cancer screening | Screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults. Coverage also provided if proctoscopy is used for this screening. |
| Depression screening | Screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up. |
| Diabetes (Type 2) screening | Screening for type 2 diabetes. |
| Diet counseling | Behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians. |
| Gestational Diabetes screening | Screening for all pregnant women at 24 weeks of gestation or after. |
| Gonorrhea screening | Screening for Gonorrhea. |
| Gynecological Examination | Coverage provided for routine gynecological examinations. |
| Hearing screening | Coverage provided for routine hearing screenings. |
| Hepatitis B screening | The USPSTF strongly recommends screening for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit. |
| Hepatitis C screening | Screening for hepatitis C infection. |
| HIV screening | Screening for HIV infection. |
| Immunization Vaccines (Standard) | Hepatitis A, Hepatitis B, Herpes Zoster (Shingles), Human Papillomavirus, Influenza, Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis, Varicella and COVID-19. |

COVERED SERVICES — Continued

| Covered Preventive Services for Adults | Special Notes |
|-------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Lung Cancer screening | Screening for adults 50 to 80 at high risk for lung cancer, i.e., heavy smoker or quit in the past 15 years. |
| Obesity screening | Screening of adult patients for obesity and counseling and behavioral interventions to promote sustained weight loss for obese adults. |
| Osteoporosis screening | Screening for osteoporosis. |
| Ovarian Cancer screening | Coverage provided for Cancer Antigen-125 (CA-125) blood test and transvaginal ultrasound screenings for ovarian cancer when ordered or provided by a physician in accordance with the standard practice of medicine. |
| Physical Examination | Coverage provided for routine physical examinations, including pre-pregnancy, prenatal, postpartum and interpregnancy well-woman exams. |
| Prediabetes screening | Adults who are overweight or obese. |
| Prostate Cancer screening | Screening for prostate cancer. |
| Rh Incompatibility screening and follow-up testing | Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care. The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24-28 weeks gestation, unless the biological father is known to be Rh (D)-negative. |
| Sexually Transmitted Infection (STI) prevention counseling | Behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adults at increased risk for STIs. |
| Syphilis screening | Screening of persons at increased risk for syphilis infection. |
| Tobacco Use screening | Screening of all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. |
| Tuberculin testing | Tuberculin testing for adults, one test every 2 years. |

| Covered Preventive Services for Children | Special Notes |
|------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Alcohol and Drug Use assessments | Alcohol and drug use assessments for adolescents. |
| Autism screening | Autism screening for children at 18 and 24 months. |
| Behavioral assessments | Behavioral assessments for children of all ages. |
| Cervical Dysplasia screening | Screening for cervical dysplasia in persons who have been sexually active and have a cervix. |
| Depression screening | Screening of children for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up. |
| Developmental screening | Developmental screening for children under age 3, and surveillance throughout childhood. |
| Dyslipidemia screening | Dyslipidemia screening for children at higher risk of lipid disorders. |

COVERED SERVICES — Continued

| Covered Preventive Services for Children | Special Notes |
|-------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Fluoride Chemoprevention supplements | Primary care clinicians may administer (or prescribe) oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride. |
| Gonorrhea preventive medication | Prophylactic ocular topical medication for all newborns against gonococcal ophthalmia neonatorum. Coverage is only available when administered by the physician. |
| Hearing screening | Screening for hearing loss in all newborn infants. Coverage also provided for routine hearing screenings for children of all ages. |
| Height, Weight and Body Mass Index measurements | Height, weight and body mass index measurements for children. |
| Hematocrit or Hemoglobin screening | Hematocrit or hemoglobin screening for children. |
| Hemoglobinopathies screening | Screening for sickle cell disease in newborns. |
| HIV screening | Screening for human immunodeficiency virus (HIV). |
| Hypothyroidism screening | Screening for congenital hypothyroidism (CH) in newborns. |
| Immunizations Vaccines (Standard) | Hepatitis A, Hepatitis B, H. Influenza type b, Human Papillomavirus, Influenza, Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Diphtheria, Tetanus, Pertussis, Inactivated Poliovirus, Rotavirus, Varicella and COVID-19. |
| Lead screening | Lead screening for children at risk of exposure. |
| Medical History | Medical history for all children throughout development. |
| Obesity screening | Screening for children aged 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status. |
| Oral Health Risk assessment | Oral health risk assessment for young children. |
| Phenylketonuria (PKU) screening | Screening for phenylketonuria (PKU) in newborns. |
| Physical (Well Child Care) Examination | Coverage provided for routine physical (well child care) examinations. |
| Sexually Transmitted Infection (STI) prevention counseling | Behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents at increased risk for STIs. |
| Tuberculin testing | Tuberculin testing for children at higher risk of tuberculosis. |
| Visual Acuity screening | Screening to detect amblyopia, strabismus, and defects in visual acuity in children younger than age 5 years. |

Reconstructive Surgery

The Plan covers reconstructive and cosmetic surgery (unless the specific surgical procedure is excluded under the Plan) if the surgery is needed:

- To alleviate an accidental (i) physical injury or (ii) mental impairment,
 - if there exists severe facial disfigurement due to injury or significant functional physical or mental impairment and
 - the purpose of the surgery is to improve physical or mental function.

COVERED SERVICES — Continued

- To improve function when the treatment of a physical or mental illness has resulted in severe facial disfigurement or significant physical or mental functional impairment.
- As part of reconstruction following a mastectomy. Coverage includes:
 - reconstruction of the breast on which a mastectomy has been performed,
 - surgery and reconstruction of the other breast to create a symmetrical (balanced) appearance,
 - prostheses, including one external breast prosthesis every two years (per diseased breast) and two post-mastectomy bras every six months (up to four per calendar year) and,
 - treatment of physical complications of all stages of mastectomy, including lymphedemas.

For Covered Persons diagnosed with gender dysphoria, it is the intention of this Plan to comply with all applicable requirements of coverage regarding non-discrimination. As outlined in the Forward, Coverage and Benefits are not affected by the sex, sexual orientation, or gender identification of the member. To the extent any provision of the Plan conflicts with those requirements, the Plan shall be automatically amended to so comply. Benefits are covered at the same Benefit levels as other similar services in accordance with, and to the extent required by, applicable law.

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| Reconstructive Surgery | |
| Inpatient Room and Board | Plan pays 100% after you pay a \$100 Copay per admission |
| Outpatient Surgery - Facility | Plan pays 100% after you pay a \$200 Copay per admission |
| Physician | Plan pays 90% after deductible You pay 10% after deductible |
| Imaging, Tests and Lab Work | Plan pays 90% after deductible You pay 10% after deductible |

Skilled Nursing Facility Care

Benefits are provided for Medically Necessary confinement in a Skilled Nursing Facility. These Benefits will be provided only if services are:

1. prescribed by the patient's Physician;
2. for skilled and not custodial care; and
3. for the continued treatment of an injury or illness.

Room and Board charges in excess of the facility's established semi-private room rate are not covered.

Admission and services in connection with confinement in a Skilled Nursing Facility require prior authorization by Anthem Blue Cross as soon as possible, but not later than three (3) business days prior to admission. Failure to obtain the required prior authorization within the specified time frame may result in a reduction or denial of Benefits. **A 100 day per person per Calendar Year limit applies to all Skilled Nursing Facility Care, regardless of cause.**

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| Skilled Nursing Facility Care | Plan pays 100% after you pay a \$100 Copay per admission |
| A 100 day per person per Calendar Year limit applies to all Skilled Nursing Facility Care, regardless of cause. | |

COVERED SERVICES — Continued

Coordination with USC's Long Term Care Plan

Benefits under this Plan will be coordinated with benefits received from the USC Long Term Care Plan or any other Long Term Care Plan, so that Benefits under this Plan will be secondary to benefits provided under any Long Term Care Plan.

Smoking Cessation

Smoking Cessation Programs are limited to two (2) per person per Calendar Year. Smoking cessation medications are covered under the **Prescription Drug Program**.

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| Smoking Cessation Program | Plan pays 100% |
| Limited to two (2) courses of treatment (programs) per person per Calendar Year. | |

Speech Therapy

Speech-language pathology services provide for the identification, assessment and treatment of speech, language and swallowing disorders in children and adults.

The Plan will provide services by a qualified provider of speech therapy services who holds the appropriate credentials in speech-language pathology; has pertinent training and experience and is certified, licensed, or otherwise regulated by the State or Federal governments. Assistants may provide services under the direction and supervision of speech language pathologist. These qualified professionals are also regulated by the State and Federal governments. Aides, athletic trainers, exercise physiologists, life skills trainers, and rehabilitation technicians do not meet the definition of a qualified practitioner regardless of the level of supervision.

Speech therapy covers Medically Necessary *rehabilitative* services intended to improve, adapt or restore functions which have been impaired or permanently lost as a result of illness*, injury, loss of a body part, or congenital abnormality involving goals an individual can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and the individual stops progressing toward those goals. Rehabilitative speech-language pathology services are considered Medically Necessary when ALL of the following criteria are met:

1. The services are used in the treatment of communication and impairment or swallowing disorders resulting from illness, injury, surgery, or congenital abnormality; and
Based on a plan of care, the therapy sessions achieve a specific diagnosis-related goal for an individual who has a reasonable expectation of achieving measurable significant functional improvement in a reasonable and predictable period of time [i.e., Medical Necessity continues until progress is no longer being made (each three to six month period) or the individual has attained the previous level of competency]; and
2. The therapy sessions provide specific, effective, and reasonable treatment for the individual's diagnosis and physical condition; and
3. The services are delivered by a qualified provider of speech therapy services; and
4. The services require the judgment, knowledge, and skills of a qualified provider of speech-language pathology services due to the complexity and sophistication of the therapy and the medical condition of the individual.

Speech therapy also covers Medically Necessary *habilitative* services that are intended to maintain, develop or improve skills which have not (but normally would have) developed or which are at risk of being lost as a result of illness, injury, loss of a body part, or congenital abnormality. Habilitative speech-language pathology services are

COVERED SERVICES — Continued

Medically Necessary when ALL of the following criteria are met:

1. The therapy is intended to maintain, develop or improve speech, language, or swallowing impairment skills which have not (but normally would have) developed or which are at risk of being lost as a result of illness, injury, loss of a body part, or congenital abnormality; and
2. The therapy is for a condition that requires the unique knowledge, skills, and judgment of a qualified provider of speech therapy services for education and training that is part of an active skilled plan of treatment; and
3. There is an expectation that the therapy, will maintain or improve the level of functioning; and
4. An individual would either not be expected to develop the function or would be expected to permanently lose the function without the habilitative service (not merely fluctuate); and
5. The therapy documentation objectively verifies that, at a minimum, functional status is maintained; and
6. The services are delivered by a qualified provider of speech therapy services; and
7. The services require the judgment, knowledge, and skills of a qualified provider of speech-language pathology services due to the complexity and sophistic action of the therapy and the medical condition of the individual.

** For purposes of clarity, illness includes, but is not limited to Autism Spectrum Disorder and Rett Syndrome.*

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| Speech Therapy | Plan pays 90% after deductible |
| Inpatient Visit | You pay 10% after deductible |
| Outpatient Visit | Plan pays 100% after you pay a \$20 Copay per visit |

Telehealth Visits

The Plan covers Telehealth provider visits for certain Covered Services. A Telehealth visit is the use of electronic information and telecommunication technologies to support long distance clinical care when you and your provider are not in the same place at the same time. Your provider must use an interactive audio and video telecommunications system that permits real-time communication between you and your provider. Telehealth providers can include Physicians, nurse practitioners, Physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, therapists (including licensed speech pathologist, physical therapists and occupational therapists), registered dietitians, and nutrition professionals. Examples of covered Telehealth visits include:

- General health care, like wellness visits
- Prescriptions for medicine
- Dermatology (skin care)
- Mental health counseling
- Therapies, includes speech, physical and occupational therapy
- Urgent care conditions, such as sinusitis, back pain, urinary tract infections, common rashes, etc.

LiveHealth Online Consultations

LiveHealth Online is a Telehealth provider. LiveHealth Online physicians (general practitioners, family medicine, internists, pediatricians, and behavioral health providers) are available year round, seven days a week, 24 hours a day.

LiveHealth Online physicians can answer questions, make a diagnosis, and even prescribe basic medications when needed and as legally permitted in certain states*. A transcript of the LiveHealth Online consultation will be sent to your primary care physician **upon request**.

COVERED SERVICES — Continued

Common conditions addressed in a LiveHealth Online consultation include, but are not limited to,:

- Cough
- Cold
- Minor rashes
- Allergies
- Ear pain
- Fever
- Flu
- Headache
- Pink Eye

You may access this service by visiting livehealthonline.com. Information on system requirements and supported mobile devices are located on the website.

* To discover where LiveHealth Online is available, visit livehealthonline.com/availability.html. In addition, you may refer to this website to determine if you reside in a state that does not allow LiveHealth Online physicians to prescribe medication. California residents are able to obtain prescriptions from a LiveHealth Online physician as appropriate.

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| Telehealth Visits (See Plan coverage section of service for visit limitation or prior authorization requirement, if any) | Plan pays 100% after you pay a \$20 Copay per visit (Copay is reduced to \$10 for PCP visits if you have designated a Primary Care Physician) |
| LiveHealth Online Consultations | Plan pays 100% after you pay a \$10 Copay per visit |
| (Copay waived ONLY for Medically Necessary screening of COVID-19 (coronavirus)) | |

Transplants – Organ and Tissue

Hospital, surgical and medical services for the following human transplants, are covered provided they meet all the Plan's requirements for the specific transplant surgery, including, but not limited to, being Medically Necessary:

- Cornea Heart
- Heart/Lung
- Kidney
- Pancreas
- Pancreas/Kidney
- Simultaneous Pancreas/Kidney
- Liver
- Lung (single or double)

Allogeneic (donor) bone marrow transplants (see donor provisions on page 47)

- Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions:
 - Acute lymphocytic or non-lymphocytic leukemia
 - Advanced Hodgkin's lymphoma
 - Advanced non-Hodgkin's lymphoma
 - Advanced neuroblastoma
 - Breast cancer
 - Multiple myeloma
 - Epithelial ovarian cancer
 - Testicular, mediastinal, retroperitoneal and ovarian germ cell tumors

COVERED SERVICES — Continued

The Plan covers:

- Evaluation
- Compatibility testing of prospective organ donors who are family members
- Charges for activating the donor search process with national registries
- The direct costs of obtaining the organ. Direct costs include surgery to remove the organ, organ preservation and transportation, and the hospitalization of a live donor, provided that the expenses are not covered by the donor’s group or individual health plan
- Physician or transplant team services for transplant expenses
- Hospital inpatient and outpatient supplies and services, including:
 - Physical, speech, and occupational therapy
 - Biomedicals and immunosuppressants
 - Home health care services and
 - Home infusion services
- Follow-up care

In order to be considered as covered services, the transplant and the transplant-related services and supplies must meet all of the following requirements:

- All organ and tissue transplant services require prior authorization by Anthem Blue Cross
- The transplant must be Medically Necessary and appropriate for the Covered Person’s medical condition
- The transplant must not be Experimental or Investigational for the Covered Person’s condition

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| Transplants – Organ and Tissue | Plan pays 100% after you pay a \$100 Copay per admission |
| Room and Board | |
| Inpatient Physician Visits | Plan pays 90% after deductible You pay 10% after deductible |
| Imaging, Tests and Lab Work | Plan pays 90% after deductible You pay 10% after deductible |

Organ Donors

The following rules apply to coverage for organ donors with respect to the transplant and transplant-related services and supplies:

- When both the recipient and the donor are covered by the Plan, each is entitled to the benefits of this EPO Plus Plan.
- When only the recipient is covered by the EPO Plus Plan, both the donor and the recipient are entitled to the benefits of this EPO Plus Plan, but the donor benefits are limited to those not available from any other source to which the donor may have access.
- When the donor is covered by the EPO Plus Plan, but the recipient is not, the EPO Plus Plan does not cover any services and supplies provided to the donor.
- If any organ or tissue is sold rather than donated to a recipient covered by this EPO Plus Plan, no expenses will be Payable.

As part of the transplant benefit, the EPO Plus Plan does ***not*** cover:

- Services and supplies provided to a donor when the recipient is not covered by this EPO Plus Plan
- Outpatient drugs, including biomedicals and immunosuppressants, except as provided above
- Harvesting or storage of organs without the expectation of an immediate transplant for an existing illness

COVERED SERVICES — Continued

- Harvesting or storage of bone marrow, tissue, or stem cells without the expectation of a transplant to treat an existing illness within 12 months or
- A pancreas transplant that is not performed in conjunction with a kidney transplant, or which is performed after the Covered Person has received a kidney transplant.

Transplantation Donor Benefit

When a Covered Person is the recipient, an organ or tissue donor who is not a Covered Person is also eligible for certain transplant-related services as described herein. Benefits are reduced by any amounts paid or payable by that donor's own coverage. The maximum allowed amount for a donor, including donor testing and donor search, is limited to expense incurred for Medically Necessary services only. The maximum allowed amount for services incident to obtaining the transplanted material from a living donor or a human organ transplant bank will be covered. Such charges, including complications from the donor procedure for up to six weeks from the date of procurement, are covered. Services for treatment of a condition that is not directly related to, or a direct result of, the transplant are not covered. The Plan's payment for unrelated donor searches for bone marrow/stem cell transplants will not exceed \$30,000 per transplant.

Transplant Travel Expense Benefits

Certain travel expenses incurred in connection with an approved, specified transplant (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures) performed at a designated Center of Medical Excellence or Blue Distinction Center of Specialty Care that is 75 miles or more from the recipient's or donor's place of residence are covered, provided the expenses are authorized by the claims administrator in advance. The Plan's maximum payment will not exceed \$10,000 per transplant for the following travel expenses incurred by the recipient and one companion* or the donor:

- Ground transportation to and from the Center of Medical Excellence or Blue Distinction Center of Specialty Care when the designated Center of Medical Excellence or Blue Distinction Center of Specialty Care is 75 miles or more from the recipient's or donor's place of residence.
- Coach airfare to and from the Center of Medical Excellence or Blue Distinction Center of Specialty Care when the designated Center of Medical Excellence or Blue Distinction Center of Specialty Care is 300 miles or more from the recipient's or donor's residence.
- Lodging, limited to one room, double occupancy.
- Other reasonable expenses. Tobacco, alcohol, drug expenses, and meals are excluded.

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

The Calendar Year deductible will not apply and no Copayments will be required for transplant travel expenses authorized in advance by the claims administrator. The Plan will provide benefits for lodging and ground transportation, up to the current limits set forth in the Internal Revenue Code.

Expense incurred for the following is not covered: interim visits to a medical care facility while waiting for the actual transplant procedure; travel expenses for a companion and/or caregiver for a transplant donor; return visits for a transplant donor for treatment of a condition found during the evaluation; rental cars, buses, taxis or shuttle services; and mileage within the city in which the medical transplant facility is located.

Details regarding reimbursement can be obtained by calling HealthComp at 855-SC-PLANS (855-727-5267). All applicable receipts must be submitted to HealthComp, in order to obtain reimbursement.

Travel Expenses for Abortion

Certain travel services specified below, incurred on or after September 1, 2022, reasonably necessary to obtain covered abortion-related services in a state other than the state where the Covered Person resides, will be covered, up to \$2,000 or such lesser amount permitted under the Section 213(d) of the Internal Revenue Code for such travel services incurred by the Covered Person during a Calendar Year, and will accumulate towards any medical deductible(s) and out-of-pocket maximum(s). An expense is "incurred" when services related to that expense are

COVERED SERVICES — Continued

provided, not when the services are billed or paid, if later. There is no lifetime maximum benefit. Subject to those limitations, the Plan will reimburse a Covered Person for reasonable costs incurred for the services below to travel more than 50 miles to another state for pregnancy termination services covered under the Plan:

- Travel in a personal car, at the current IRS standard mileage rate.
- Economy class air or train fare.
- Public transportation, taxis, Lyft, Uber, or similar services (Limos, luxury or upgraded vehicles will not be reimbursed).
- Parking and tolls.
- Hotel or similar accommodations if an overnight stay is required prior to or following a covered procedure. Reimbursement is limited to the charge for a single (double occupancy) room, including taxes, not to exceed IRS limits, for under Section 213(d) of the Internal Revenue Code 1 or 2 nights as required.
- No reimbursement is provided for entertainment, meals, food, or beverages.
- Reimbursement will be made to the Covered Person upon submission of receipts and evidence of payment satisfactory to the Plan.
- Travel expense reimbursement will not be provided if the Covered Person receives or is eligible for payment from any other employer or any other third party.

Travel expense reimbursement will not be provided if the Plan Administrator, in its sole discretion, determines reimbursement may violate any law. The Plan Administrator may also, in its sole discretion, modify or terminate coverage for travel reimbursements. Such modification or termination will be reflected in a written instrument signed or approved by the Plan Administrator.

Urgent Care Center

The Plan covers the services of an urgent care center to evaluate and treat an urgent condition. Urgent care centers are Physician-staffed facilities offering unscheduled medical services.

Urgent care services are provided for the care of a medical condition that requires medical attention, but a brief time lapse before care is obtained does not endanger life or permanent health.

Urgent care centers are a convenient alternative to Hospital emergency rooms for conditions such as (but not limited to) minor sprains, fractures, pain, heat exhaustion and breathing difficulties that require prompt medical attention, but do not pose an immediate, serious health threat. To find a participating urgent care center, go to hconline.healthcomp.com/usc, select “Find a Provider”, filter your search by location and select “Urgent Care” as the provider type.

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| Urgent Care Center | Plan pays 100% after you pay a \$35 Copay per visit (Copay waived ONLY for Medically Necessary screening and testing of COVID-19 (coronavirus)) |
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Well Child Care

Also see Preventive Care section.

This coverage pays Benefits for charges incurred for physical exams and immunizations of your child. Well Child Care Benefits apply to:

1. nursery charges;
2. newborn exam and circumcision at Hospital;
3. eligible immunizations administered by, or under the immediate direction of, a Physician;

COVERED SERVICES — Continued

4. periodic physical examinations by a Physician.

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|-------------------------------------------|--------------------------------------------------------------------|
| Well Child Care | |
| Nursery Charges* | Plan pays 100% |
| Newborn exam and circumcision at Hospital | Plan pays 100% |
| Periodic Physical Exams | Plan pays 100% |
| Immunizations** | Plan pays 100% (through age 25) for the immunizations listed below |

*Note: Does not include admission to NICU. See Inpatient Benefit section for NICU coverage.

**Covered immunizations include:

- Diphtheria, Tetanus, Pertussis
- Haemophilus influenza type b
- Hepatitis A
- Hepatitis B (limited to one each of three injections, to be completed within 12 months)
- Human Papillomavirus (HPV)
- Inactivated Poliovirus
- Influenza
- Measles, Mumps, Rubella (MMR)
- Meningococcal
- Pneumococcal
- Rotavirus
- Varicella
- COVID-19

The 100% Well Child Care Benefits do not apply to (1) immunizations not listed above and (2) charges made by a Hospital for a service or supply furnished to an inpatient.

X-Ray / Radiology Services

The Plan covers **Medically Necessary** services to diagnose an illness or injury, including:

- Angiograms
- Angioplasty
- Embolization
- Discograms
- Myelograms
- Magnetic Resonance Imaging (MRI)
- PET scans

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| X-Ray / Radiology Services | Plan pays 90% after deductible You pay 10% after deductible |
|-----------------------------------|----------------------------------------------------------------|

EXCLUSIONS

The following are not covered under this Plan but nothing below will exclude, limit or restrict benefits in any way that would violate 45 CFR 92.207 to the extent it applies to the Plan, and the Plan shall be automatically amended to the extent necessary to avoid any such violation.

1. Services or supplies received as a result of an accident related to employment, or sickness covered under Workers' Compensation or similar law.
2. Services or supplies (1) furnished by or for the U.S. Government or any other government, unless payment is legally required; or (2) to the extent provided under any governmental program or law under which the individual is, or could be, covered. This (2) does not apply to a state plan under Medicaid or to any law or plan when, by law, its Benefits are in excess to those of any private insurance program or other non-governmental program.
3. Services, supplies and tests that are not Medically Necessary.
4. The portion of a charge for a service or supply in excess of the Usual, Customary and Reasonable charge prevailing in the community for a service of the same nature and duration and performed by a person of similar training and experience, or for a substantially equivalent supply, except as required under the No Surprises Act.
5. Services and supplies for which the Covered Person has no legal obligation to pay, or for which no charge would be made if the Covered Person was not eligible under this Plan.
6. Professional services, including nursing, speech therapy, physical therapy, occupational therapy or Home Health Care rendered by yourself, spouse, or a child, brother, sister, or parent of yourself or spouse or someone living in your home or volunteering to assist.
7. All services in connection with a home birth, including services provided by a Midwife in the home.
8. Expenses incurred as a result of illegal activity, unless the illness or injury results from domestic violence or a medical condition as determined at the discretion of the Plan Administrator.
9. Services or supplies received as a result of an act of war, riot, or insurrection.
10. Expenses incurred while on active military duty with any armed forces.
11. Expenses in connection with Cosmetic Surgery. The following are **not** considered to be Cosmetic Surgery:
 - a. Surgery to correct the result of an accidental injury occurring while covered.
 - b. Surgery to treat a condition, including a birth defect, which impairs the function of a body organ.
 - c. Surgery to reconstruct a breast after a mastectomy.
12. Expenses in connection with:
 - a. exams to determine the need for (or changes of) eyeglasses or lenses of any type;
 - b. eyeglasses or lenses of any type;
 - c. eye surgery such as radial keratotomy when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring);
 - d. visual training.
13. Treatment of weak, strained, flat, unstable or unbalanced feet, fallen arches, chronic foot strain, metatarsalgia or bunions, except surgical treatment.
14. Foot care (routine), including but not limited to removal of corns, calluses or toenails, except the removal of nail roots and necessary services in the treatment of metabolic or peripheral-vascular disease.
15. Orthopedic shoes, cushions, insoles, arch supports, or foot orthotics (custom molded shoe inserts).
16. Covered services for the treatment of infertility will exclude elective sterilization reversal, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), over-the-counter products, the purchase of donor sperm and any charges for the storage of donor sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to, fees for laboratory tests or any other service for infertility not specifically stated above.
17. Services or supplies received before you or your dependent(s) became covered under the Plan or after coverage ended.
18. Services or supplies received during an inpatient stay which began before you or your dependent(s) became covered under the Plan to the extent permitted by law.

EXCLUSIONS — Continued

19. Services or supplies received after coverage for you or a covered dependent ends.
20. Services or devices or substances which are Experimental or Investigational in nature.
21. Expenses not incurred for treatment of an injury or sickness, except as specified in this booklet for preventive and wellness care (e.g., pre-employment physicals and work-related/travel immunizations).
22. Services or supplies provided without charge or where there would be no charge in the absence of medical coverage.
23. Dental care except those services or supplies shown under “Dental Coverage”.
24. Orthodontic appliances and services including braces.
25. Except as otherwise provided under the Plan or as required by law, nutritional or other services for dietary control, weight reduction or treatment of obesity.
26. Rest home or nursing home care that is custodial in nature.
27. Custodial care.
28. Private duty nursing.
29. Private room charges in excess of the rate for a standard semi-private room.
30. Non-durable medical equipment and supplies. Most medical supplies of an expendable, non-reusable nature, such as incontinent pads, ace bandages, or elastic stockings are considered non-durable and are not covered items.
31. Conditions caused by atomic explosion or non-therapeutic release of nuclear energy.
32. Any confinement, treatment, service or supply not recommended by a Physician.
33. Recreational, educational, vocational, art, dance, yoga, voice or music therapy.
34. Chelation therapy and orthomolecular treatment.
35. Reversal or attempted reversal of sterilization.
36. Exercise equipment.
37. Weekend Hospital admissions, except for an Emergency.
38. Expenses incurred in connection with the donation of an internal body organ (except as provided in the Transplantation Donor Benefit provision).
39. Treatment for non-medical disorders, including services that are primarily oriented towards treating a social, developmental, learning disability or mental impairment, except as otherwise specifically covered under the Plan.
40. Recreational, educational or sleep therapy, including any related diagnostic testing, except as provided as part of an otherwise covered inpatient hospitalization.
41. Any service or supply provided or received primarily for religious, personal or philosophical reasons, beliefs or requirements.
42. Any service or supply for, or relating to, full body scans or similar services or supplies.
43. Massage therapy.
44. Counseling, assessment or psychological testing ordered by or for use in a court of law, unless determined to be Medically Necessary.
45. Professional training.
46. Charges for services that are not received, such as broken or missed appointments.
47. Treatment that does not meet the national standards by mental health, alcohol and drug treatment professionals.
48. Supervision of patient discharge team.
49. Administrative psychiatric services.
50. Recheck chart review.
51. L-Tryptophan and vitamins, except thiamine injections on admissions for alcoholism or with a diagnosis or nutritional deficiency.
52. Megavitamin orthomolecular therapy.
53. Transcendental meditation.
54. Rolfing.
55. Z therapy.

EXCLUSIONS — Continued

56. EST (Erhard).
57. Primal therapy.
58. Bioenergetics therapy.
59. Carbon dioxide therapy.
60. Guided imagery.
61. Confrontation therapy.
62. Narcotherapy with LSD.
63. Marathon therapy.
64. Sensitivity training.
65. Educational remediation.
66. Crystal healing treatment.
67. Inpatient treatment of “sexual addiction” except as required by law.
68. Sex therapy (without DSM-IV-TR diagnosis).
69. Hemodialysis for schizophrenia.
70. Training analysis (Tuitional, Orthodox).
71. Poetry/Art therapy.
72. Consultations with a mental health professional for purposes of adjudication of marital, child support and custody cases.
73. Inpatient substance abuse program admissions of co-dependent will not be authorized. If the spouse or a dependent of a substance abuse patient presents symptoms of a psychiatric disorder of such severity that inpatient treatment is required, such treatment should be delivered in a comprehensive, multi-modal, approved psychiatric setting. In all cases, medical/psychological necessity must be established before an individual with such symptoms can be admitted to an inpatient unit. Issues specifically related to “enabling” or other components of alcohol/drug dependency constellations will be referred to an appropriate level of care. In the majority of cases, this will be at the level of outpatient therapy or as part of the family therapy component of the primary substance abuse patient's inpatient or partial Hospital treatment.

HOW TO USE THE EPO PLUS PLAN

EPO Plus Network Participating Providers

You may select Network providers from listings on one of two websites. To view providers from Keck Medicine of USC, visit keckmedicine.org. If you would like to view a complete list of USC EPO Plus Plan providers, visit the HealthComp website at hconline.healthcomp.com/usc.

Making Appointments

Select an appropriate provider and be sure to identify yourself as a USC EPO Plus Plan participant when making the appointment. For assistance in making appointments with Keck Medicine Providers, call (833) KECK-USC (833-532-5872). Claims should be sent to the appropriate address listed on the back of your identification card.

If Hospital admission is required, be sure to notify Anthem Blue Cross as required and identify yourself as a USC EPO Plus Plan participant at the time of admission.

If You Or A Covered Dependent Is Scheduled To Be Hospitalized

Inpatient hospitalizations, as well as selected outpatient procedures, require prior authorization. Your Physician must seek prior authorization from Anthem Blue Cross at least three (3) business days prior to admission. You must verify that services have been authorized before the procedure. At the time of admission, present your identification card to the admissions clerk. Prior to admission or at the time of admission, the Hospital may confirm your Hospital Benefits by contacting HealthComp. You may be required to pay your Hospital Copayment at the time of admission or at the time of discharge. Most Hospitals will submit claims directly to the address found on your identification card.

Claim Payments

All claim payments should be assigned to the provider whenever possible. The assignment ensures that the provider will receive a copy of the Explanation of Benefits to facilitate correct billing of any Copayments, Coinsurance and other non-covered amounts that may be your financial responsibility.

Patient Responsibility For Payment

If any EPO Plus Network Provider waives any obligation to pay amounts not covered by the Plan (e.g., Coinsurance or Copayments up to 100% of the allowed amount), **the EPO Plus Plan will not pay ANY Benefit for any related Covered Service from that Provider.** See Exclusions, page 50, #5. The Plan's claims administrator, HealthComp, has the authority to audit any such Provider who bills the Plan and to require evidence that Coinsurance and Copayments have been paid by the Covered Person. HealthComp may audit the Provider before paying claims for the Covered Services related to such Coinsurance or Copayment amounts and not pay the Provider until the Provider can demonstrate that such amounts have been received. HealthComp may audit the Provider after payment and require reimbursement from the provider or offset future payments to any provider who does not collect Copayments or Coinsurance.

How To Present A Claim

In most cases, the provider of service will file your claims directly with the Plan. All medical claims should be sent to:

HOW TO USE THE EPO PLUS PLAN — Continued

| PROVIDERS SUBMITTING CLAIMS | | COVERED PERSONS SUBMITTING CLAIMS |
|-----------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|
| For Services In California | For Emergency Services Outside of California | For Services Inside California or Emergency Services Outside of California |
| Prudent Buyer Plan P.O. Box 60007 Los Angeles, CA 90060-0007 | Submit to your local Blue Cross and / or Blue Shield plan in the state where the service is rendered. To ensure prompt claims processing, include the 3 digit alpha prefix (U7S/U6C) that precedes the patient’s ID number. | HealthComp Administrators P. O. Box 45018 Fresno, CA 93718-5018 |

If the provider will not bill on your behalf you will have to submit your claims for payment. Be certain to obtain an itemized statement from the provider. A “Medical Claim Form” must accompany all claims you submit. A claim form can be obtained from the HealthComp website at hconline.healthcomp.com/usc.

When you submit a claim, please complete the following steps:

Complete the “Patient and Employee Information” section of the claim form. A separate form will be required for each accident or illness of each family member. Also, a separate form will be required for each provider who is billing for medical services. **To avoid delay, be sure to answer each question completely.**

Staple (do not use paper clip) the fee bill prepared by the provider to the claim form or have the provider complete the “Physician or Supplier Information” section of the claim form. Please be certain to submit the original bills and retain copies for your files. If you choose to attach a fee bill, you must confirm that all of the information needed for the “Physician/Supplier Information” section is contained on the fee bill. Bills and receipts should be itemized and include:

- Patient’s full name
- Date(s) the service was rendered or purchase was made
- Diagnoses (nature of the sickness or illness)
- Type of service or supply furnished
- Service provider name, address and tax ID number
- Itemized charges
- Copies of the explanation of benefits for any payments or denials made by any other insurance payor
- Receipts, if you have already paid for the services

If information is missing from the fee bill, you will need to obtain it from the provider and include it on the claim form. If HealthComp needs more information from you, please reply promptly to avoid a delay in processing your claim.

When You Have A Claim

A claim should be submitted within 30 days after treatment or as soon as reasonably possible. **No claims for expenses submitted more than one year from the date of service will be considered for payment.**

Refer to *How to Submit a Claim (above)* for the claims submission address(es).

If any Benefits are payable to your estate or to a person not competent to give valid release, the Plan may pay up to \$1,000 to any person related to you or to your beneficiary whom it deems to be entitled; USC will then be discharged to the extent of the payment due.

What to Expect

Each time a bill is submitted to HealthComp by either the patient or the provider of services, an explanation of benefits (EOB) is sent to the insured. If payment is assigned to the provider of service, then an EOB is sent to the provider as well. **Please wait for the EOB before you pay the provider.** You and the Plan are entitled to special discounts which will be indicated on the EOB.

HOW TO USE THE EPO PLUS PLAN — Continued

The EOB describes how HealthComp adjudicated the claim. It indicates the names of the insured, patient, and provider as well as the details of the charge and the payment calculation. It will list the billed amount, allowed amount (contracted rate), Copay amount, % Benefit (percentage paid by the Plan), Plan payment and patient responsibility (Copayment and Coinsurance combined).

The EOB will indicate to whom payment was made. If the bill indicates that the patient has assigned Benefits, then the check will be issued to the provider.

Sometimes you will receive two or more bills for the same transaction from different providers. This is particularly true for lab and x-ray services. For outpatient lab and X-ray charges, you will often be charged both a facility charge (a bill from the Hospital, imaging center or lab where the test/X-ray was performed) and a bill from the Physician who read the X-ray or interpreted the lab results. When you have surgery, there will often be a bill from the facility, the surgeon, the assistant surgeon (if one was present) and the anesthesiologist. You can expect to receive EOBs for each one of the bills.

If you have any questions after you receive your EOB or if you do not receive the EOB in a timely fashion, you may call the customer service representative at HealthComp at (855) SC-PLANS (855-727-5267).

GENERAL INFORMATION

Coordination Of Benefits

The Plan contains the provisions for coordinating with other similar health plans when Covered Persons are covered by more than one plan. This allows combining coverage to benefit the Covered Person, but not to permit reimbursements to be made which would exceed the actual Eligible Expenses incurred. For instance, if you are covered under two plans because your spouse lists you as a dependent under a group plan where he/she is employed, this will apply. If both, husband and wife are covered under the USC Plan as employees, each may be considered an eligible dependent of the other except that both may not enroll in the **USC EPO Plus Plan** and be covered as employees and dependents at the same time.

When a claim is made, the **primary** plan pays its benefits without regard to any other plan. A **secondary** plan adjusts its benefits to pay the balance of the remaining Eligible Expenses, if any, up to its maximum responsibility as set forth in this booklet. No plan pays more than it would without the coordination provision.

Example: Primary Plan (other than the USC EPO Plus Plan) has a maximum allowable charge of \$1,000 with 20% coinsurance for the service in question, so the Primary Plan pays \$800 for that service, leaving the Covered Person with a liability of \$200. The USC EPO Plus Plan is the secondary plan for that service and the maximum allowable rate for that service under the USC EPO Plus Plan is also \$1,000. Therefore, for this service the USC EPO Plus Plan will reimburse the Covered Person in the amount of \$200.

All applicable Copayments and Coinsurance will remain the Covered Person's responsibility.

When the Benefit payable under the primary plan is reduced or denied as a result of the Covered Person's failure to comply with the provisions of the primary plan (e.g. prior authorization, second surgical opinion, etc.) the USC EPO Plus Plan will not consider such non-payments or penalties to be Eligible Expenses and will not cover such penalties or non-payments by the primary plan.

Example: Primary plan requires prior authorization for Medically Necessary outpatient surgery. Patient fails to obtain prior authorization. Primary plan would have paid 80% of a contracted rate of \$1,000 or \$800 with prior authorization. Without it, primary plan pays only 50% of the contracted rate or \$500. The 30% or \$300 difference is a penalty assessed by the primary plan for failure to comply with its requirements. Provider is also a participating provider under the USC EPO Plus Plan with the same contract rate. USC EPO Plus Plan will subtract any penalty from the remaining balance after primary plan payment, and pay up to its contractual amount.

| | |
|----------------|-----------------------------------------------------------|
| \$1,000 | Contract rate of primary plan and USC EPO Plus |
| <u>- \$500</u> | Only 50% of contract rate (penalty for non-authorization) |
| \$500 | Remaining balance |
| <u>- \$300</u> | Penalty assessed by primary plan (paid by the patient) |
| \$200 | maximum that USC EPO Plus pays as secondary plan |

Any health plan that *does not* contain a Coordination of Benefits provision will be considered primary. When another plan covering you and/or your dependents contains a coordination of Benefits provision, the order of payments will be as follows:

1. the plan covering the patient directly as an employee, rather than as an employee's dependent, is primary and the other plan is secondary;
2. if a child is covered under both parents' plans and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year is primary; but if both parents have the same birthday, the plan that covered the parent longer is primary;
3. if a child is covered under both parents' plans and the parents are separated or divorced, their plans pay in the following order:
 - a. if a court decree has established financial responsibility for the child's health care expenses, the plan of the parent with this responsibility;
 - b. the plan of the parent with custody of the child;
 - c. the plan of the stepparent married to the parent with custody of the child;

GENERAL INFORMATION — Continued

- d. the plan of the parent not having custody of the child;
 - e. if there is joint custody and no court decree establishing financial responsibility, the birthday rule is used.
4. the plan covering the patient as an active employee or as that employee's dependent is primary and the plan which covers the patient as a laid off or retired employee or as that employee's dependent is secondary;
 5. if (1), (2), (3) or (4) do not apply, the plan covering the patient longest is primary.

The Benefit of a plan which covers a person as an employee (or a dependent of an employee) will be determined before those of a plan which covers that person as a former employee (or a dependent of such person). Furthermore, to the extent a person is legally permitted under COBRA to maintain coverage under this EPO Plus Plan and another group health plan, the Benefits of that other group health plan will be determined before those of this EPO Plus Plan.

Special Coordination of Benefits Rule for Non-Group Insurance and Travel Health Insurance

Where a Covered Person is covered under any form of non-group health insurance or travel health insurance (group or non-group), the following special coordination of benefits rule applies: This Plan is always secondary to any form of non-group health insurance and/or travel health insurance (group or non-group).

ACA Benchmarking

To the extent any provision of the Plan conflicts with the ACA or other applicable law, as determined by USC, the Plan shall be automatically amended to so comply. Any dollar limitations under the Plan on essential health benefits under the ACA shall be benchmarked for ACA purposes against a benchmark plan of any state permitting those limitations as selected by USC, in its sole discretion, but nothing herein shall be interpreted as requiring the Plan to provide essential health benefits or any Benefits other than as expressly stated in the Plan. USC in its sole discretion, may modify such benchmarking from time to time in any manner it sees fit.

Modification Of Benefits

Under certain conditions, Benefits payable under the Plan may be modified by the Plan Administrator to provide alternative treatment for a Covered Person's catastrophic (or which, in the Plan Administrator's judgment, could become catastrophic) sickness or injury. Benefit modification will be determined exclusively by the Plan Administrator in its discretion. The Plan Administrator shall have the right to review the patient's medical needs and determine which services, supplies and providers are available under the modification of Benefits, taking into consideration such factors as the Plan Administrator deems appropriate, including, but not limited to, the cost-effectiveness of any Benefit modification. The Plan Administrator shall determine the Benefit coverage under which the alternative treatment shall be considered payable and the duration of the Benefit modification. Alternative treatment does not include services and supplies which the Plan Administrator determines to be experimental or investigational or otherwise inappropriate.

Subrogation

The following provision shall apply to all Benefits provided under any section of this Plan:

A Covered Person may incur medical or other charges related to injuries or illness caused by the act or omission of another person; or Another Party may be liable or legally responsible for payment of charges incurred in connection with the injuries or illness. If so, the Covered Person may have a claim against that other person or another Party for payment of the medical or other charges. In that event, the Plan will be secondary, not primary, and the Plan will be Subrogated to all rights the Covered Person may have against that other person or Another Party and will be entitled to Reimbursement. In addition, the Plan shall have the first lien against any Recovery to the extent of Benefits paid or to be paid and expenses incurred by the Plan in enforcing this provision. The Plan's first lien supersedes any right that the Covered Person may have to be "made whole". In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Covered Person procures or may be entitled to procure regardless of whether the Covered Person has received compensation for any of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. As a condition to receiving Benefits under the Plan, the Covered Person agrees that acceptance of Benefits is constructive notice of this provision.

GENERAL INFORMATION — Continued

The Covered Person must:

1. Execute and deliver a Subrogation and Reimbursement Agreement;
2. Authorize the Plan to sue, compromise and settle in the Covered Person's name to the extent of the amount of medical or other Benefits paid for the injuries or illness under the Plan and the expenses incurred by the Plan in collecting this amount, and assign to the Plan the Covered Person's rights to Recovery when this provision applies;
3. Within 10 business days, reimburse the Plan, out of any Recovery made from Another Party, 100% of the amount of medical or other Benefits paid for the injuries or illness under the Plan and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) incurred by the Plan in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise);
4. Notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and
5. Cooperate fully with the Plan in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan.
6. When a right of recovery exists, and as a condition to any payment by the Plan (including payment of future Benefits for other illnesses or injuries), the Covered Person will execute and deliver all required instruments and papers, including a Subrogation and Reimbursement Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other Benefits will be paid by the Plan for the injuries or illness. However, failure or refusal on the Covered Person's part to execute such agreements or furnish information does not preclude the Plan from exercising its right to Subrogation or obtaining full reimbursement. In addition, the Covered Person will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines.

The Plan Administrator has maximum discretion to interpret the terms of this provision and to make changes, as it deems necessary.

Any amounts recovered will be subject to Subrogation or Reimbursement. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other Benefits paid for the injuries or illness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, out of any Recovery without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the Covered Person does not receive full compensation for all of his charges and expenses.

"Covered Person" means anyone covered under the Plan, including minor Dependents.

"Another Party" shall mean any individual or organization, other than the Plan, who is liable or legally responsible (or who is alleged or claimed to be liable or legally responsible) to pay expenses, compensation or damages in connection with a Covered Person's injuries or illness.

"Another Party" shall include the party or parties who caused the injuries or illness (or are alleged or claimed to have caused the injuries or illness); the insurer, guarantor or other indemnifier of the party or parties who caused the injuries or illness; a Covered Person's own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or organization that is liable or legally responsible (or is alleged or claimed to be liable or legally responsible) for payment in connection with the injuries or illness.

"Recovery" shall mean the specific fund of any and all monies paid to the Covered Person by way of judgment, settlement or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the injuries or illness. Any Recovery shall be deemed to apply, first, for Reimbursement.

"Reimbursement" shall mean repayment from the Recovery to the Plan for medical or other Benefits that it has paid toward care and treatment of the injury or illness and for the expenses incurred by the Plan in collecting this Benefit amount.

GENERAL INFORMATION — Continued

“Subrogation” shall mean the Plan’s right to pursue the Covered Person’s claims for medical or other charges paid by the Plan against Another Party.

If the Covered Person retains an attorney, that attorney must sign the Subrogation and Reimbursement Agreement as a condition to any payment of Benefits and as a condition to any payment of future Benefits for other illnesses or injuries. Additionally, the Covered Person’s attorney must recognize and consent to the fact that the Plan precludes the operation of the “made-whole” and “common fund” doctrines, and the attorney must agree not to assert either doctrine in his pursuit of Recovery. The Plan will neither pay the Covered Person’s attorneys’ fees and costs associated with the recovery of funds, nor reduce its reimbursement pro rata for the payment of the Covered Person’s attorneys’ fees and costs. Attorneys’ fees will be payable from the Recovery only after the Plan has received full Reimbursement.

A Covered Person or his attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. Furthermore, a Covered Person agrees to direct his or her attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) that he or she has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. A Covered Person or his attorney who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan, because the Covered Person or his attorney is not the rightful owner of the Recovery and should not be in possession of the Recovery until the Plan has been fully reimbursed out of the Recovery.

These provisions apply to the parents, trustee, guardian or other representative of a minor Covered Person and to the heir or personal representative of the estate of a deceased Covered Person, regardless of applicable law and whether or not the minor’s representative has access or control of the Recovery.

When a Covered Person does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for Benefits by the Covered Person and to deny or reduce future Benefits payable (including payment of future Benefits for other injuries or illnesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future Benefits (including future Benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Covered Person to enforce this provision, then that Covered Person agrees to pay the Plan’s attorneys’ fees and costs, regardless of the action’s outcome.

In certain circumstances, a Covered Person may receive a Recovery that includes amounts intended to be compensation for past and future expenses for treatment of the illness or injury, which is the cause of the Recovery. This Plan will not cover any expenses for which compensation was provided through a previous Recovery. This exclusion will apply to the full extent of such Recovery or the amount of the expenses submitted to the Plan for payment, whichever is less. The Plan also precludes operation of the made-whole and common-fund doctrines in applying this provision.

It is the responsibility of the Covered Person to inform the Plan Administrator when expenses are incurred related to an illness or injury for which a Recovery has been made. The Covered Person is required to submit full and complete documentation of any such Recovery in order for the Plan to consider eligible expenses that exceed the Recovery.

Medicare Program

Beneficiaries who are covered under Medicare will be subject to coordination of Benefits with the USC EPO Plus Plan assuming primary payor status to the extent required by applicable law. Medicare assuming secondary payor status may pay the balance of the remaining Eligible Expenses, if any, less payments from the Plan. All applicable Copayments and Coinsurance will remain the Covered Person’s responsibility. To the extent Medicare is the primary payor under applicable law, the Plan will be the secondary payor. For example, to the extent permitted by law the USC EPO Plus Plan (the Plan) will be secondary to Medicare for a Covered Person who has been eligible for Medicare for 30 months due to End Stage Renal Disease (ESRD) or for a disabled employee who is not actively working and is eligible for Medicare due to that disability. In such cases, the USC EPO Plus Plan will pay on a secondary basis to Medicare, even if the Medicare-eligible Covered Person has not enrolled in Medicare. Therefore, to prevent a gap in coverage, it is very important for a Medicare-eligible Covered Person, for whom the Plan can legally be a secondary payor to Medicare, to be covered by Medicare as soon as he or she is eligible or, if later, by

GENERAL INFORMATION — Continued

the first day of the ninth month of any available Medicare Part B Special Enrollment Period immediately following the Covered Person's termination of employment at USC. For any Covered Person enrolled in Medicare Part A, but not in Medicare Part B, and who is also enrolled for continuation coverage under COBRA for this Plan, the Plan will not estimate any Medicare Part B Benefits during the first eight months of COBRA and will instead pay as the primary payor. Contact Medicare for more information about Part B Special Enrollment Periods.

Termination Of Coverage

The coverage for yourself and your covered dependents will terminate if you cease to be an eligible employee or if the Plan is discontinued or if you or your covered dependent commits any fraudulent or illegal act in connection with participation in the Plan. The coverage for which contributions are required, if any, will terminate if you stop making contributions.

A dependent's coverage will terminate when he/she is no longer an eligible dependent. However, if you or any of your covered dependents cease to be eligible, you must initiate your deletion request through the Workday Employee Self Service system in order to remove that person from your coverage.

In the event of termination of employment, your coverage will terminate the last day of the month in which you terminate. In the event of termination for cause (fraud or illegal activity), subject to the ACA, termination will be retroactive to the date participation in the Plan commenced and the Plan will be entitled to full refund of all claims paid on behalf all Covered Persons.

Q & A

1. Q. Do I have to choose a Primary Care Physician (PCP) when I enroll in this Plan?
A. No. The USC EPO Plus Plan does not mandate you to choose a PCP; however, your PCP office visit copay will be lower when you do designate one.
2. Q. How do I change my Primary Care Physician (PCP) designation?
A. You can change your PCP designation any month, provided you make your change in the HealthComp website at hconline.healthcomp.com/usc before the 15th of the month for change to take effect the 1st of the following month.
3. Q. What is the difference between a Copayment and Coinsurance?
A. A Copayment is a fixed dollar amount, like \$150.00 for an Emergency Room visit. Coinsurance is a percentage of the cost of the visit, such as a 10% co-insurance for an x-ray or lab test done at the Keck Hospital of USC.
4. Q. I was treated by a provider who agreed to accept “whatever [my] insurance covers” as payment in full and not bill me for my Coinsurance. Why is the Plan refusing to pay for my treatment?
A. Under the terms of the USC EPO Plus Plan you have a legal obligation to pay your Coinsurance or Copayment. If you do not pay the provider what you are obligated to pay under the Plan, the Plan is released from its obligation to pay (See Exclusions, #5 and #22). This means that if a provider releases you from your obligation to pay the applicable Copayment and/or Coinsurance amounts, the Plan will not pay any amount for any Covered Service from that provider related to those waived Copayment or Coinsurance amounts. However, if a provider releases you from the amounts you must pay in excess of the lifetime limits for infertility Benefits, that release will not affect the Plan’s payment for those Benefits up to those limits.
5. Q. How can I find out if my Doctor has already billed my insurance for a service I had done?
A. You can register on HealthComp’s website at hconline.healthcomp.com/usc as a “Member” and you will be able to view all of your claims received and processed by HealthComp.
6. Q. Are routine eye exams covered under the EPO Plus Plan?
A. No. Routine eye exams are not covered.
7. Q. My dependent child who is covered under my insurance needs to waive their college student health insurance offer. Where can I find our Plan’s Group Number that is being requested?
A. Use the “Anthem Group Number” located on the front of your dependent child’s Plan ID card.

NOTICE OF NON-DISCRIMINATION

USC EPO Plus Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. USC EPO Plus Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

USC EPO Plus Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Alice Chen.

If you believe that the USC EPO Plus Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Alice Chen, Assistant Vice President, USC Health Plans, 851 Downey Way, Suite 101B, Los Angeles, CA 90089-1057, telephone: 213-740-0035, fax: 213-740-0265, email: chenalic@usc.edu. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Alice Chen, Assistant Vice President, USC Health Plans, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

If you speak Spanish, Chinese, Vietnamese, Tagalog, Korean, Armenian, Persian-Farsi, Russian, Japanese, Arabic, Punjabi, Cambodian, Hmong, Hindi, or Thai, language assistance services, free of charge, are available to you. Call 1-213-740-0035.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-213-740-0035.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-213-740-0035。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-213-740-0035.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-213-740-0035.

NOTICE OF NON-DISCRIMINATION – Continued

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-213-740-0035 번으로 전화해 주십시오.

ՈՒՇԱԴՐՈՒԹՅՈՒՆՆԵՐ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Ջանգահարեք 1-213-740-0035.

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-213-740-0035 تماس بگیرید.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-213-740-0035.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-213-740-0035 まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-213-740-0035 (رقم هاتف الصم والبكم).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-213-740-0035 'ਤੇ ਕਾਲ ਕਰੋ।

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អឺ គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-213-740-0035 ។

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-213-740-0035.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-213-740-0035 पर कॉल करें।

เรียນ: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-213-740-0035.

NO SURPRISES ACT NOTICE

Notice of Your Rights and Protections Against Surprise Medical Bills

When you receive emergency care or you are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network. “Out-of-network” means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called “**balance billing**”. This amount is likely more than in-network costs for the same service and may not count toward your plan's deductible or annual out-of-pocket limit. “Surprise billing” is an unexpected balance bill. This can happen when you don't have control over who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and receive emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). An out-of-network provider cannot balance bill you for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you receive services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **cannot** balance bill you and **may not** ask you to give up your protections not to be balance billed. If you receive other types of services at these in-network facilities, out-of-network providers **cannot** balance bill you, unless you give written consent and give up your protections. **You are never required to give up your protections from balance billing. You are also not required to get out-of-network care. You can choose a provider or facility in your plan's network.**

When balance billing is not allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (such as copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Your health plan generally must: Cover emergency services without requiring you to get approval for services in advance (also known as “prior authorization”). Cover emergency services by out-of-network providers. Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits. Count any amount you pay for emergency services and certain out-of-network provider services performed at an in-network hospital or ambulatory surgical center toward any in-network deductible and out of pocket.

If you believe you have been wrongly billed, visit <https://www.cms.gov/nosurprises/consumers> or call 1-800-985-3059.

Visit www.cms.gov/nosurprises for more information about your rights under federal law.

NO SURPRISES ACT NOTICE – Continued

Benefits of Using In-Network Providers and Facilities

The above protections are very important. There are still some benefits of using in-network providers and facilities whenever reasonably possible and medically appropriate. For example, if you intend on voluntarily seeing a network provider after stabilization of your emergency for that condition, in some cases it may be a smoother transition if the emergency care was also provided by an in-network provider or facility. Furthermore, for a provider or facility to be treated as in-network, the provider or facility is subject to credentialing and oversight by Anthem, the Anthem Provider Network Administrator. If you have questions about network provider availability for emergency care, visit [anthem.com/ca](https://www.anthem.com/ca) and choose Prudent Buyer PPO/EPO.

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