



**Collective
Health[®]**



2021 Plan Details

Tower Semiconductor PPO

Hello!

Welcome to your Tower Semiconductor PPO plan, presented in partnership with Collective Health.

We always try to keep things simple at Collective Health. This booklet is not exactly short, but here's why it's important to share it with you: this is your summary plan description (SPD). It describes the benefits of your health plan and it's something that you can refer to when you have questions.

This SPD is organized by topic so you can quickly find what you need. Here are some of the topics that you can read about inside:

- What's covered by the plan, what's not covered, and how much you can expect to pay for your healthcare
- Who is eligible for coverage, and how to enroll
- When your coverage begins and ends, and when you might be able to continue coverage
- How to submit a claim, and what to do if your claim is denied
- Your rights and responsibilities as a member of this plan

Collective Health wants to help you understand everything about your healthcare benefits and what's covered for you and your dependents. You can get 24/7 access to information about your plan and your healthcare claims by activating your account at my.collectivehealth.com. If you have any additional questions, get in touch with us by calling 833-440-1639 or chatting with one of our Member Advocates through my.collectivehealth.com or mobile app from 4 am to 6 pm PT, Monday through Friday, and 7 am to 11 am PT on Saturdays. You can also sign into your Collective Health account and use Messages to communicate with a Member Advocate directly.

Here's to a happy and healthy year ahead!

Este folleto tiene un resumen en inglés de los derechos y beneficios de su PPO plan. Si tiene dificultades entendiendo la información que se encuentra aquí, por favor contacte 833-440-1639. También nos puede contactar directamente ingresando a su cuenta de Collective Health y usando la opción "Messages."

本手册含有您 PPO plan 保险计划提供的福利和权利的英文总结。如果您对本手册的内容有任何疑问, 请拨打 833-440-1639。你也可以登入你的 Collective Health 账号, 用 Messages 功能和我们直接交流。

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Fast Facts About Your Health Plan

What kind of health plan is this?

This is a "PPO" (preferred provider organization) plan. This includes a preferred network (Anthem Blue Cross of California) that includes many, but not all, doctors and hospitals. You do not need to designate a primary care physician or get your primary care physician's referrals to see specialists; you can see the doctors you choose for your medical needs. If you see in-network doctors, you will generally pay less than if you see doctors out-of-network.

Who pays?

The Tower Semiconductor PPO is a self-insured healthcare plan. That means there is no health insurance company paying for your claims; Tower Semiconductor Newport Beach Inc. ("Tower Semiconductor") is the plan sponsor, and they pay doctors and hospitals for the medical care you receive. Collective Health partners with Tower Semiconductor and takes on many administrative responsibilities for this plan (such as processing your claims and answering your questions). Anthem Blue Cross of California provides the medical network for the plan, and gives you access to a nationwide network of healthcare providers through the BlueCard program. CVS Caremark provides pharmacy benefit management services for the plan. You help pay for the cost of your healthcare under this plan. More information about cost sharing is in Section 3.

Key Plan Information

- The plan year begins on January 1 and ends on December 31.
- Depending on how many people you enroll, your in-network deductible will be:
 - > \$500 for an individual
 - > \$1,500 for your family
- Depending on how many people you enroll, your in-network out-of-pocket maximum will be:
 - > \$3,000 for an individual
 - > \$9,000 for your family
- Find information about what's covered in Section 5. Information about what's not covered is in Section 6.

Questions? We're here to help.

Register for 24/7 access to your healthcare information at my.collectivehealth.com. Collective Health Member Advocates are available at 833-440-1639. You can also sign into your Collective Health account and use Messages to communicate with a Member Advocate directly.

Section 1: Who Is Eligible for Coverage

Eligible Employees

If you are an active, full-time Non-Union Employee, meaning you have begun working for the Company, and you are normally scheduled to work at least 30 hours per week, you are also eligible to participate in this plan. You can cover yourself, your eligible child dependents, and your spouse or domestic partner; coverage for dependents of dependents is not available.

You—a Union Employee at the Newport Beach location at Tower Semiconductor and its family of companies ("the Company")—are eligible to participate in this plan if you are an active, full-time employee, meaning you have begun working for the Company, and you are normally scheduled to work at least 30 hours per week. If you choose to participate in this plan, in addition to covering yourself, you may also elect to cover your eligible child dependents, and your spouse or domestic partner; coverage for dependents of dependents is not available.

Eligible Dependents

When you enroll someone in addition to yourself on your plan, they are called your “dependent.” They become eligible for coverage when you become eligible for coverage. Your contribution may be higher if you choose to enroll your dependent(s).

Your spouse is the person to whom you are legally married and who is treated as your “spouse” for tax purposes. You may be required to provide documentation that an individual is your spouse, such as a marriage license or registration certificate. Your domestic partner is the person with whom you are in a committed relationship that is substantially similar to a marriage. You may be required to provide documentation that an individual is your domestic partner, such as a notarized affidavit documenting your partnership.

For a child to be eligible to join this plan as your dependent, they must be one of the following:

- Your natural child
- Your spouse's natural child (stepchild)
- Your domestic partner's natural child
- Your adopted child
- Your spouse's adopted child
- Your domestic partner's adopted child
- A child placed with you for adoption (meaning the legal process of adoption has begun, and you have taken some responsibility for that child)
- A child placed with your spouse for adoption (meaning the legal process of adoption has begun, and you have taken some responsibility for that child)
- A child placed with your domestic partner for adoption (meaning the legal process of adoption has begun, and you have taken some responsibility for that child)
- Your foster child

- Your spouse's foster child
- Your domestic partner's foster child
- A child for whom you have been named legal guardian
- A child for whom your spouse has been named legal guardian
- A child for whom your domestic partner has been named legal guardian
- A child for whom you must provide coverage because of a Qualified Medical Child Support Order (QMCSO)
- A child for whom your spouse must provide coverage because of a QMCSO
- A child for whom your domestic partner must provide coverage because of a QMCSO

A child dependent can be deemed eligible for medical coverage up until the end of the month that they turn age 26. Your child must be a US citizen or a resident of the United States, Mexico, or Canada.

If you have a child that has a severe physical or mental condition that makes them indefinitely dependent on you for primary support, then they will continue to be eligible after age 26, as long as their condition and dependency persists. You may be required to provide information or documents to prove your child's eligibility for coverage (such as tax records, birth certificates, or documentation of your child's disability).

Who Cannot Be Your Dependent?

Some people are not eligible to participate in this plan as your dependents, even if they meet the criteria above:

- Your former spouse, if you are legally separated or divorced
- Your former domestic partner, if your relationship has ended
- Anyone who is separately covered under this plan as an employee
- Any child who is separately covered under this plan as another employee's dependent

Section 2: Enrollment & When Coverage Begins

You must be enrolled in this plan to receive benefits from this plan. If you want your dependents to receive benefits, you must enroll them too. No one can receive the benefits of this plan without being enrolled for coverage.

Each year, the Company will set the procedures for all eligible employees to enroll themselves and their eligible dependents for health benefits. You must follow these procedures to enroll yourself and your dependents, including authorizing the Company to deduct your contribution directly from your paycheck.

You can only enroll yourself and your dependents at specific times of the year:

- During the annual open enrollment period
- After you are newly hired or first become eligible

- During a special enrollment period after a qualifying event

If you miss your enrollment window, your enrollment will be considered “late” and your coverage will not begin until the next plan year. You must enroll on time to get covered on time.

Annual Open Enrollment Period

Each year, before the new plan year begins, there will be an open enrollment period. During the open enrollment period, you may choose whether you would like to be covered by this plan for the next plan year, and you may add or remove dependents. If multiple health benefits options are available, you will be able to choose the package you prefer. The Company will determine when and how long the open enrollment period will be.

The selections you make during open enrollment will become effective at the beginning of the next plan year, which is January 1st. You won't be able to change your selections again until the next open enrollment period, unless you experience a qualifying event during the year.

New Hire or Newly Eligible Employee Enrollment

If you begin work at the Company and are eligible for health benefits, you will have an opportunity to choose whether you would like to participate in this plan, and whether you want to enroll your dependents. The same is true if you become newly eligible while employed at the Company (for example, if you switch from part-time to full-time). You must enroll for coverage within 31 days of becoming eligible.

If you are a new Union Employee, you must satisfy a 30-day waiting period before you become eligible for healthcare benefits. After you satisfy the waiting period, which starts on the first day you meet the eligibility criteria (for new hires: on your date of hire), your coverage will begin. If you are a newly eligible Union Employee, your coverage will begin on the first day you meet the eligibility criteria.

If you are a new or newly eligible Active Non-Union Employee, your coverage will begin on the first day you meet the eligibility criteria (for new hires: on your date of hire).

Special Enrollment Periods

In general, once you make your coverage selections during open enrollment or new hire enrollment, those choices are fixed for the plan year and can't be changed. But certain events trigger special enrollment periods, where you will be allowed to make changes to your coverage selections outside of open enrollment.

1. You can enroll mid-year if you lose other healthcare coverage. You might initially decline coverage because you or your dependents are already covered by another group health plan, or by insurance from another source (including COBRA). For example, you may be a dependent on your spouse's plan, and for that reason you may decline to enroll in your company's health benefits during your initial new hire/newly eligible period or open enrollment. If you or your dependents lose your healthcare coverage from that other source (or if your dependent's company stops contributing toward that other coverage), you have the right to enroll yourself and all of your eligible dependents in this plan. But you must enroll within 31 days after the other coverage ends (or the

company stops contributing). If you enroll on time, your coverage will be effective as of the date you enroll in the plan.

2. You can enroll if you get married or have a child. If you acquire a new dependent as described in the “Eligible Dependents” section through an event such as marriage, birth, adoption, placement for adoption, or a Qualified Medical Child Support Order (QMCSO), you have the right to enroll yourself and your eligible dependents in your company’s health plan. But you must enroll within 31 days after that life event (for example, after your marriage or after your child is born). If the special enrollment is due to the birth or adoption of a child, coverage will be retroactive to the date of birth or adoption. Otherwise, your family's coverage will begin on the first day of the month after you submit your enrollment request.

3. You can enroll if you gain or lose coverage under Medicaid or a state children’s health insurance program. If you or your dependents lose coverage under your state’s Medicaid or children’s health insurance program (CHIP), or you become eligible for health insurance subsidies under one of those programs, you will have the opportunity to enroll your family in this plan. You must enroll within 60 days of your Medicaid or CHIP eligibility change.

These special enrollment periods are governed by the Health Insurance Portability and Accountability Act (HIPAA) and will be interpreted to comply with HIPAA regulations and requirements. QMCSOs are governed by ERISA and will be interpreted to comply with ERISA regulations and requirements. Note that the plan also extends the special enrollment rights described above to domestic partners and their children.

There may be more circumstances where you have the right to enroll for coverage in the middle of a plan year. For additional information on eligibility, check your plan document (titled, "Tower Semiconductor EPO 2019 SPD 2019.01.28 Tower Semiconductor HDHP 2019 SPD 2019.01.28 Tower Semiconductor PPO 2019 SPD 2019.01.28"). Contact Tower Semiconductor's Benefits Team for more information.

Section 3: Your Contributions & Costs

Your membership in this plan includes a responsibility to contribute to the cost of your healthcare benefits. You may be required to pay an employee contribution. In most cases, when you actually receive healthcare services, you must also pay part of the cost of those services. The plan is designed so you generally pay less when you use providers and facilities in the Anthem Blue Cross of California network.

Employee Contribution

You do not pay employee contributions to participate in this plan, but Tower Semiconductor has discretion to change it. If there is a substantial increase in costs, you may be given an opportunity to change your benefits selections.

How the Network Can Work for You

Your membership in this plan includes access to a network of healthcare service providers (doctors, nurses, and other licensed professionals) and facilities (such as hospitals, urgent care centers, and pharmacies). The providers and facilities in this network have agreed to accept negotiated rates for the services they provide to you and your dependents. Because health services from in-network providers and facilities often cost less than the same services outside the network, this plan is designed to encourage you to use in-network services whenever possible. Please note that if you have signed a waiver with an in-network provider, they may bill you for amounts in excess of the network's allowed amount. This amount will not be covered by the plan (see Section 4 for other circumstances for which you may be responsible for the full cost of your care).

- Anthem Blue Cross of California is this plan's preferred medical network. Through Anthem Blue Cross of California, you have access to providers outside of California in the BlueCard program. You can find additional important information about Anthem Blue Cross of California and BlueCard in Appendix A. Anthem Blue Cross of California, an independent member of the Blue Shield Association, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.
- This plan's preferred pharmacy network is CVS Caremark, which includes all major retail pharmacies as well as a mail order pharmacy option.
- The plan may also have preferential arrangements that provide enhanced benefits if you use specific healthcare facilities or services.

In most circumstances, this plan provides richer benefits for services provided by in-network healthcare providers or facilities. If you receive services out-of-network, you will generally be responsible for a greater share of the cost.

If your in-network doctor refers you to an out-of-network provider or facility for a covered service, or you choose to see an out-of-network provider because there is no in-network provider available, the plan may authorize the in-network benefits to an out-of-network provider claim. If this applies to your situation, please contact Collective Health in advance of obtaining the covered service. If you receive authorization for in-network benefits to apply to a covered service received from an out-of-network provider, you may still be responsible for the difference between the allowed amount and the out-of-network provider's billed amount.

Ultimately, the choice of which provider or facility to use (whether in- or out-of-network) is yours. To find out whether a doctor is in your network, check my.collectivehealth.com or contact a Collective Health Member Advocate. Because provider or facility network status may change throughout the year, it is best practice to always double check with the provider or facility on their current status with the Anthem Blue Cross of California network. If you receive care from an out-of-network provider (other than your primary doctor) during a stay at an in-network facility, you may be entitled to your plan's in-network benefits.

This plan requires your provider to have specific credentials in order to cover your treatment. This helps the plan ensure that you receive medically necessary, quality care. In most cases, the required credentials are state medical licenses, which must be active and unrestricted in the state where you are receiving care.

If a provider's license is not active or current, your claim will not be covered. If a provider has an active professional certification to provide covered benefits in that state, the claim will be covered. If a mental or behavioral health provider, with the appropriate and relevant training, is practicing under the guidance of a licensed and active provider, the claim will be covered as long as the services rendered are covered benefits on your plan.

The following table provides examples of specific provider credentials required for plan coverage. If you choose to visit an out-of-network provider, make sure to confirm that the provider has the appropriate credentials to administer the care you need. You may be responsible for submitting validation of their credentials. Contact Collective Health if you have questions about your specific provider. Remember that services still need to be medically necessary to be covered by your plan.

Provider Type	Sample Credentials by Provider Type
Acupuncturist	Licensed Acupuncturist (LAc) Doctor of Oriental Medicine (DOM)
Audiologist	Doctor of Audiology (Au.D) American Board of Audiology (ABA) Certified Audiologist
Chiropractor	Doctor of Chiropractic (DC)
Dentist	Doctor of Dental Surgery (DDS) Doctor of Medicine in Dentistry (DMD)
Lactation consultant	International Board Certified Lactation Consultant (IBCLC), Academy of Lactation Policy and Practice (ALPP)
Massage Therapist	Licensed Massage Therapist (LMT)
Midwife	Certified Nurse Midwife (CNM) (certified midwives are not covered)
Naturopath	Doctor of Naturopathy (ND) Doctor of Naturopathic Medicine (NMD)
Nurse	Nurse Practitioner (NP) Registered Nurse (RN) Licensed Vocational Nurse (LVN)
Nutritionist or Registered Dietician	Licensed Dietitian (LD) Licensed Nutritionist (LN) Licensed Dietician Nutritionist (LDN)
Occupational Therapist	Registered/Licensed Occupational Therapist (OTR)
Optometrist	Doctor of Optometry (OD)
Pharmacist	Doctor of Pharmacy (PharmD)
Physician	Doctor of Medicine (MD) Doctor of Osteopathic Medicine (DO)
Physical Therapist	Physical Therapist (PT) Master of Physical Therapy (MPT or MSPT) Doctor of Physical Therapy (DPT)
Physician Assistant	Physician Assistant (PA)

Provider Type	Sample Credentials by Provider Type
Podiatrist	Doctor of Podiatric Medicine (DPM)
Psychiatrist	Doctor of Medicine (MD) Doctor of Osteopathic Medicine (DO)
Psychologist	Clinical Psychologist (PhD) Doctor of Psychology (PsyD)
Respiratory Care Practitioner	Certified Respiratory Therapist (CRT) Registered Respiratory Therapist (RRT)
Speech Therapist/Pathologist	Licensed Speech Language Pathologist (SLP)
Therapist/Counselor/Social Worker	Licensed Clinical Social Worker (LCSW) Licensed Master Social Worker (LMSW) Marriage and Family Therapist (MFT/LMFT)

If you have questions about whether your provider may be covered by your plan, contact Collective Health.

Allowed Amounts

One benefit of visiting an in-network doctor or hospital is that Anthem Blue Cross of California has negotiated the rates for most healthcare services in advance. When you choose to visit an out-of-network provider or facility for medical treatment, it's much harder to know how much your treatment might cost. The providers may charge a reasonable rate for the services they provide you, or they may charge a lot more.

This plan will not pay charges that are excessive. Instead, this plan sets an allowed amount for each medical service, and this allowed amount is the most the plan will pay for that service when you receive it from an out-of-network provider. Allowed amounts are determined by reference to industry benchmarks. The plan will use Medicare reimbursement rates as a benchmark and will set the allowed amount as 200% of the Medicare reimbursement rate. If Medicare pricing is not available, the plan will set the allowed amount to 40% of charges. The allowed amount for out-of-network emergency room and ambulance claims may be based on your medical network's in-network pricing. You may contact Collective Health for more information.

Because the plan doesn't have contracts in place with out-of-network providers, those providers may charge more than the allowed amount for the treatment you receive. Your benefits under this plan will be based on the allowed amount, and the provider may bill you for the excess. (This practice is called balance billing.) It is your responsibility to pay any amounts in excess of the allowed amount—in addition to any deductibles, copays, or coinsurance. Balance billed charges can be significant, and they also don't count toward your out-of-pocket maximum. If you choose to see an out-of-network provider, you may want to ask them about their billed charges before you receive care.

If you can gather some information from your out-of-network provider in advance, Collective Health can help you determine whether you're likely to be balance billed. Contact Collective Health for guidance.

If you are balance billed by an out-of-network provider at an in-network facility or after an out-of-network ambulance ride or emergency room visit, please contact Collective Health. You may be eligible for additional coverage.

Paying for Treatment You Receive

For most healthcare services, the plan pays for some, but not all, of the cost of treatment. Generally, you and the plan share the cost of your care. This plan shares the cost of healthcare with you in a couple of ways: an annual deductible, copays, coinsurance, and an out-of-pocket maximum (OOPM).

Until you hit your OOPM, you'll have to share the cost of your healthcare with the plan. You'll have to meet an annual deductible, and also pay a copay or coinsurance for most services you receive.

Coverage Tier	In-Network Deductible	Out-of-Network Deductible
Individual	\$500	\$1,000
Family	\$1,500	\$3,000

What is a deductible?

- A deductible is the amount you'll pay up-front for care until your benefits kick in. This applies only to some benefits.
- Remember that in-network preventive care is fully covered, even if you haven't met your deductible yet.

What is the difference between copays (\$) and coinsurance (%)?

- Copays are fixed dollar amounts. You typically pay the copay at the time you receive a medical service or fill a prescription.
- Coinsurance is a percentage of the cost of care. Your provider will typically bill you later.
- The cost sharing for each medical service, and whether or not the deductible applies to the benefit, is listed in the benefits table in Section 5.

What spending counts toward your deductible?

- The amount you pay for covered prescriptions does not accumulate toward your medical deductible. Additionally, you do not need to meet your medical deductible before your pharmacy benefits kick in.
- Benefits can interact differently with your deductible:
 - › Some benefits are entirely separate from your deductible. For these benefits, if a service requires a copay or coinsurance, you only pay that amount, even if you haven't met your deductible. However, when you pay these copay or coinsurance benefits, that amount doesn't accumulate toward your deductible.

- > For other benefits, you must pay the full cost of care for services until you meet your deductible for the year. After you've met your deductible, the benefits will kick in, and you'll be responsible only for your copay or coinsurance amount.
- Regardless of whether the medical service was in- or out-of-network, when you spend money on covered expenses, those dollars go toward satisfying both your in- and out-of-network deductibles.
- Your employee contributions don't count toward your deductible, and neither do the amounts you pay for non-covered services (like cosmetic surgery) or amounts in excess of the allowed amount.

How do deductibles work if you have a family plan?

- Each person on the plan has an individual deductible. After an individual reaches their individual deductible, their coinsurance benefits will kick in. Even on a family plan, no one member will ever have to satisfy more than their individual deductible.
- If you have dependents, then your family has a family deductible. Once your whole family combined has paid enough to meet the family deductible, benefits will kick in for the entire family. This is true even for members who haven't yet hit their individual deductible.

The OOPM is the most you'll be required to pay for covered services in a plan year.

Coverage Tier	In-Network Out-of-Pocket Max	Out-of-Network Out-of-Pocket Max
Individual	\$3,000	\$10,000
Family	\$9,000	\$30,000

What spending counts toward your OOPM?

- All money you pay for covered medical and pharmacy services counts toward your OOPM (including your deductible, copays, and coinsurance).
- Regardless of whether the medical service was in- or out-of-network, when you spend money on covered expenses, those dollars go toward satisfying both your in- and out-of-network OOPMs.
- Your employee contributions don't count toward your OOPM, and neither do the amounts you pay for non-covered services (like cosmetic surgery) or balance-billed amounts.

What happens after you hit your OOPM?

- Once you meet your OOPM for in-network care, the plan will pay for all of your covered in-network healthcare costs for the rest of the plan year. Your out-of-network OOPM works the same way.
- Remember that the OOPM only applies to covered services; even after you hit your OOPM, the plan won't pay for non-covered services or amounts in excess of the allowed amount.

How do OOPMs work if you have a family plan?

- Each person on the plan has an individual OOPM. After an individual reaches their individual OOPM, their healthcare will be fully covered by the plan, and they won't have to share the cost of medical and pharmacy services.
- Your whole family's costs are also capped at the family OOPM amount. Once your family's covered medical and pharmacy costs hit the OOPM, all enrolled members will have full coverage for the rest of the plan year. This is true even if some individuals haven't yet hit their individual OOPM.

Assignment of Benefits

You (or your dependents) may not assign or transfer in any manner your benefits or other rights that you have under this plan (other than with the express written consent of the plan sponsor or plan administrator or as expressly required by law). For example, you may not assign your rights to receive payment for medical services under this plan to your doctor.

Section 4: Quality & Value Programs

Maximum Medical Benefits

This plan does not cap the total aggregate value of medical benefits you can receive, either in a given year or over your lifetime as a plan member. So long as you remain eligible, and your treatment falls within the scope of the plan and the allowed amount, your healthcare costs will continue to be covered by the plan.

If specific services have maximum visits or benefit caps, that information will be clearly stated alongside the service costs in the benefit table in Section 5.

Prior Authorization for Certain Procedures

This plan requires your provider to receive prior authorization for certain services. This means the provider must get clearance from the plan in advance, before providing treatment to you. If the provider does not get prior authorization for a service that requires it, the plan may not pay for the treatment. You may be responsible for the full cost of your care in the following cases:

- Your provider does not apply for prior authorization or a post-service review (also called a "post authorization") with the medical network.
- The prior authorization or post-service review is denied.
- You sign a waiver promising to pay for charges not allowed by your plan.

Prior authorization is typically required anytime you will be admitted to the hospital on an elective (non-emergency) basis—for example, if you need to be admitted for a scheduled surgery. Prior authorization may also be required for services such as non-emergency imaging (CT, MRI, MRA, and PET scans), rental or purchase of certain durable medical equipment, and intensive spinal procedures (surgery, injections, and implants). Routine preventive care services never require prior authorization. When a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, could cause severe pain, your provider should request expedited processing.

The prior authorization requirements change from time to time. The current list of services requiring prior authorization will always be available from Anthem Blue Cross of California. Please visit www.anthem.com/provider/prior-authorization/ to see which services require a prior authorization.

If prior authorization is denied, your physician can appeal that denial. You can also file your own appeal with Anthem Blue Cross of California to contest a prior authorization denial (see Section 9).

If you have questions about prior authorization in general, or about whether a specific treatment needs prior authorization, contact Collective Health. If you would like to request a prior authorization, contact Anthem Blue Cross of California.

Case Management Services

This plan's preferred medical network, Anthem Blue Cross of California, also provides a case management program for members whose healthcare requirements are more complicated than usual. The purpose of case management is to improve both the quality and value of healthcare treatments.

Collective Health and Anthem Blue Cross of California will identify members who are likely to benefit from the case management program. If you are identified, a case manager (usually, a registered nurse) will reach out to you, your caregivers, and your healthcare providers. Your case manager can help you manage your healthcare by explaining your treatment options, coordinating care between multiple providers or facilities, and dealing with related issues holistically.

You also have access to a program called Care Navigation, an interdisciplinary care management program offered by Collective Health. The Care Navigation team will identify and engage members with more complex care needs. If you feel you could benefit from the Care Navigation program but no one has reached out to you, please contact Care Navigation at 833-834-1170.

Participation in the case management program is completely voluntary. You do not have to speak to the case manager if you prefer not to. Your participation (or not) in the case management program will not affect your benefits.

If you feel you could benefit from case management services but no one has reached out to you, you can contact Collective Health for a referral.

Get a Second Opinion

A second opinion is a process where you consult with an expert in the field of your diagnosis to make sure that your diagnosis is correct and that you are set on the right treatment path. We encourage you to get a second opinion under the following circumstances:

- You have, or are diagnosed with, a rare or complex condition that requires the navigation and understanding of treatment options.
- Whenever your doctor recommends that you have surgery—that is, any surgery that can be scheduled in advance (not an emergency). Even if your doctor recommends surgery, there may be other, less invasive treatment options that could give you as good (or better) results. In some cases, having surgery could actually make your overall health worse.

In these situations, not only can you get a second opinion—you can even get a third opinion if you wish. A second or third opinion is 100% voluntary, and you are not required to get one if you prefer not to. You can choose to get a second or third opinion anytime your doctor recommends elective surgery, for any reason.

The doctor who gives you a second (or third) opinion about your complex condition or elective surgery would be independent from the doctor who either diagnosed you or recommended the surgery in the first place.

How much will this cost? The plan will cover second and third opinions like other covered services described in Section 5. So, if you visit a specialist's office to get a second opinion, you will pay your regular copay or coinsurance for a specialist doctor visit. When you choose to visit an out-of-network provider or facility for medical treatment, the plan will cover the allowed amount, and the provider may balance bill you for any excess. It is your responsibility to pay any amounts in excess of the allowed amount—in addition to any deductibles, copays, or coinsurance.

Section 5: What's Covered & How Much It Costs

This section describes your plan's benefits in detail. Benefits are split into three categories: preventive care, emergency care, and everything else.

This plan covers most medically necessary healthcare services, except those that are specifically excluded. All services may be subject to a medical necessity review by the medical network or an independent review organization (IRO). The plan administrator and/or claims administrator has full discretionary authority to adjudicate benefit claims, including taking a holistic view of the member's healthcare needs and condition, and current and future financial implications. Section 6 of this document includes a definition of medical necessity as well as a list of services that are excluded from your plan.

Preventive Care

Preventive care is generally provided when you are well and is intended to keep you healthy. The federal government—specifically, the U.S. Preventive Services Task Force, the Health Resources and Services Administration, and the Centers for Disease Control and Prevention—has recommended certain healthcare services as preventive care.

This plan must cover the full cost of in-network preventive care services, even if you haven't met your deductible. You can get preventive care services from out-of-network providers if you choose, but this plan will pay for only part of the cost of out-of-network preventive care, and may require you to meet your deductible before benefits kick in. When you choose to visit an out-of-network provider or facility for preventive care services, the plan will cover the allowed amount, and the provider may balance bill you for any excess. If no in-network provider of a specific preventive care service is available in your geographic area, the plan will provide in-network benefits for that out-of-network care.

Certain medical services qualify as "preventive care" depending on your age, biological sex, medical conditions, or timing. The following services are examples of preventive care:

- Breastfeeding supplies and support (including breast pumps) if you become pregnant, both during pregnancy and while nursing.
- Colorectal cancer screening (including colonoscopy) for adults aged 50 to 75.
- Immunizations against whooping cough, measles, chickenpox, and other diseases for children from birth to age 18, at recommended doses and cadence.

Preventive and diagnostic care may occur during the same visit. For more information about which preventive services are recommended for you, visit www.healthcare.gov/coverage/preventive-care-benefits. Services you receive as part of your annual wellness exam may not always be considered preventive and be subject your plan's regular cost share. Please contact Collective Health for more information on the specific procedure and diagnosis codes that comprise your preventive benefits.

Service	Description	What You Pay
Preventive care for adults	<p>Routine annual physical exam and associated counseling and screening, including immunizations and some lab services.</p> <p>The list of recommended services is available at: www.healthcare.gov/preventive-care-adults</p>	<p>In-network:</p> <p>Fully covered (the plan pays 100%). You do not have to meet your deductible first.</p> <p>Out-of-network:</p> <p>You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>
Preventive care for women	<p>Annual well-woman exam and associated counseling and screening, including contraception, routine recommended mammograms, and lab services. Includes preventive care during pregnancy and breastfeeding support and supplies.</p> <p>The list of covered services is available at: www.healthcare.gov/preventive-care-women</p>	<p>In-network:</p> <p>Fully covered (the plan pays 100%). You do not have to meet your deductible first.</p> <p>Out-of-network:</p> <p>You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>
Preventive care for babies and children	<p>Periodic exams and associated counseling and screening, including immunizations, behavioral assessments and autism screening, and lab services.</p> <p>Also includes routine care for your healthy newborn child while they are in the hospital immediately after birth.</p> <p>Newborn care charges are only covered if you enroll your newborn within 31 days of birth—otherwise, charges will not be covered.</p> <p>The list of covered services is available at: www.healthcare.gov/preventive-care-children</p>	<p>In-network:</p> <p>Fully covered (the plan pays 100%). You do not have to meet your deductible first.</p> <p>Out-of-network:</p> <p>You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>

Emergency Care

Emergency care is designed to diagnose and treat an illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm. You should seek emergency care in an urgent care center or in a hospital's emergency room.

Urgent care centers are generally cheaper than emergency rooms, especially if you use an urgent care center in your network. If you are in a position to choose—and if you know your condition is not too serious—you should consider going to a local urgent care center instead of a hospital emergency room. If your condition is life-threatening (or you're not sure), you can and should go to the emergency room.

This plan provides the same level of coverage for in-network and out-of-network emergency care in an emergency room. The same level of coverage is provided if you need emergency care when you are traveling outside the United States. The out-of-network provider may balance bill you for the difference between its charge and the allowed amount paid by the plan. If you are balance billed after an out-of-network ambulance ride or emergency room visit, please contact Collective Health within one year of the statement date, which is located at the top of your medical benefits statement. You may be eligible for additional coverage. See Appendix A for additional information about access to Anthem Blue Cross of California's network services outside the U.S. These providers will be out-of-network but may assist with coordinating your coverage.

This plan covers medically necessary emergency air and ground ambulance services.

Ground emergency ambulance services are considered medically necessary when all of the following criteria are met:

- The ambulance is equipped with appropriate emergency and medical supplies and equipment;
- The patient's condition is such that any other form of transportation would not be advisable by a physician or other licensed medical provider; and
- The member is transported to the nearest hospital with the appropriate facilities and requisite level of care for the treatment of the member's illness or injury.

Air ambulance services are considered medically necessary when all of the criteria pertaining to ground transportation (listed above) are met and at least one of the following criteria are met:

- The member's medical condition requires immediate and rapid ambulance transport to the nearest appropriate medical facility that could not be reached by land ambulance;
- The point of pick-up is inaccessible by a ground ambulance;
- Great distances, limited time frames, or other obstacles limit the member's access to the nearest hospital with appropriate facilities for treatment; or
- The member's condition is such that the time needed to transport the member by land to the nearest appropriate medical facility poses a threat to the member's health.

Service	Description	What You Pay
Emergency ambulance	<p>Medically necessary emergency transport by an air or ground ambulance to the nearest hospital with the appropriate facilities and requisite level of care for the treatment of the member's illness or injury.</p> <p>An ambulance is a specially designed vehicle that is staffed with qualified medical personnel and appropriately equipped to provide life-saving and supportive treatments or interventions during the transportation of ill or injured members. See "Emergency Care" above for more details on ambulance service requirements.</p>	<p><i>May require a prior authorization.</i></p> <p>In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 10% of the cost; the plan pays the rest.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 10% of the allowed amount; the plan pays the remainder of the allowed amount.</p> <p>Regardless of whether you receive services in-network or out-of-network, this benefit is subject to your in-network deductible and out-of-pocket maximum.</p>
Emergency room expenses	<p>Services and supplies in a hospital emergency room (including doctor fees), which are required to stabilize you or initiate treatment in an emergency.</p> <p>Follow-up treatment after you leave the emergency room is covered separately.</p> <p>If you go to an emergency room and you are admitted to the hospital, your emergency room copay is waived.</p>	<p>In-network: You pay a \$150 copay per visit. After that, you pay the remaining cost of this service until you've met your deductible. Then, you pay 10% of the cost; the plan pays the rest.</p> <p>Out-of-network: You pay a \$150 copay per visit. After that, you pay the remaining cost of this service until you've met your deductible. Then, you pay 10% of the allowed amount; the plan pays the remainder of the allowed amount.</p> <p>Regardless of whether you receive services in-network or out-of-network, this benefit is subject to your in-network deductible and out-of-pocket maximum.</p>
Urgent care center expenses	<p>Services and supplies in a licensed urgent care center, for conditions reasonably requiring immediate treatment.</p> <p>An urgent care center is a clinic or acute-care facility that provides outpatient treatment for illnesses or injuries that require immediate treatment but are not necessarily life-threatening.</p>	<p>In-network: You pay a \$50 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible).</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>

Treatment for Medical Conditions other than Preventive or Emergency Care

The benefits table on the following pages describes what the plan will pay for medical treatment other than preventive or emergency care. Different medical services may require you to pay different copays or coinsurance, and some services are subject to limits and annual benefit maximums. When you choose to visit an out-of-network provider or facility for medical treatment, the plan will cover the allowed amount, and the provider may balance bill you for any excess. It is your responsibility to pay any amounts in excess of the allowed amount—in addition to any deductibles, copays, or coinsurance.

The table below may not fully address every possible medical situation. If you have questions about how your unique medical needs may be covered by the plan, contact Collective Health.

Service	Description	What You Pay
Acupuncture	Acupuncture and associated treatment by a licensed provider.	<p>In-network: You pay a \$40 copay per session; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible).</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>
Addiction treatment	<p>Care by (or directed by) psychiatrists, psychologists, counselors, social workers, or other appropriate licensed healthcare providers to treat the dependency on, and excessive use of, chemical substances.</p> <p>Plan coverage for addiction treatment services depends on the setting of your treatment: in an office visit, in an outpatient facility, or in an inpatient or residential facility.</p> <p>Tobacco: Prescription therapies to quit smoking are covered by your pharmacy benefits.</p>	<p><u>Office visits</u> <i>Certain services or items provided during your visit may require prior authorization. Please see Section 4 for how to check for prior authorization requirements.</i></p> <p>In-network: You pay a \$40 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible).</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p> <hr/> <p><u>Outpatient facility</u> <i>May require a prior authorization.</i></p> <p>In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 10% of the cost; the plan pays the rest.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>

Service	Description	What You Pay
		<p><u>Inpatient/Residential stay</u> <i>May require a prior authorization.</i></p> <p>In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 10% of the cost; the plan pays the rest.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>
Allergy care	Testing and appropriate treatment (including allergy serum and injections) by a healthcare provider.	<p><u>Allergy testing</u></p> <p>In-network: Services and supplies are covered based on who provides your care and where you receive your treatment.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p> <hr/> <p><u>Allergy serum/Allergy therapy</u></p> <p>In-network: Services and supplies are covered based on who provides your care and where you receive your treatment.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>

Service	Description	What You Pay
Ambulance (non-emergency)	<p>Medically necessary, non-emergency transport by an air or ground ambulance to the nearest medical facility where you can receive the treatment you need.</p> <p>An ambulance is a specially designed vehicle that is staffed with qualified medical personnel and equipped to transport an ill or injured person.</p>	<p><i>May require a prior authorization.</i></p> <p>In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 10% of the cost; the plan pays the rest.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 10% of the allowed amount; the plan pays the remainder of the allowed amount.</p>
Anesthesia	Medication, supplies, and administration of anesthetics when administered by a healthcare provider.	Anesthesia services and supplies are covered based on where you receive your treatment (for example, in a doctor's office or in a hospital).
Autism	Diagnosis, care and treatment for adults and children with autism spectrum disorders, including applied behavioral analysis and, physical, occupational, and speech therapies.	<p><u>Applied behavioral analysis/Applied behavioral therapy</u> <i>May require a prior authorization.</i></p> <p>In-network: You pay a \$40 copay per session; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible).</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>

Service	Description	What You Pay
		<p><u>Other rehabilitation services for mental health treatment</u></p> <p><i>May require a prior authorization.</i></p> <p>In-network: You pay a \$40 copay per session; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible).</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>
Auditory rehabilitation	Auditory rehabilitation, by a licensed therapist, as part of a short-term rehabilitative program following illness or injury.	<p>In-network: You pay a \$40 copay per session; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible).</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>
Bariatric surgery	<p><i>Coverage for bariatric surgery recipients only.</i></p> <p>Surgical procedures performed to induce weight loss in people for whom it is medically necessary.</p> <p><i>Travel expenses for bariatric surgery are not covered.</i></p>	<p><i>May require a prior authorization.</i></p> <p>In-network: Services and supplies are covered based on who provides your care and where you receive your treatment.</p> <p>Out-of-network: Services and supplies are covered based on who provides your care and where you receive your treatment.</p>

Service	Description	What You Pay
Cancer treatment	<p>Diagnosis and treatment for cancer, including doctor visits, labs and scans, radiation and chemotherapy treatment, and routine patient care costs for clinical trials (please see "Clinical trials," below).</p> <p><i>Travel expenses for cancer treatment are not covered.</i></p>	<p><u>Specialist visit</u></p> <p>In-network: You pay a \$40 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible).</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>
		<p><u>Labs</u></p> <p><i>May require a prior authorization.</i></p> <p>In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 10% of the cost; the plan pays the rest.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>
		<p><u>X-rays</u></p> <p><i>May require a prior authorization.</i></p> <p>In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 10% of the cost; the plan pays the rest.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>

Service	Description	What You Pay
		<p><u>Scans</u></p> <p><i>May require a prior authorization.</i></p> <p>In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 10% of the cost; the plan pays the rest.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p> <hr/> <p><u>Chemotherapy & radiation</u></p> <p><i>May require a prior authorization.</i></p> <p>In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 10% of the cost; the plan pays the rest.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>
Cardiac rehabilitation	Cardiac rehabilitation to treat or prevent heart attack, heart failure, or coronary artery disease, or to recover after heart surgery.	<p>In-network: You pay a \$40 copay per session; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible).</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>

Service	Description	What You Pay
Chiropractic care	Chiropractic treatment and spinal manipulation by a licensed provider.	<p><i>Limited to 20 sessions per year per member.</i></p> <p>In-network: You pay a \$40 copay per session; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible).</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>
Clinical trials	<p>Routine patient care (as defined by the ACA) costs provided as part of a clinical trial that is recommended by your physician and covered by the plan as determined upon medical necessity review.</p> <p>Routine patient care includes the non-experimental health services you receive during the clinical trial (doctor's visits, medical equipment, treatment of complications), but does not include the cost of unapproved drugs (including the subject of the trial) or research administration costs.</p>	<p><i>May require a prior authorization.</i></p> <p>Services and supplies are covered based on who provides your care and where you receive your treatment (for example, an oncologist visit, medical equipment, or labs/scans).</p>
Diabetes	<p>Diagnosis, care, and treatment for adults and children with diabetes (type I and II), including diagnostic testing, doctor visits, foot care, medical equipment, and education and training for diabetes patients in disease management (when recommended by your physician).</p> <p>Certain services related to your diabetes may be considered preventive. Contact Collective Health for more information.</p>	<p><u>Specialist visit</u></p> <p>In-network: You pay a \$40 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible).</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>

Service	Description	What You Pay
	<p>Insulin and other prescription medications are covered by your pharmacy benefits.</p>	<p><u>Diabetes self-management training</u></p> <p>In-network: You pay a \$20 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible).</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p> <hr/> <p><u>Labs</u></p> <p><i>May require a prior authorization.</i></p> <p>In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 10% of the cost; the plan pays the rest.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p> <hr/> <p><u>Medical equipment</u></p> <p><i>May require a prior authorization.</i></p> <p>In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 50% of the cost; the plan pays the rest.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 50% of the allowed amount; the plan pays the remainder of the allowed amount.</p>

Service	Description	What You Pay
Dialysis	Kidney dialysis services for hemodialysis, peritoneal dialysis, and home dialysis.	<p>In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 10% of the cost; the plan pays the rest.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>
Doctor's office visits	<p>Visits and services from your primary care provider or specialist healthcare provider when you need treatment for a medical condition.</p> <p>In-network preventive care visits are free for you. Please contact Collective Health for more information on the specific procedure and diagnosis codes that comprise your preventive benefits.</p>	<p><u>Primary care provider</u> <i>Certain services or items provided during your visit may require prior authorization. Please see Section 4 for how to check for prior authorization requirements.</i></p> <p>In-network: You pay a \$20 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible).</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p> <hr/> <p><u>Specialist provider</u> <i>Certain services or items provided during your visit may require prior authorization. Please see Section 4 for how to check for prior authorization requirements.</i></p> <p>In-network: You pay a \$40 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible).</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>

Service	Description	What You Pay
Eye care	<p>Medically necessary eye care related to specific medical conditions, including but not limited to diabetic retinopathy, glaucoma, cataracts, and other diseases and infections of the eye.</p> <p>This plan also covers routine eye care, such as vision screenings (including refraction).</p>	<p><u>Medically necessary eye care</u> Services and supplies are covered based on what care you receive and who provides it (for example, medical equipment or outpatient surgery).</p> <hr/> <p><u>Routine eye care</u> <i>Limited to 1 exam every 2 years per member.</i></p> <p>In-network: Fully covered (the plan pays 100%). You do not have to meet your deductible first.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>
Family planning	<p>Coverage for preventive contraceptives includes prescription barrier methods, prescription female condoms, generic hormonal methods, implanted devices, and emergency contraception.</p> <p>Coverage for non-preventive contraceptives includes male sterilization.</p> <p>Termination of pregnancy (including elective abortion) is covered.</p>	<p><u>Preventive contraceptive services (generic)</u></p> <p>In-network: Fully covered (the plan pays 100%). You do not have to meet your deductible first.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p> <p><u>Non-preventive covered birth control services</u> Covered based on what care you receive and where (for example, a brand-name prescription, OB/GYN appointment, or outpatient surgery).</p>
Fertility	<p>This plan only provides coverage for the diagnosis and treatment of underlying medical conditions (such as endometriosis) that also cause infertility. Fertility-specific treatments are not covered.</p>	<p>Diagnosis and treatment of underlying medical conditions are covered based on what care you receive and who provides it (for example, medical equipment or outpatient surgery). Otherwise, not covered.</p>

Service	Description	What You Pay
Foot care	<p>Exams by podiatrists, foot care associated with metabolic or peripheral-vascular disease (including related to diabetes), and custom-made foot orthotics, when prescribed by a physician.</p> <p>Pedicures, spa treatments, and cosmetic treatment of corns, calluses, or toenails are not covered.</p>	<p><u>Podiatrist visit</u></p> <p>In-network: You pay a \$40 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible).</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p> <hr/> <p><u>Orthotics</u></p> <p>In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 50% of the cost; the plan pays the rest.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 50% of the allowed amount; the plan pays the remainder of the allowed amount.</p>
Habilitation	<p>Habilitative services that help you keep, learn, or improve skills and functional abilities for daily living that may not be developing normally, including physical, occupational, and speech therapies.</p>	<p><i>May require a prior authorization.</i></p> <p>In-network: You pay a \$40 copay per session; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible).</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>

Service	Description	What You Pay
<p>Hearing screening & aids</p>	<p>Hearing exams for newborns and children as part of preventive care, or for adults when recommended by a medical provider. Additional services and supplies associated with hearing aids are excluded.</p>	<p><u>Preventive hearing screenings for newborns and children (office visit)</u></p> <p>In-network: Fully covered (the plan pays 100%). You do not have to meet your deductible first.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>
		<p><u>Non-preventive hearing screenings</u></p> <p>In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 10% of the cost; the plan pays the rest.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>
		<p><u>Hearing aids</u></p> <p>In-network: Not covered.</p> <p>Out-of-network: Not covered.</p>

Service	Description	What You Pay
Home-based care	<p>At-home care and treatment of an illness or injury, with a prescription from your doctor that specifies how long you'll need home care.</p> <p>Includes visits by trained medical personnel (including nurses) and supplies.</p>	<p><i>Limited to 120 days per year per member.</i></p> <p><i>May require a prior authorization.</i></p> <p>In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 10% of the cost; the plan pays the rest.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>
Hospice care	<p>Hospice care is an integrated program that provides comfort and support services for people who are terminally ill (usually meaning they are not expected to live more than six months).</p> <p>Hospice care often includes emotional support services for the immediate family. Respite care provides caregivers a temporary rest from caregiving. Respite care as part of hospice care is covered under this benefit.</p>	<p><i>May require a prior authorization.</i></p> <p>In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 10% of the cost; the plan pays the rest.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>
Hospital stays	<p>Inpatient hospital stays (admission for a scheduled procedure, or admission after an emergency).</p> <p>Includes room & board, doctor visits, supplies (like dressings, splints, or other materials), and medications or other substances (like blood, oxygen, fluids) during your stay.</p> <p>See "Surgery" below for more details on costs for surgical procedures.</p>	<p><i>May require a prior authorization.</i></p> <p>In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 10% of the cost; the plan pays the rest.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>

Service	Description	What You Pay
Infusion therapy	Intravenous or other infusion-based administration of medication in a medical facility (hospital or outpatient center) or as part of an office or home healthcare visit, under the care of a physician.	<p><i>May require a prior authorization.</i></p> <p>In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 10% of the cost; the plan pays the rest.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>
Injectable medications	<p>Injections (other than allergy injections or other benefits separately listed in this chart) administered by a medical provider. Includes, for example, steroid or pain medication injections when medically necessary.</p> <p>Drugs you take yourself (not administered by a healthcare provider) are covered separately, under your pharmacy benefits.</p>	<p><i>May require a prior authorization.</i></p> <p>In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 10% of the cost; the plan pays the rest.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>
Medical equipment and supplies	<p>Rental or purchase of durable medical equipment, which is medical equipment that is not disposable and is customarily used for a medical purpose, and associated supplies. A prescription from your physician is required.</p> <p>You may repair or replace equipment that is outgrown or after reasonable wear and tear.</p>	<p><i>May require a prior authorization.</i></p> <p>In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 50% of the cost; the plan pays the rest.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 50% of the allowed amount; the plan pays the remainder of the allowed amount.</p>

Service	Description	What You Pay
<p>Medical tests</p>	<p>Medically necessary diagnostic tests, including laboratory tests, radiology (such as X-rays or ultrasounds), and advanced imaging (such as MRI, PET, or CT scans), when recommended by a healthcare provider.</p> <p>Preventive care medical tests (for example, routine recommended mammograms) are covered at 100% in-network.</p>	<p><u>Preventive care tests</u></p> <p>In-network: Fully covered (the plan pays 100%). You do not have to meet your deductible first.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>
		<p><u>Diagnostic labs</u></p> <p><i>May require a prior authorization.</i></p> <p>In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 10% of the cost; the plan pays the rest.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>
		<p><u>Radiology</u></p> <p><i>May require a prior authorization.</i></p> <p>In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 10% of the cost; the plan pays the rest.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>

Service	Description	What You Pay
		<p><u>Advanced imaging</u> <i>May require a prior authorization.</i></p> <p>In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 10% of the cost; the plan pays the rest.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>
Mental health	Care and treatment by (or directed by) psychiatrists, psychologists, counselors, social workers, or other qualified medical professionals to address conditions impairing behavior, emotion reaction, or thought process.	<p><u>Office visits</u> <i>Certain services or items provided during your visit may require prior authorization. Please see Section 4 for how to check for prior authorization requirements.</i></p> <p>In-network: You pay a \$40 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible).</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p> <hr/> <p><u>Rehabilitative services (physical, occupational, and speech therapy) for mental health treatment</u> <i>May require a prior authorization.</i></p> <p>In-network: You pay a \$40 copay per session; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible).</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>

Service	Description	What You Pay
		<p><u>Outpatient facility</u> <i>May require a prior authorization.</i></p> <p>In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 10% of the cost; the plan pays the rest.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p> <hr/> <p><u>Inpatient/residential stays</u> <i>May require a prior authorization.</i></p> <p>In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 10% of the cost; the plan pays the rest.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>

Service	Description	What You Pay
Mouth, tooth & jaw injury	<p>Routine dental care (such as cleanings or fillings) is not covered by this plan. Coverage is limited to:</p> <ul style="list-style-type: none"> • Medical treatment of jaw joint disorders (like TMJ) • Excision of tumors and benign bony growths in the jaw or mouth • Emergency repair of natural teeth after injury • Surgical repair of jaws, cheeks, lips, tongue, and floor/roof of mouth after injury • External incision and drainage of cellulitis • Incision of sensory sinuses, salivary glands or ducts • Removal of impacted teeth 	<p>Services and supplies are covered based on who provides your care and where you receive your treatment (for example, in a doctor's office or in a hospital).</p>
Nutritional counseling	<p>Nutritional evaluation and counseling by a registered dietitian or licensed nutritionist.</p>	<p>In-network: Not covered, unless considered a preventive service or a medically necessary condition.</p> <p>Out-of-network: Not covered, unless considered a preventive service or a medically necessary condition.</p>

Service	Description	What You Pay
Occupational therapy	<p>Occupational therapy, by a licensed therapist and under the direction of a physician, as part of a short-term rehabilitative program following illness or injury.</p> <p>Recreational or exercise programs are not covered.</p>	<p><i>Limited to 35 sessions per year per member. Note that this session limit is a combined limit with physical therapy and speech therapy. Mental health, substance abuse, and preventive care claims are not subject to this limit.</i></p> <p><i>May require a prior authorization.</i></p> <p>In-network: You pay a \$40 copay per session; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible).</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>
Orthotics	<p>Initial purchase, fitting, and repair of orthotic appliances (like back braces or leg splints) required to support a body part that is disabled after injury or because of a congenital condition.</p> <p>Also includes custom-made foot orthotics, when prescribed by a physician, to treat weak, unstable, unbalanced, or flat feet.</p>	<p>In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 50% of the cost; the plan pays the rest.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 50% of the allowed amount; the plan pays the remainder of the allowed amount.</p>

Service	Description	What You Pay
Physical therapy	<p>Physical therapy, by a licensed therapist and under the direction of a physician when required, as part of a short-term rehabilitative program following illness or injury.</p> <p>Recreational or exercise programs are not covered.</p>	<p><i>Limited to 35 sessions per year per member. Note that this session limit is a combined limit with occupational therapy and speech therapy. Mental health, substance abuse, and preventive care claims are not subject to this limit.</i></p> <p><i>May require a prior authorization.</i></p> <p>In-network: You pay a \$40 copay per session; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible).</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>
Pregnancy & childbirth	<p>Care and treatment during pregnancy and childbirth, including required prenatal care, hospital stays, physician services, surgery, breastfeeding support and supplies, and hospital nursery care for your newborn child. Please keep in mind that some services related to your pregnancy may be considered preventive and will be covered under the plan's preventive care benefit.</p> <p>The plan covers inpatient care for at least 48 hours after delivery (96 hours after cesarean section), though your physician may discharge you earlier.</p> <p>Newborn care charges are only covered if you enroll your newborn within 31 days of birth—otherwise, charges will not be covered.</p> <p>If you are pregnant or you have just given birth, rental or purchase of a hospital-grade or commercial breast pump (manual or electric) is covered during and after the pregnancy.</p> <p>Many traditional retailers stock a variety of breast pumps at a comparable cost to in-</p>	<p><u>Prenatal care (primary care visits)</u></p> <p>In-network: You pay a \$20 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible).</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p> <hr/> <p><u>Prenatal care (specialist visits)</u></p> <p>In-network: You pay a \$40 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible).</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>

Service	Description	What You Pay
	<p>network breast pumps. To make it easier for you to obtain a breast pump in a timely manner, your plan covers out-of-network breast pumps and accessories with the same cost sharing as your in-network preventive benefit, up to an allowable amount. Please contact Collective Health to find out what the allowable amount is for an out-of-network breast pump based on your geographic area. If the cost of the out-of-network breast pump and supplies you purchase is less than or equal to the allowed amount, they will be covered with no additional cost to you. If the cost of the out-of-network breast pump and supplies you purchase is greater than the allowed amount, you will be responsible for the difference.</p>	<p><u>Genetic testing</u> <i>May require a prior authorization.</i> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 10% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p> <hr/> <p><u>Ultrasounds</u> <i>May require a prior authorization.</i> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 10% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p> <hr/> <p><u>Hospital admission for delivery</u> <i>May require a prior authorization.</i> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 10% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>

Service	Description	What You Pay
		<p><u>Newborn nursery</u> <i>May require a prior authorization.</i></p> <p>In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 10% of the cost; the plan pays the rest.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p> <hr/> <p><u>Breastfeeding support and counseling (excluding breast pumps and accessories)</u></p> <p>In-network: Fully covered (the plan pays 100%). You do not have to meet your deductible first.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p> <hr/> <p><u>Breast pumps and accessories</u></p> <p>In-network: Fully covered (the plan pays 100%). You do not have to meet your deductible first.</p> <p>Out-of-network: The plan pays 100% of the allowed amount. You do not have to meet your deductible first.</p>

Service	Description	What You Pay
Prosthetics	<p>Initial purchase, fitting, and repair of artificial limbs and other prosthetic devices to replace body parts that are missing after amputation or because of a congenital condition.</p> <p>Includes replacement for prosthetic devices that have been outgrown or that require replacement due to reasonable wear and tear.</p>	<p><i>May require a prior authorization.</i></p> <p>In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 50% of the cost; the plan pays the rest.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 50% of the allowed amount; the plan pays the remainder of the allowed amount.</p>
Pulmonary rehabilitation	<p>Pulmonary rehabilitation, by a licensed therapist, to improve lung function, reduce symptom severity, and improve quality of life as part of a treatment plan for chronic illness.</p>	<p>In-network: You pay a \$40 copay per session; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible).</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>
Respiratory rehabilitation	<p>Respiratory rehabilitation, by a licensed therapist, as part of a short-term rehabilitative program following illness or injury.</p>	<p>In-network: You pay a \$40 copay per session; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible).</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>

Service	Description	What You Pay
Skilled nursing facilities	<p>Inpatient care at a skilled nursing facility, after or in place of hospitalization or home healthcare, with a doctor's prescription (which specifies how long you should stay at the facility).</p> <p>A skilled nursing facility is licensed by Medicare to provide 24-hour inpatient care by registered nurses, directed by a physician, for patients convalescing from physical illness or injury (also known as a rehab hospital, nursing home, or extended care facility).</p> <p>Coverage includes care by doctors and nurses, supplies (like dressings, splints, or other materials), and medications or other substances (like blood, oxygen, fluids) during your stay.</p>	<p><i>Limited to 100 days per year per member.</i></p> <p><i>May require a prior authorization.</i></p> <p>In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 10% of the cost; the plan pays the rest.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>
Speech therapy	Speech therapy by a licensed therapist as part of a short-term rehabilitative program.	<p><i>Limited to 35 sessions per year per member. Note that this session limit is a combined limit with occupational therapy and physical therapy. Mental health, substance abuse, and preventive care claims are not subject to this limit.</i></p> <p>In-network: You pay a \$40 copay per session; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible).</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>

Service	Description	What You Pay
Surgery	Professional services, supplies, medications, and other services provided with or during surgery. "Surgery" includes open or minimally-invasive surgical operations, sutures and skin grafts, and manipulation of broken bones and dislocations. Surgery performed to improve your appearance is considered cosmetic and is not covered, but reconstructive surgery of abnormal congenital conditions and reconstructive surgery after a mastectomy are covered.	<p><u>Ambulatory surgery center</u></p> <p>In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 10% of the cost; the plan pays the rest.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>
		<p><u>Hospital outpatient</u></p> <p><i>May require a prior authorization.</i></p> <p>In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 10% of the cost; the plan pays the rest.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>
		<p><u>Hospital inpatient</u></p> <p><i>May require a prior authorization.</i></p> <p>In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 10% of the cost; the plan pays the rest.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>

Service	Description	What You Pay
<p>Telemedicine</p>	<p>Your employer has partnered with LiveHealth Online to provide access to telemedicine services.</p> <p>You are not limited to using LiveHealth Online for telemedicine services. Your plan also covers telemedicine visits with other licensed providers.</p>	<p><u>LiveHealth Online medical visits</u></p> <p>In-network: You pay a \$10 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible).</p> <p>Out-of-network: Not covered.</p>
		<p><u>LiveHealth Online mental health visits</u></p> <p>In-network: You pay a \$10 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible).</p> <p>Out-of-network: Not covered.</p>
		<p><u>Medical visits (through Anthem Blue Cross of California)</u></p> <p>In-network: You pay a \$20 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible).</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>
		<p><u>Mental health visits (through Anthem Blue Cross of California)</u></p> <p>In-network: You pay a \$20 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible).</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>

Service	Description	What You Pay
Transgender services	<p><i>Coverage for transgender services recipients only.</i></p> <p>Diagnosis and treatment for services related to transgender care. Gender affirmation surgery is not covered on this plan.</p> <p>Hormones will be covered by your pharmacy benefits; see the “Pharmacy Benefits” section below.</p> <p><i>Travel expenses for transgender surgery are not covered.</i></p>	<p><u>Counseling (office visit)</u></p> <p><i>Certain services or items provided during your visit may require prior authorization. Please see Section 4 for how to check for prior authorization requirements.</i></p> <p>In-network: You pay a \$40 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible).</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p> <hr/> <p><u>Gender affirming surgery</u></p> <p>In-network: Not covered.</p> <p>Out-of-network: Not covered.</p>
Transplants	<p>Transplants are defined as the transplant of organs or tissues from human to human or the transplantation of bone marrow, stem cell or cord blood.</p> <p>If you are the recipient, this plan will cover the cost of your and your donor’s evaluations, harvesting and transplant surgeries, transportation of the organ, and post-surgical treatments.</p> <p>If you are the donor, your recipient's plan will pay first, and this plan will cover the allowable amount that is left.</p> <p><i>Travel expenses for transplant services are not covered.</i></p> <p><i>Search expenses to find an organ donor are not covered.</i></p>	<p><i>May require a prior authorization.</i></p> <p>In-network: Services and supplies are covered based on who provides your care and where you receive your treatment.</p> <p>Out-of-network: Services and supplies are covered based on who provides your care and where you receive your treatment.</p>

Service	Description	What You Pay
Vaccines	<p>Immunizations for children and adults at recommended ages and doses, along with additional elective vaccines (for example, if recommended for foreign travel) recommended and administered by a physician.</p> <p>The recommended vaccine schedule is available at www.vaccines.gov.</p>	<p><u>Preventive vaccines</u></p> <p>In-network: Fully covered (the plan pays 100%). You do not have to meet your deductible first.</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>
		<p><u>Travel vaccines</u></p> <p>In-network: Not covered.</p> <p>Out-of-network: Not covered.</p>
Walk-in retail clinic	<p>Services supplied in a licensed walk-in retail clinic, such as one located in a drug store or supermarket.</p> <p>A walk-in retail clinic provides services for less complex conditions like a sore throat or earache, or preventive care like vaccines.</p>	<p>In-network: You pay a \$20 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible).</p> <p>Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 30% of the allowed amount; the plan pays the remainder of the allowed amount.</p>

Pharmacy Benefits

The pharmacy benefits in this plan help you pay for the medications you need. In general, this plan covers all medically necessary medications prescribed to you by your doctor, except those that are specifically excluded (see Section 6 and Appendix B for more on exclusions).

The benefits described below cover the medications you get from a pharmacy. The drugs administered to you by a healthcare provider during an office visit, outpatient procedure, or hospital stay are covered separately by your medical benefits. In addition, certain infusions or implantable products (such as plasma, blood products, or implantable androgen products) are covered by your medical benefits and not your pharmacy benefits.

Your Pharmacy Network

CVS Caremark is the pharmacy benefits manager for this plan, and most retail pharmacies are in-network. As is the case with the rest of your benefits under this plan, you will typically pay less if you use an in-network pharmacy than if you go out-of-network. To find out whether a pharmacy is in your network, you can contact Collective Health; you can check the CVS Caremark website by logging in via my.collectivehealth.com, then navigating to Get Care and clicking on “Pharmacy”; or you can ask the pharmacist whether the pharmacy is in the CVS Caremark network.

You can get your medications from an in-network retail pharmacy or CVS Caremark's mail order pharmacy. If your drugs are available through mail order, they may cost less overall, for you and for the plan, so these benefits are designed to encourage you to use mail order whenever possible. If you use out-of-network retail pharmacies, you will need to submit a claim for reimbursement after you purchase your medication. Contact Collective Health for guidance.

Types of Prescriptions

Certain medications are classified as “preventive care.” (These include medications like hormonal birth control, aspirin for heart attack prevention, and tobacco cessation products.) For preventive care prescriptions, if you use in-network pharmacies and select generic alternatives, your plan will cover 100% of the cost. If you'd like to know if your medication is considered preventive, you can contact Collective Health for help.

On this plan, some medications will cost you more than others. Generic prescriptions are less expensive versions of brand name drugs. Generic drugs are considered identical to their brand name equivalents (in terms of efficacy and safety) by the FDA.

If you take a brand name drug, it's important to know that some brands are treated differently under this plan. Brand name drugs are more expensive than generics, but your plan has negotiated discounts on some—these are called preferred brand drugs. Non-preferred brands aren't discounted, so you'll pay more for these. Often, there will be generic options for medications prescribed by your doctor. When you fill your prescription, you can ask the pharmacist whether a generic or preferred brand name version of your medication is available.

You must fill a prescription within the time specified by the doctor. Only the number of refills specified by the doctor will be covered.

What You Pay

- You do not need to meet your medical deductible before your pharmacy benefits kick in, but your medical out-of-pocket maximum does apply.
- Money you spend on covered prescriptions will accumulate toward your out-of-pocket maximum just like money you spend on covered medical care.
- You can get preventive care medications fully covered from in-network pharmacies from day one on this plan. But to learn how much you will owe for any other medications, see the table below.

- If the total cost for a medication is less than your copay, you'll only have to pay the lesser amount.
- Maintenance medications are typically prescribed for chronic, long-term conditions and are taken on a regular, recurring basis. Maintenance medications include those used to treat high blood pressure, heart disease, asthma, or diabetes. In addition to allowing you to pick up a 30-day supply of your medication at an in-network retail pharmacy, your plan also allows you to pick up a 90-day supply of your medication through a CVS retail pharmacy or a CVS mail-order pharmacy.
- If you choose a brand-name medication when a generic version is available, after 2 grace fills, you'll pay what you normally do for generic drug cost sharing, plus the difference in cost between the generic and the brand-name drug. The difference you pay does not accumulate towards your deductible or your out-of-pocket maximum. Though you will not be responsible for the drug cost sharing, you will continue to be responsible for the difference in cost after you have met your out-of-pocket maximum.
- Your plan allows you to pick up your specialty medication one time at an in-network retail pharmacy. However, your next fills will no longer be covered at retail and you will need to move the prescription to a CVS Specialty pharmacy. If you would like to know if your medication is considered specialty, please contact Collective Health for help.
- Your plan is enrolled in a vaccination program that allows you to receive your annual flu shot at retail pharmacies, rather than having to make an appointment at a doctor's office.
- Insulin pumps and insulin pump supplies are not covered through your pharmacy benefits and are instead covered through your medical benefits.

Some medications are excluded from coverage. See Appendix B for more information.

Drug Type	In-Network Retail Pharmacy (30-day supply)	In-Network Mail Order Pharmacy (90-day supply, may vary by drug type)	Out-of-Network Retail Pharmacy (30-day supply)
Preventive drugs	Fully covered (the plan pays 100%).	Fully covered (the plan pays 100%).	You pay 30% of the cost (up to \$250); the plan pays the rest.
Generic drugs	You pay a \$20 copay; the plan pays the rest.	You pay a \$40 copay; the plan pays the rest.	You pay 30% of the cost (up to \$250); the plan pays the rest.
Preferred brand drugs	You pay a \$40 copay; the plan pays the rest.	You pay a \$80 copay; the plan pays the rest.	You pay 30% of the cost (up to \$250); the plan pays the rest.
Non-preferred brand drugs	You pay a \$70 copay; the plan pays the rest.	You pay a \$140 copay; the plan pays the rest.	You pay 30% of the cost (up to \$250); the plan pays the rest.

Drug Type	In-Network Retail Pharmacy (30-day supply)	In-Network Mail Order Pharmacy (90-day supply, may vary by drug type)	Out-of-Network Retail Pharmacy (30-day supply)
Specialty drugs	You pay 20% of the cost (up to \$250); the plan pays the rest.	You pay 20% of the cost (up to \$250); the plan pays the rest. <i>Limited to a 30-day supply.</i>	Not covered.
Fertility medication	Not covered.	Not covered.	Not covered.

When you go to an in-network retail pharmacy, you can pick up a 30-day supply of your medication. Enroll in mail order if you would like to receive more than a 30-day supply at a time. See the table above to check if any limits apply to mail order medications.

You will not be able to collect more than the numbered day supply indicated in the above table in one order whether you purchase at an in-network or out-of-network retail pharmacy or mail order pharmacy. You will have to wait until your supply is low before you can refill your prescription.

Over-the-Counter Medications

Over-the-counter medications (ibuprofen, vitamins, etc.) are not covered by this plan. In accordance with Affordable Care Act guidelines, there are four exceptions to this exclusion:

- When a drug is prescribed by your doctor and you purchase it behind the counter, from the pharmacist (for example, aspirin or folic acid), then you may be able to use your pharmacy benefits even if the drug is also available over-the-counter.
- Over-the-counter supplies for treating diabetes (such as insulin and blood sugar detection equipment) are not excluded from coverage.
- If covered contraceptives are available over-the-counter in your area, those will be covered by this plan if prescribed by a doctor.
- Over-the-counter smoking cessation treatments are covered by this plan if prescribed by a doctor.

If you have questions about your pharmacy benefits, including whether certain medications are preferred, non-preferred, or excluded, you can always contact Collective Health for help. If additional detail is required in relation to appeals or excluded medications, Collective Health may transfer you to RxBenefits Member Services who work with CVS as your Pharmacy Benefit Manager.

Section 6: What's Not Covered (Exclusions)

Some treatments and services are not covered by this plan. Items that are not covered are called exclusions and are listed below. Certain exclusions may also be described in the benefits table in Section 5.

Any service, item, or treatment that is not medically necessary is excluded. Services are medically necessary if all the following criteria are met:

1. Recommended and provided by a licensed physician, dentist or other medical practitioner who is covered by the plan and practicing within the scope of their license;
2. Generally accepted as the standard of medical practice and care for the diagnosis and treatment of your condition, or for preventive care;
3. Appropriate (in terms of type, frequency, duration, and other factors) for your condition;
4. Not performed mainly for your convenience or the convenience of your doctor;
5. Approved by the FDA, if applicable.

The plan administrator and/or claims administrator has full discretionary authority to adjudicate benefit claims, including taking a holistic view of the member's healthcare needs and condition, and current and future financial implications. When you choose to visit an out-of-network provider or facility for medical treatment, the plan will cover the allowed amount, and the provider may balance bill you for any excess. It is your responsibility to pay any amounts in excess of the allowed amount—in addition to any deductibles, copays, or coinsurance. This plan may not cover all possible medically necessary treatments; in other words, some services are excluded from coverage even if they would be medically necessary for you.

Non-medical services are excluded:

- **Custodial care**, which can be provided by individuals without medical training, and is given principally for personal hygiene or for assistance in daily activities (however, treatment typically considered custodial care is covered if the treatment is considered medically necessary as part of the individual's Adaptive Behavioral Therapy)
- Dietary or nutrition supplements, except when prescribed to treat specific medical conditions (such as PKU)
- Any type of education or training, except as expressly stated in Section 5 as covered or services that are medically necessary and performed by licensed medical professionals
- Exercise programs (except for physician-supervised cardiac rehabilitation, physical therapy, or occupational therapy expressly stated in Section 5 as covered)
- Hypnotherapy
- Personal comfort items, including:
 - > Air conditioners
 - > Air purification units
 - > Humidifiers
 - > Electric heating units
 - > First aid supplies
 - > Elastic bandages or stockings

- › Non-hospital adjustable beds
 - › Orthopedic mattresses
 - › Non-prescription drugs and medicines, except as expressly stated in Section 5 as covered
 - › Scales
- Rest cures
- Charges for travel or non-medical accommodations, except as expressly stated in Section 5 as covered

This plan excludes any care you receive when you are not a member. Healthcare services you receive before your coverage effective date are excluded—even if you are charged for the services after your coverage begins. Services you receive after your coverage ends are excluded—even if you got sick while you were still covered.

This plan also excludes the following services, supplies, or treatments:

- Compound medication ingredients that have not shown clinical benefit over lower-cost alternatives, or bulk ingredients used in compound medications where a standard equivalent exists.
- Concierge membership fees, retainers, or premiums paid to a concierge medical practice in order to access the medical services provided by that practice.
- Charges for cosmetic procedures or pharmaceuticals, which are procedures performed or medications taken for plastic, reconstructive, or cosmetic purposes, or which are intended primarily to improve, alter, or enhance appearance.
 - › Wigs are excluded, except for wigs provided for the loss of hair resulting from alopecia areata, endocrine diseases, chemotherapy or radiation to treat cancer, or permanent loss of hair from an accidental injury.
 - › Hair transplants are excluded, except for medically necessary transplants provided for the loss of hair resulting from chemotherapy or radiation to treat cancer.
 - › Drugs for cosmetic effect, such as Retin-A or hair removal substances, are excluded unless they are medically necessary to treat a medical condition.
 - › Growth hormones, anabolic steroids, and appetite suppressants are excluded unless they are prescribed by a physician to treat a covered medical condition (such as HGH deficiency).
 - › Reconstructive surgery to correct congenital abnormality or deformity caused by accident, injury, or illness (including after mastectomy) is not excluded.
- Routine dental care, except specific treatments for mouth, tooth, or gum injury expressly stated in Section 5 as covered.
- Charges for services provided by a **doula**.
- Excess charges for services, items, or treatment—in other words, charges by out-of-network providers that exceed the allowed amount for the services provided.
- Care or treatment provided or prescribed by excluded providers, including:
 - › Yourself;
 - › A member of your immediate family by birth, adoption, or marriage;
 - › A person residing in your household;
 - › A provider operating without a license or operating outside the scope of his or her license.

- › If you are treated by a hospital or other healthcare facility, additional payments to an employee or contractor of that facility are excluded, when the facility is itself obligated to pay that individual for their services.
- Charges associated with experimental treatments, which are treatments that are not accepted as good medical practice by most practitioners or that lack credible evidence to support positive short- or long-term outcomes for patients.
 - › Treatments include any treatment, procedure, service, device, supply or drug provided to a covered person.
 - › Drugs that are not approved by the FDA for any use are considered unproven and experimental and are excluded. Off-Label Drug Use is defined as the use of a drug for a purpose other than that for which it was approved by the FDA. Off-Label Drug Use may be covered on the plan if:
 1. The drug is not excluded under your plan; and
 2. The drug has been approved by the FDA; and
 3. It can be demonstrated that the Off-Label Drug Use is appropriate for the condition being treated.
 - › Clinical trials are not covered by this plan, unless determined to be eligible for coverage upon medical necessity review and not deemed to be experimental or investigational. Routine patient care costs for approved clinical trials may be covered by this plan, as described in Section 5.
 - › Experimental/Investigational treatment is not covered by this plan.
- Routine eye care and vision-correction surgery, except:
 - › Care and treatment of aphakia and aniridia.
 - › Lenses or shells for use as corneal bandages.
 - › As otherwise covered by the Preventive Care provisions of this plan.
 - › As expressly stated in Section 5 as covered.
- Charges beyond the plan's financial obligations, including:
 - › Amounts in excess of the "allowed amount."
 - › Medical treatments outside the plan's scope (i.e., services that are not listed as covered benefits).
 - › Services, items, medications, or treatment for which there would not have been a charge, if no coverage were available.
 - › Expenses actually incurred by other persons (not you or your covered dependents).
 - › Charges that should be repaid to the plan under the subrogation, reimbursement, or third-party responsibility provisions (Section 12).
 - › Expenses for services that are also covered under any government-sponsored plan or program (e.g., Tricare, CHAMPUS, VA), unless the government program expressly provides otherwise.
 - › For services you obtain before you were covered under this plan.
 - › For services you obtain after your coverage under this plan ends.
- Non-medical foot treatments, such as pedicure or spa treatments or non-medical treatment of corns, calluses, or toenails.

- **Hearing aids** and any associated charges for accessories or services related to their implantation and maintenance.
- Illegal drugs, including otherwise legal medications (such as oxycodone) procured through illegal means.
- Care, supplies, medications, and services for the treatment of infertility, except as expressly stated in Section 5 as covered, including:
 - › Egg and sperm freezing are not covered.
 - › Fertility services are not covered if your infertility is the result of a prior voluntary sterilization procedure.
 - › The purchase of donor sperm and purchase of donor oocytes or embryos and any charges associated with care of the donor required for donor oocytes retrievals or transfers or gestational carriers (surrogacy); all charges associated with a gestational carrier program for the person acting as the carrier (if that person is not a member of this plan), including but not limited to fees for laboratory tests.
 - › Home ovulations prediction kits.
 - › Services and supplies furnished by an out-of-network provider.
- Marijuana or marijuana-derived substances (like THC oil), even if you have a prescription and marijuana is legal in the state where you live.
- Non-emergency medical care outside the United States, including all medical tourism.
 - › Emergency care outside the United States is covered. This includes services or treatment that you must receive in order to safely travel back to the United States. See Appendix A for more information.
- Over-the-counter drugs, except as expressly stated in Section 5 as covered.
- Pharmaceutical medications that are specifically excluded by CVS Caremark from coverage. See Appendix B for more information.
- Private duty nursing provided in a setting outside the home.
- Respite care, unless received as part of hospice care.
- Treatments for intentionally self-inflicted injuries—but if the injury is due to a medical or mental health condition, or is the result of domestic violence, this exclusion does not apply.
 - › Treatments for injuries that you sustain while incarcerated are also excluded.
- Charges for sterilization reversal procedures, except as expressly stated in Section 5 as covered.
- Vitamins or other dietary supplements, except as expressly stated in Section 5 as covered.
- Charges for health services received as a result of an act of war or foreign terrorism.
- Services, items, or treatment for work-related illness or injury—that is, an illness or injury that arises from work for wage or profit (including self-employment).

Section 7: When Your Coverage Ends

Certain events will cause your coverage under this plan to end. If multiple terminating events happen around the same time, your coverage will end on the earliest possible termination date.

Triggering Event		What It Means for You
If you are no longer eligible for coverage.	You and your dependents are only covered under this plan as long as you and they continue to meet the eligibility requirements described in Section 1 of this SPD.	If you become ineligible, your dependents will also automatically become ineligible. Your coverage and your family's coverage will end on the last day of the month that eligibility ends. You may have the right to continue coverage under COBRA (see Section 10).
If you stop paying for coverage.	If you are required to pay an employee contribution to receive benefits under this plan, then you must pay each period to continue coverage.	Your coverage and your dependents' coverage will end on the last day of the last fully-paid period.
If you defraud the plan.	Your coverage can be terminated if you commit fraud on the plan, or if you make an intentional, material misrepresentation to the plan, in the course of obtaining coverage or benefits. (For example, if you submit false claims for reimbursement.)	Tower Semiconductor has discretion to determine when your coverage or your dependents' coverage will terminate. Your termination may be retroactive—if so, you may be required to repay the plan for prior coverage (this is called rescission). The plan administrator or Collective Health will give you 30 days' notice of rescission, and you will have the right to appeal this determination.
If the entire plan ends.	Tower Semiconductor has the right to terminate this plan, and any other health plans (in other words, to stop offering coverage for employees), at any time and for any reason.	Your coverage and your dependents' coverage will end on the date the plan ends. The plan administrator is responsible for notifying you that your coverage has ended.

There may be more circumstances where your coverage may terminate in the middle of the plan year, including factors that give you a right to discontinue your coverage. These circumstances are described in the governing documents describing Tower Semiconductor's employee benefits plans. Contact Tower Semiconductor's Benefits Team for more information.

After your coverage ends, the plan will still pay claims for services you received before your coverage ended. However, once your coverage ends, your benefits under this plan end immediately—even if you are hospitalized, and even if you need further treatment for conditions that occurred before your end date.

If your coverage ends, your dependents' coverage will also end. But in some circumstances, if your dependent's coverage ends (for example, if your child turns age 26), you and your remaining dependents may continue to receive coverage.

If your employment with Tower Semiconductor ends, and you are rehired after more than 30 days have passed, you will be treated as a new hire, and you and any family members will need to satisfy all of the eligibility and enrollment requirements detailed in Sections 1 and 2. If you are rehired within 30 days after you leave Tower Semiconductor and are still eligible for benefits, you will be reinstated with the same healthcare benefits when you return.

Section 8: How to File a Claim

When you use in-network services, the provider will generally collect your copay from you at the time of your treatment and send a claim to the plan for payment. Sometimes out-of-network providers will do the same. Other times, out-of-network providers may bill you for the total cost of your treatment, and you will need to submit the claim to the plan to be paid. Whether you pay out-of-pocket or your provider bills the plan directly, you are still entitled to the same benefits.

This section summarizes the procedures you must follow to submit a claim to the plan for payment of medical care, as well as the procedures the plan will use to determine whether and how much to pay for that claim. Your claim will be decided in accordance with the plan's claims procedures, as required by ERISA. If your claim is denied in whole or in part, you will receive a written notification setting forth the reasons for the denial and describing your rights, including your right to appeal the decision.

Claims are considered filed and received by the plan when they are received by Collective Health. If you have an HSA, distributions and all other matters relating to your HSA are outside of the plan and are governed by the agreement between you and the HSA custodian. If you would like more details about claims procedures and your rights and responsibilities, contact Collective Health.

Regular Post-Service Claims

Post-service claims are non-urgent claims after you have received treatment. (Other types of claims have different timelines and requirements; see below.) Generally, you do not need to file a claim when you receive services from in-network providers—the provider, Anthem Blue Cross of California, and Collective Health will handle the processing of the claim. For bills from out-of-network providers or emergency care providers outside of the United States that will not submit claims to Anthem Blue Cross of California, you may receive reimbursement from the plan by following this procedure.

You can submit a post-service claim by mail or through my.collectivehealth.com. You will need to provide several pieces of information for Collective Health to be able to process your claim and determine the appropriate plan benefits:

- The name and birthdate of the patient who received the care
- The member ID listed on the patient ID card
- An itemized bill from the patient's provider, which must include:
 - › The provider's name, address, and license number (if available)
 - › The date(s) the patient received care
 - › The medical diagnosis and procedure codes for each service provided
 - › The charges for each service provided
- Information about any other health coverage the patient has
- Proof of payment as needed to substantiate your claim (but is not required upon initial submission to Collective Health)

For breast pumps, an itemized bill is not required. Instead, please submit a detailed receipt.

Your out-of-network claim must be submitted within one year from the date you received the healthcare services. If your claim relates to an inpatient stay, the date you were admitted counts as the date you received the healthcare service for claims purposes. Contact Collective Health if you have any questions on the items above.

Within 30 days of Collective Health receiving your claim, you'll receive a decision. Claims will be processed when administratively feasible, typically in the order they are received. If we need more information to process a claim, we will send you notice that your claim is denied due to missing information. If you are able to submit the requested missing information, we will review it and process your claim accordingly. This additional information must be received by the later of (1) one year from the date of service, or (2) 180 days from receipt of the initial claim determination.

Claims for pharmacy benefits will be reviewed by CVS Caremark. Claims for medical (non-pharmacy) benefits will be reviewed by Collective Health and/or Anthem Blue Cross of California depending on the type of claim. If more time is needed to decide your claim due to matters beyond the control of Collective Health and/or Anthem Blue Cross of California, the plan may make a one-time extension of not more than 15 days. If this additional time is needed, you will be notified before the end of the initial 30 day period.

If your claim is ultimately denied, you'll receive an explanation of why it was denied and how you can appeal. This explanation will include the specific reason(s) for the denial; reference to the specific plan provision(s) on which the denial is based; a description of additional material or information necessary to perfect the claim; a description of the plan's review procedures and applicable time limits; and a statement that a copy of any rule, guideline, protocol, or other similar standard relied on in the denial will be provided free of charge upon request. If the denial is based on medical necessity or experimental treatment, an explanation of the determination will be provided free of charge upon request.

Urgent Care Claims

An urgent care claim is a claim for services when a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, could cause severe pain. An urgent care prior authorization is considered an urgent care claim. Because your provider is the one who initiates prior authorization with Anthem Blue Cross of California, it will usually be your provider who will request expedited processing. If a physician with knowledge of your medical condition determines that the claim is an urgent care claim as described above, then the plan will treat the claim as an urgent care claim. Urgent care claims will be decided within 72 hours after submission. Urgent care claims filed improperly or missing information may be denied.

If your urgent care claim is denied, you'll receive an explanation of why it was denied and how you can appeal (including how to request expedited review).

Concurrent Care Claims

In some cases, you may have an ongoing course of treatment approved for a specific period of time or a specific number of treatments, and you will want to extend that course of treatment. This is called a concurrent care claim or a concurrent care review. Similar to urgent care claims, your provider is typically the one who initiates a concurrent care claim with Anthem Blue Cross of California.

If your extension request is not "urgent" (as defined in the previous section), your request will be considered a new request and will be decided according to the applicable procedures and timeframes. If your request for an extension is urgent and you submit the claim at least 24 hours before the end of the course of treatment, you (or your provider) will be notified of the determination within 24 hours.

Section 9: How to Appeal

Whenever the plan makes a decision about your benefits that adversely impacts you (also known as an adverse benefit determination), you have the right to appeal. You cannot appeal changes to the plan's terms, termination of the plan, or other decisions that affect plan members beyond you and your family; appeals of an adverse benefit determination must be specific to you and/or your dependents.

Adverse benefit determinations include:

- A decision that you are not eligible to participate in the plan
- Determinations that certain services are not covered benefits
- Rescission of coverage
- Determinations that certain treatments are not medically necessary
- Termination of your membership in this plan

Some things that are not adverse benefit determinations are:

- If Tower Semiconductor decides to stop offering this plan to employees
- If the plan is amended to exclude certain treatments

Anthem Blue Cross of California and Collective Health share the responsibility of rendering appeal determinations. This section describes your appeal rights and the steps you must take to exercise those rights with each party.

If you are confused or dissatisfied about a determination of your benefits (for example, if a particular claim has been paid at a lower rate or denied), we encourage you to contact Collective Health before filing an appeal. You are not required to call Collective Health first, but reaching out to the Member Advocate team may help clear up any preliminary questions you have about why a particular decision was made. The Member Advocate team can also help guide you as you compile the information you need to submit an appeal.

You may have someone else help you to file an appeal. If someone submits an appeal for you, it must include documentation that they are your authorized representative. The documentation must be signed by both you and the authorized representative. Contact Collective Health if you would like to request an authorized representative appointment form.

The section below explains where to submit different types of appeals. If you are still unsure of where to submit your appeal, please reach out to Collective Health for assistance. If your appeal is submitted to the incorrect party, we will coordinate to get it to the right place. Please note, the appeal determination timeline begins when the appropriate party receives the appeal.

How to Appeal Prior Authorization and Medical Necessity Determinations

Because your provider is the one who initiates prior authorizations (including urgent claims) with Anthem Blue Cross of California, it will usually be your provider who appeals if prior authorization is denied. You can choose to appeal the denial if you wish—for example, if your provider doesn't want to pursue an appeal.

You must appeal a denial of prior authorization to Anthem Blue Cross of California, not Collective Health. But if you need or want help navigating this process, you can contact Collective Health for assistance.

You can also appeal your prior authorization by phone or in writing. To appeal by phone, call Collective Health. If you would like to appeal in writing, written requests should be sent to Grievances and Appeals, P.O. Box 4310,

Woodland Hills, CA 91365-4310. In your request, please indicate that you are asking for an appeal and include any additional information you have that supports the request. Your appeal should include the following:

- The member's name and ID number;
- The name of the provider who will or has provided care;
- The date(s) of service;
- The claim or reference number for the specific decision with which you don't agree; and
- The specific reason(s) why you don't agree with the decision.

Anthem will send a written decision within 30 calendar days from the date the appeal is received. You have the right to an expedited decision if delay could seriously jeopardize your life or health or cause you severe pain. If you are dissatisfied with Anthem's mandatory first level appeal decision, a voluntary second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request to CH for an external review.

How to Appeal Non-Urgent Adverse Benefit Determinations

This section describes Collective Health's appeals process for any adverse benefit determination other than a prior authorization or medical necessity denial by Anthem Blue Cross of California (for example, if your benefits have been rescinded, or if coverage for a particular treatment has been denied because it is outside the scope of this plan).

Use this procedure for medical benefit appeals. For pharmacy appeals, reach out to Collective Health with the information below so we can help route your appeal to the right place. You must submit your appeal within 180 days of receiving the adverse benefit determination.

To appeal, you must submit the following information to Collective Health in writing:

- Enough information to identify the adverse benefit determination that is the subject of your appeal—either attach a copy of the relevant Medical Benefit Statement, or provide:
 - > Member ID
 - > Patient name
 - > Claim number
 - > Provider name
 - > Date of the medical service
- Your explanation of what happened and why you believe the original decision was incorrect
- Any documents or other information that support your appeal—for example:
 - > A letter or prescription from your doctor
 - > A receipt for money you paid
 - > Relevant excerpts of your medical records

You can send the appeal submission and attachments by mail or through Messages in your Collective Health account.

Attn: Appeals Team
Collective Health
1557 W Innovation Way, Suite 125
Lehi, UT 84043
833-440-1639

Collective Health will review your appeal and issue a decision within 60 days. If a medical opinion is required, it will be provided by a medical professional appropriate for the issue being appealed. You can request copies of the information relating to your appeal, including billing and diagnosis codes, and the name and title of any experts who assisted with the determination. If Collective Health upholds the original adverse benefit determination, you will receive a notice of final adverse benefit determination that explains the reason for that decision and describes your rights. In all cases, your appeal will be reviewed by individuals who were not involved in the original determination, and who will thoroughly review your claim and come to a complete and final answer. Because of this exhaustive review, Collective Health only does one level of appeal. If your internal appeal is denied, you may have the right to an external review as described below. You have four months from the date of the most recent adverse determination to send in additional relevant information or request an external review.

External Review Program

If you are not satisfied with Collective Health's or Anthem Blue Cross of California's determination of your claim or internal appeal, you may have the right to request review by an independent review organization (IRO). All external reviews are facilitated by Collective Health, regardless of which party rendered the internal appeal determination. The plan has entered into agreements with three or more IROs that have agreed to perform external reviews. The external review process is available at no charge to you.

External review is available only when Collective Health's or Anthem Blue Cross of California's adverse benefit determination is based on one of the following:

- Medical necessity or clinical reasons;
- The plan exclusions for experimental, investigational, or unproven services;
- Rescission of coverage (coverage that was cancelled retroactively); or
- As otherwise required by applicable law.

Every external review request should include all of the following information:

- A specific request for an external review
- The subscriber's name, patient's name, and member ID and group number
- If you have an authorized representative, that person's name and contact information
- The service that was denied
- Any new, relevant information that was not provided during the internal appeal

Appeal determinations provide information about the external review program where review requests may be submitted. A request for external review must be made within four months after you receive the internal appeal determination. An external review is the final level of appeal available under the plan.

Standard External Review

When you submit a request for standard external review, here's what will happen:

First, Collective Health will do a preliminary review of your request within five business days. This preliminary review will confirm that:

- The patient was covered by the plan at the time they received the healthcare service(s)
- The patient has finished the internal appeal process (this is called "exhaustion")
- The claim or appeal decision is eligible for external review
- All of the required information has been provided

After that, Collective Health will provide a notification to you in writing about its preliminary review. If all four criteria above are met, your case will be assigned to an IRO for review. Collective Health will randomly select from one of the contracted IROs so your review is not biased. The IRO will then confirm with you that your request has been accepted for external review.

Then, the IRO will review your case. You may send the IRO any additional information you think will be helpful within 10 business days of receiving the IRO's acceptance notice. If you submit information later than that, the IRO may (but is not required to) consider that additional information. Either way, Collective Health will give the IRO all of the documents and information that were used in making the internal appeal determination, such as:

- Internal appeal determination letter(s)
- Any other documents relied upon by Collective Health
- All other information or evidence that you or your physician submitted for consideration as part of the internal appeal

Finally, the IRO will make a decision. The IRO will provide an unbiased assessment that will not be bound by any decisions or conclusions reached in the initial appeal determination. The IRO will provide its final external review decision to you in writing within 45 days after receipt of the request for the external review—unless the IRO requests additional time, and you agree. The notice, including the clinical basis for the determination, will be provided to you and Collective Health.

If the IRO reverses the internal appeal determination, the plan will provide coverage or payment for your claim, in accordance with the terms of the plan.

Expedited External Review

An expedited external review is just like a standard external review, except shorter. If your case qualifies for expedited external review, you can submit your request before you've completed the internal appeals process.

A case qualifies for expedited external review when the adverse benefit determination involves a medical condition where the standard review timeline would seriously jeopardize the patient's life, health, or ability to regain maximum function. Expedited external review is also available if the case concerns emergency services and the patient hasn't yet been discharged from the medical facility.

Requests for expedited external review do not need to be submitted in writing; you may request review by phone, by calling Collective Health.

Collective Health will use the quickest means to submit your case to the IRO, such as by phone or digital transmission. The IRO's decision-making process will be the same, except that the IRO will notify you within 72 hours of receiving your request. The IRO may notify you of its decision by phone; if so, you'll also receive written confirmation within 48 hours after that.

Limitation on Your Right to Sue

You generally cannot bring any legal action against the plan, the plan administrator, or Collective Health unless you first complete all the steps in the appeal process and exhaust your appeal rights. The appeal process is complete only when you have received a final determination from the plan or claims administrator.

After completing the appeal process, if you want to bring a legal action, you must do so within two years of the date you are notified of the final decision on your appeal. If you do not sue within two years, you lose any rights to bring such an action against the plan, the plan administrator, or Collective Health.

Section 10: Your Rights to Continue Coverage

This plan is sponsored by your employer; it's intended to cover you (and your dependents, if any) only while you are employed by the Company and you meet the plan's eligibility requirements. But in some circumstances, you may have the right to continue your membership in this plan beyond the time when your coverage would otherwise end. This section describes when and how you can keep yourself and your dependents covered:

- Continuing your benefits coverage under Consolidated Omnibus Budget Reconciliation Act (COBRA).
- Continuing your benefits coverage during uniformed service.
- Continuing your benefits coverage during a leave of absence from work.

Continuing Your Benefits Coverage Under COBRA

COBRA is a federal law that gives you and your family the opportunity to extend your Tower Semiconductor healthcare benefits in certain circumstances where your coverage would otherwise end. This section describes your COBRA rights and responsibilities. You may also receive a separate notice from Tower Semiconductor's COBRA administrator, which describes COBRA in more detail.

What is COBRA? When something happens that would cause your coverage under this plan to end (for example, if you lose your job with the Company), COBRA may give you the right to a temporary extension of your coverage. COBRA allows you to continue coverage only in certain circumstances (called qualifying events), and only if you and your dependents meet certain criteria (if you are qualified beneficiaries). To get COBRA coverage, you will have to follow very specific rules for notifying the plan, you may have to pay more than your normal employee contribution, and you will have to pay on time until your COBRA coverage ends. While you have COBRA coverage, your right to participate in open enrollment also continues.

Who is in charge of COBRA administration? Tower Semiconductor uses a company named PlanSource to administer its COBRA program. If you experience a qualifying event, PlanSource will send you a COBRA packet with information and election instructions. If you elect to receive COBRA benefits, you will send your payments to PlanSource, and they may reach out to you directly as part of their administration responsibilities. You should contact PlanSource with any COBRA-specific questions, or reach out to Collective Health for general assistance.

PlanSource
877-549-8549
<https://cobrapoint.benaissance.com/>

What are the qualifying events that trigger COBRA rights? A qualifying event is one of the following events, which would cause you or your dependents to lose your Tower Semiconductor healthcare benefits:

- If you quit your job at the Company, or if you are fired (except if you are fired for gross misconduct).
- If your work hours are reduced enough that you are no longer eligible for benefits under this plan.
- If your marriage ends by divorce or legal separation.
- If your dependent child stops being eligible for benefits under this plan (because they turn age 26 or are no longer disabled).
- If you become entitled to Medicare and this results in you losing coverage under this plan.
- In the case of your dependents' rights to continue coverage.
- If you die.

If you and/or your dependents experience a qualifying event, you each may have a right to continue coverage under this plan.

Who are the qualified beneficiaries who have COBRA rights? You (an employee of the Company), your spouse, and/or your children (including Qualified Medical Child Support Order children) are qualified beneficiaries if you were each enrolled in this plan the day before the qualifying event happened, and if the qualifying event caused you to lose coverage under this plan.

For example: if you lose your job at the Company, your coverage and your enrolled dependents' coverage will terminate. All of you will be qualified COBRA beneficiaries.

Another example: if you divorce your dependent spouse but retain custody of your children, your spouse's coverage will terminate, but yours (and your enrolled children's) will not. Your spouse will be the only qualified COBRA beneficiary.

If you are covered by COBRA, and you have a child (naturally or through adoption) during your COBRA coverage, your new child is also a qualified beneficiary with COBRA rights.

You can elect to receive COBRA coverage even if you are already eligible for Medicare or you are already covered under another group health plan. However, keep in mind:

- If you are eligible for or enrolled in Medicare, this plan may reduce its benefits as if you were covered by Medicare.
- If you are covered under another plan, your COBRA coverage may be secondary.

How much will it cost me to have COBRA coverage? Tower Semiconductor will not subsidize your healthcare benefits under this plan. Your COBRA packet will tell you exactly what your COBRA premium will be.

What do I have to do to get COBRA coverage? Your notice responsibilities and the amount of time you have to elect COBRA coverage will vary depending on what qualifying event you experience.

If you get divorced or separated, or if your dependent child loses eligibility:

- You must notify Tower Semiconductor's Benefits Team in writing within 30 days of the qualifying event.
- You must provide the notice form to Tower Semiconductor within 60 days of the qualifying event. THERE ARE NO EXCEPTIONS: if you miss the 60-day notice window, all qualified beneficiaries will lose their right to elect COBRA.
- If your qualifying event was the end of your marriage, you may be required to provide a copy of your legal divorce decree or legal separation document to Tower Semiconductor.
- Once you notify Tower Semiconductor of the qualifying event, the COBRA Administrator will send you a COBRA packet with election forms/instructions which you must return by the deadline specified in the packet.
- You must pay your COBRA premium within 45 days of the day you elect COBRA. THERE ARE NO EXCEPTIONS: if you miss the 45-day payment window for your first payment, all qualified beneficiaries will lose their COBRA benefits.

If you lose your job, your hours are reduced, or you become Medicare-eligible:

- You do not need to notify anyone of your qualifying event or request materials. You should automatically receive a COBRA packet, including election paperwork, in the mail from PlanSource shortly after your qualifying event. Your packet will have all of the forms and instructions you need to make your election.
- You must return your election form within 60 days of the date you receive your COBRA packet or the date your coverage would terminate, whichever is later.
- You must pay your COBRA premium within 45 days of the day you elect COBRA. THERE ARE NO EXCEPTIONS: if you miss the 45-day payment window for your first payment, all qualified beneficiaries will lose their COBRA benefits.

Notice or election by any other method is not acceptable. You must follow the procedures exactly to ensure you and your dependents receive your COBRA coverage. Contact PlanSource with any specific questions, or reach out to Collective Health for general guidance.

How long does COBRA coverage last? The amount of time you can keep COBRA benefits will vary based on what qualifying event you experience.

- If you lose your job or have a reduction in work hours, you have up to 18 months of COBRA coverage.
 - › If your family has a second qualifying event during these 18 months—if your dependent child loses eligibility, your marriage ends, you enroll in Medicare, or you die—your dependents' coverage will be extended to 36 months from the date of the original qualifying event. The same notice requirements apply.
 - › If you or your dependents are determined to have been disabled (for Social Security disability purposes) at the time of, or within 60 days after, the COBRA qualifying event, you may extend your COBRA coverage for all qualified beneficiaries for up to 29 months total, from the date of the original qualifying event. You must notify PlanSource of the disability determination within 60 days of the disability determination or the qualifying event, whichever is later (and before the expiration of the original 18-month period).
- If you became eligible for Medicare while an active employee of the Company and then, within 18 months, lose your job or have a reduction in work hours, your spouse or dependents will have up to 36 months of COBRA coverage from the date you became eligible for Medicare.
- If you have a divorce or legal separation, your dependent loses dependent status, you enroll in Medicare or you die, you (and your family members that are qualified beneficiaries) have up to 36 months of COBRA coverage.

In some cases, your COBRA coverage will end before your 18, 29, or 36 months are up. Your coverage will terminate immediately:

- If Tower Semiconductor stops providing healthcare benefits to its employees.
- If you don't pay your COBRA premium on time. (After the first payment, which must be on time, you will have a 30-day grace period for remaining payments.)
- On the day you begin coverage under another group health plan after electing COBRA coverage.
- When you first enroll in Medicare after electing COBRA coverage.
- For cause under the plan (such as if you commit fraud), to the extent permitted by law.
- If Social Security makes a final determination that you or your dependent is not disabled, and this disability was the basis for your COBRA coverage.

I still don't understand COBRA. Help? You're not alone—COBRA can be very confusing, and the procedures you must follow to make sure you retain your COBRA rights are very specific. Don't hesitate to ask questions: contact PlanSource, reach out to Collective Health, or ask Tower Semiconductor's Benefits Team if you need assistance.

Continuing Your Benefits Coverage During Uniformed Service

USERRA (the Uniformed Services Employment and Reemployment Rights Act) protects the job rights of individuals who—voluntarily or involuntarily—leave their jobs to serve in this country’s uniformed services. This protection extends to the healthcare benefits that you received as part of your employment.

If you leave your job to perform qualifying service, you have the right to continue your existing employer-sponsored health plan coverage for you and your dependents (if any) for up to 5 years while you serve. (USERRA continuation coverage will run concurrently with any COBRA continuation coverage.) You must notify Tower Semiconductor or Collective Health that you want USERRA coverage within 60 days of your first day of qualifying service (in other words, within 60 days from the first day you are absent from work because you are performing service). Your coverage will be retroactive to your first day of qualifying service. Unlike COBRA, USERRA doesn’t provide independent continuation rights to your dependents: they will only be eligible for continued coverage if you elect USERRA coverage for yourself. Any USERRA coverage you have runs concurrently with any rights to COBRA coverage.

USERRA coverage requires you to pay for your continued benefits. You must pay the same employee contribution that you would usually pay while employed. Payment is due on the first day of the month, and you will have a 30-day grace period to make each payment. If you fail to make your payment on time (including the grace period), your coverage will be terminated, and cannot be reinstated until you return to work.

Your USERRA coverage may be terminated if:

- Tower Semiconductor stops providing group health coverage to its employees.
- You fail to return from service or re-apply for employment with the Company.
- There is good cause to terminate your coverage under the terms of this plan (for example, if you submit fraudulent claims).

Even if you don’t elect to continue coverage during your service, you have the right to be reinstated in your employer-sponsored health plan when you are re-employed. However, the plan will not cover service-connected illnesses or injuries (which should be covered by your military insurance).

Continuing Your Benefits Coverage During a Leave of Absence from Work

If you take a leave of absence from work, you may be able to continue receiving coverage under this plan, in accordance with your company’s policy, for yourself and any dependents, during your leave. Your specific rights and responsibilities are described in the governing documents for Tower Semiconductor’s employee benefits plans. Contact Tower Semiconductor’s Benefits Team for more information about your rights to continue coverage during a leave of absence, including whether you must pay the full cost of coverage and whether your coverage will be reinstated when you return to work.

Family and Medical Leave: This plan will comply with the Family and Medical Leave Act of 1993 (FMLA) and the Department of Labor regulations that implement FMLA, along with applicable state and local leave laws. While on FMLA leave, your coverage will continue on the same terms (and at the same cost to you) as you had before your

leave began, for the full period of your FMLA leave. If you choose to end your coverage for the period of your FMLA leave or other legally mandated leave, your coverage will be reinstated when you return to work.

Other employer-approved leave of absence: If you take a leave of absence that is approved by Tower Semiconductor and that is a paid leave (meaning you continue receiving your wages while you are on leave), your coverage will continue on the same terms (and at the same cost to you) as you had before your leave began. This is true if, for example, you take a statutory, parental, medical, or other contractually protected leave of absence.

While you are on leave, you will have the same rights to participate in open enrollment as all other participating employees who are not on leave. This means that if open enrollment falls during your leave, you will still be able to make elections for coverage for the next plan year, as long as you and your dependents still meet the eligibility requirements. Contact Tower Semiconductor's Benefits Team for information on your open enrollment rights during a leave of absence.

All of these determinations will be made in accordance with Tower Semiconductor's leave of absence policies. Contact Tower Semiconductor's Benefits Team for information about how you can continue coverage while you are on leave.

Section 11: Coordination of Benefits

This section describes how benefits under this plan will be coordinated with any other healthcare plan that provides benefits to you or your dependents. For example, if you are a member of this plan and also enrolled as a dependent on your spouse's employer-sponsored health plan, this plan will coordinate its benefits with your other plan's benefits. One plan will pay out full benefits first (called primary), and then the other plan will begin paying benefits (called secondary), until all of the benefits are exhausted or until the allowed amount for your care is paid. Your total benefits from all of your healthcare plans will never exceed the actual cost of your care.

The rules governing who pays primary and who pays secondary are different depending on the other healthcare benefits plan you have. This section lays out those rules. If you are confused or have any questions, you can contact Collective Health for guidance.

When the Plan Will Coordinate Benefits

This plan will coordinate benefits with any insurance, program, or other arrangement that entitles you or your dependents to payment or reimbursement of medical expenses. For example: if you are also covered under your spouse's employer-sponsored healthcare plan; if you have disability insurance that reimburses medical expenses; or if you are covered by Medicare or Tricare. The only time we will not is when coordination of benefits is legally prohibited.

How is Collective Health informed of your additional insurance?

Sometimes we receive an indication of an additional insurance plan on a claim your provider submits. When this occurs, we'll send you a form to confirm whether you or your dependent has another insurance plan. If you respond and it is determined that this plan is the member's primary plan, we'll process the claim and apply benefits to covered services. If this plan is determined to be the member's secondary plan and the primary plan has not processed the claim, we will deny the claim so that the primary plan can process it first. Then, the provider can re-submit the claim to us so we can apply secondary benefits to it. Please note that if you do not respond, the claim will be denied until you have confirmed whether you or your dependent has additional insurance.

You don't have to wait to receive a claim in order reach out to Collective Health to let us know whether you or your dependents have an additional insurance plan. Please contact a Member Advocate at 833-440-1639 to inform them of your or your dependents' additional coverage (or lack thereof).

This Plan's Coordination Rules

1. Does the other plan have a coordination of benefits (COB) provision—a section like this one? If it does not, then the other plan will always pay primary.
2. No-fault auto coverage, personal injury protection coverage, and home, auto, and commercial medical payment coverage are always primary to this plan.
3. The plan that covers a person as a retiree or laid-off employee (not an active employee), including COBRA, will pay secondary to a plan covering that person as an active employee.
 - a. Not all plans have this “retiree” rule in their COB provisions. If the other plan does not have the retiree rule, and that results in a conflict over who pays secondary, the retiree rule does not apply.
4. If a person is covered under a disability extension from a previous plan, that plan will pay primary and this plan will pay secondary.
5. The plan that covers a person as an active employee will always pay primary over the plan that covers that person as a dependent. (For example: if your spouse is covered by their employer plan and is also a dependent on your Tower Semiconductor plan, their plan will pay primary and the Tower Semiconductor plan will pay secondary.)
6. For a dependent child covered by more than one parent (including step-parents):
 - a. If there is a court order establishing that one parent has financial responsibility for the healthcare expenses of the child (or a Qualified Medical Child Support Order), that parent's plan will always pay primary.
 - b. If the child's parents are married (not separated or divorced):
 - i. The plan of the parent whose birthday is earlier in the calendar year will pay primary, and the plan of the other parent will pay secondary. (For example: if you [DOB Jan. 12, 1960] and your spouse [DOB Nov. 15, 1955] both cover your child as a dependent, your plan will pay primary and your spouse's plan will pay secondary.)
 - ii. Not all plans have this “birthday” rule in their COB provisions. If the other plan that covers a dependent child does not have the birthday rule, and that results in a conflict

- over who should pay primary, the other plan (the one without the birthday rule) will control.
- c. If the child's parents are separated or divorced:
 - i. The plan of the parent with custody of the child will pay primary.
 - ii. If the parent with custody has remarried, the plan of that parent's spouse (the child's step-parent) will pay secondary.
 - iii. The plan of the parent without custody of the child will be the last to pay.
7. Medicare, Tricare, and state children's health insurance plans will pay primary, secondary, or last as required by federal and state laws.
 - a. Medicare is generally the secondary payer when you have group health plan coverage through Collective Health. If you or a dependent is eligible for COBRA and is enrolled in Medicare, or could enroll in Medicare in the future, you may want to consult your health care advisor before electing COBRA as the coordination of COBRA and Medicare, and which one pays first, is complicated. You may find additional information at <https://www.doi.gov/sites/doi.gov/files/migrated/flert/training/upload/Medicare-Guide-to-Who-Pays-First.pdf>
 - b. This plan will pay primary (and Medicare will pay secondary) for Medicare-eligible individuals who:
 - i. Are active current employees age 65 and older, and spouses age 65 and older of active current employees;
 - ii. Have end-stage renal disease, for a limited period of time; or
 - iii. Are active current employees and disabled.
 8. If none of the rules above apply, then the plan that has covered the person for a longer period of time will pay primary. (For example: if this plan has covered you for four months and your other plan has covered you for four years, the other plan will pay primary and this plan will pay secondary.)
 9. The plan will never reduce benefits because you or your dependents are eligible for or covered by Medicaid.

What Coordination Means for Your Benefits

If this plan is paying primary, then the plan will pay benefits as usual, without any reduction. In other words, the fact that you have additional secondary coverage will not reduce your benefits under this plan. Your providers may invoice your secondary plan to cover your copay or excess charges.

If this plan is secondary to another plan, the plan will calculate its standard benefit payment for the services in absence of another insurer. The standard benefit payment will be calculated using the lesser of the plans' allowed amounts, with the exception of the primary insurer being Medicare; in that case, this plan will always use Medicare's allowed amount. The plan will only pay as secondary if the amount your primary plan paid is lower than the allowed amount used for the standard benefit payment. The plan's secondary payment will not exceed its normal benefit payment in the absence of a primary insurer. This payment methodology is called "traditional coordination of benefits."

If your primary plan does not cover certain services that are covered by this plan, then this plan will pay for those services as primary. If this plan is supposed to pay primary, but your secondary coverage pays instead, Collective Health may provide repayment to your other coverage. This repayment will be considered benefits to you under this plan.

Section 12: The Plan's Right to Repayment

In some circumstances, this plan will be entitled to a refund for some or all of the benefits it pays for your medical care—for example, because a third party is responsible for your injuries, or your provider over-billed the plan, or the plan made a payment in error. This section describes the plan's rights to seek recovery from the person responsible for your injuries and refunds of overpayments.

Read this section carefully, because it describes your obligations to the plan and the potential consequences of not meeting those obligations.

Recovery from the Person Responsible for Your Injuries

Your illness or injury may be someone else's fault. For example, if you are in a car accident and you dislocate your shoulder, the other driver may be held responsible for the accident and for your resulting injuries. The plan may pay for the treatment of your dislocated shoulder in the first instance after your accident. But if you receive money from the person responsible for your injuries, the plan is entitled to be paid back from those proceeds. Even if you choose not to pursue your claim, the plan is entitled to seek recovery from the person who is financially responsible for your injuries (in the car accident example, this could be the other driver or his insurance company or even your own insurance company).

This section describes the rules that apply when another person or entity (a "third party") may be responsible for your injury or illness. Third party includes, but is not limited to, no-fault auto coverage, personal injury protection coverage, medical payment coverage, uninsured and underinsured motorist coverage, and third-party assets and insurance coverage. The rights and obligations described in this section apply to you and also independently to your dependents.

By accepting healthcare benefits under this plan, you agree to automatically assign to the plan any rights you may have to recover from third parties for your injuries.

- The plan has the right to repayment for the full cost of your care (both medical and pharmacy), from the first dollar you recover, up to 100% of what the third party pays you. But the plan will not seek recovery for amounts over what the plan paid for your care.
- The plan is entitled to any funds you recover from the third party, even if they are labeled as something other than medical costs, such as "non-economic damages" or "punitive damages."

- The plan has the right to recover funds even if you are not made whole. The “make whole” doctrine does not apply.
- The plan is not required to reimburse you for any attorneys’ fees or costs that you incur during the process of seeking damages from a third party. The “common fund,” “fund,” or “attorneys’ fund” doctrines do not apply.
- Whether or not you decide to pursue a claim against the third party responsible for your illness or injury, the plan can make its own claim against the third party.
- You must cooperate with the plan’s efforts to seek recovery from a responsible third party. Specifically, you must:
 - › Respond to any requests for information about any accidents or injuries. These requests may come from someone other than Collective Health.
 - › Provide any relevant information requested.
 - › Sign, and deliver, any required documents.
 - › Notify the plan of any legal claims you may have against third parties for your injuries or illness.
 - › Participate as needed in the plan’s efforts to recover funds, including participating in medical examinations and appearing at legal proceedings (such as depositions or court hearings).
 - › If requested, assign to the plan all rights of recovery you have against third parties, to the extent the plan paid benefits to you.
- You may not settle or release your claims against the third party without first obtaining the consent of the plan administrator.
- If you receive any payment from a third party, and the plan claims that those funds are owed to the plan, you must hold those funds in trust—either in a separate bank account in your name, or in your attorney’s trust account. You must serve as trustee over those funds, to the extent the plan paid benefits to you.
- You must promptly reimburse the plan if you receive any recovery related to your injuries or illness.
- The plan’s rights under this section apply even if you die as a result of your injuries, if a third party is responsible to your survivors.

If a child receives benefits from the plan for an illness or injury caused by a third party, then these rules apply to the parents, guardians, or other representatives of that child.

If you fail to meet your obligations under this section, the plan may refuse to pay benefits for your injuries, or may reduce your future benefits until the plan has been fully repaid.

Refund of Overpayments

When you need medical treatment, this plan may pay benefits first and ask questions later so that your care is not unnecessarily delayed. Sometimes, this approach may result in the plan paying more for your care than it should. This is called overpayment.

You or your provider may need to submit specific information with a claim, such as medical information and coordination of benefits information. The plan cannot always wait until all of the information has been submitted, or verify the accuracy of all the information, before the claim is treated as filed. For example, the plan may pay a

physician's invoice for your treatment, and later discover that the invoice was billed for services you didn't receive. Or, the plan may pay the provider and reimburse you for the same treatment. In any case where the plan pays more than it should (even if the mistake was ours), the plan may seek a refund.

In the case of overpayment, the plan has the right to seek a refund from you, your physician, a medical facility, another health benefit plan, or other person or entity as appropriate. You agree, as a member of this plan, to refund the plan or have your future claims offset if you receive the overpayment, and to assist the plan in recovering overpayments from others.

If you fail to meet your obligations under this section, the plan may refuse to pay benefits for your injuries or may reduce your future benefits until the plan has been fully repaid.

Section 13: Changes to This Plan's Terms

Tower Semiconductor (as the plan's sponsor) reserves the right to change, interpret, modify, withdraw or add benefits to, or terminate this plan—at any time, in its sole discretion, and without your approval. Any amendments, changes, or termination are effective on the date specified by Tower Semiconductor. If the terms of this plan or its costs change substantially, you may be given a right to change your enrollment selection mid-year.

If this plan is terminated, your rights and benefits are limited to the healthcare services you incurred before termination. Tower Semiconductor may set a deadline for submission of claims after termination of the plan.

Any amendment to or termination of the plan will be made in writing, and you will receive notice of termination or any material modification to the plan. No one has the authority to make any oral modification to this plan's terms.

Section 14: Plan Administration

Plan Administrator's Responsibilities

Tower Semiconductor Newport Beach Inc. (referred to as "Tower Semiconductor") is the sponsor of this plan. Tower Semiconductor is also the plan administrator for this plan. At its discretion, Tower Semiconductor may appoint an individual or committee to serve as plan administrator.

The plan administrator has the sole and exclusive discretion to:

- Interpret this SPD;
- Develop policies, practices, and procedures for this plan; and
- Administer this plan in accordance with those policies, practices, and procedures.

The plan administrator will exercise its discretion and fulfill its responsibilities in accordance with the provisions of ERISA. The plan administrator may delegate some of its responsibilities to Collective Health or to other individuals or entities as appropriate. Collective Health is the claims administrator. This plan is self-insured; therefore, Collective Health is not an insurer and is not responsible for the payments of benefits or claims.

The plan administrator serves without compensation. However, all expenses for administration of the plan (including compensation for hired services) will be paid by the plan, unless paid by Tower Semiconductor.

Plan Information Summary

Plan name	Tower Semiconductor PPO plan
Plan sponsor's Employer Identification Number (EIN)	020541231
Plan number	501
Plan year	January 1 through December 31
Type of plan	Group health plan
Type of administration	Self-insured, with Collective Health serving as the third-party administrator
Plan administrator	Tower Semiconductor Newport Beach Inc. 4321 Jamboree Rd Newport Beach, CA 92660
Plan sponsor	Tower Semiconductor Newport Beach Inc. 4321 Jamboree Rd Newport Beach, CA 92660
Agent for legal service	Tower Semiconductor Newport Beach Inc. 4321 Jamboree Rd Newport Beach, CA 92660 Service of legal process may be made to the head of the legal department or to the plan administrator.
Named fiduciary	Tower Semiconductor Newport Beach Inc. 4321 Jamboree Rd Newport Beach, CA 92660
Medical claims administrator	Attn: Collective Health Claims Administrators CollectiveHealth Administrators, LLC 1557 W Innovation Way, Suite 125 Lehi, UT 84043 833-440-1639 Not an insurer; does not guarantee benefits

Funding medium and contributions	<p>This plan is self-insured: benefits are paid from the general assets of the plan sponsor (Tower Semiconductor Newport Beach Inc.) and not guaranteed under an insurance policy or contract.</p> <p>The operating expenses for this plan are paid with contributions by the plan sponsor (Tower Semiconductor Newport Beach Inc.) and contributions by participating employees. Employee contributions will be used first to cover benefits under the plan.</p>
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Section 15: Legal Provisions and Your Legal Rights

Your ERISA Rights

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

- Receive information about your plan and benefits

You may examine, without charge, at the plan administrator's office and at other specified locations, all documents governing the plan.

You may obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan and updated SPD. The plan administrator may make a reasonable charge for the copies.

- Continue group health plan coverage

You may continue healthcare coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage.

Review this SPD and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

- Prudent actions by plan fiduciaries

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

- Enforce your rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

- Assistance with your questions

If you have any questions about this plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Your HIPAA Privacy Rights

Federal regulations under the Health Insurance Portability and Accountability Act (HIPAA) require group health plans to safeguard the privacy of your protected health information (PHI). However, as explained below, the plan may use and disclose PHI, including your PHI, in some cases.

PHI is data about a past, present or future physical or medical condition, treatment received, or payment for healthcare that also identifies the person it relates to. Your PHI will not be used or disclosed by the plan without a written authorization from you, except as described in the HIPAA notice of privacy practices you received from the plan. The plan is allowed to use or disclose PHI for a variety of reasons, including (but not limited to): for treatment, payment and healthcare operations, pursuant to your authorization, for public health purposes, to Tower Semiconductor as the plan sponsor for its plan administrative purposes, as required by law, and as described in the HIPAA notice of privacy practices. If the plan discovers an unauthorized access, use, disclosure, modification, or destruction of your PHI (also called a "breach"), the plan will notify you.

You and your covered dependents will have the rights set forth in the plan's HIPAA notice of privacy practices and any other rights and protections required under HIPAA. The notice may periodically be revised.

The plan's privacy practices and your rights under HIPAA are contained in the notice of privacy practices that has been distributed to you. To request a copy of the plan's notice of privacy practices, you may contact the plan's Privacy Officer, whose contact information is provided below. You may receive the notice of privacy practices by email if you wish.

The plan has established a complaint procedure concerning the handling of PHI, which is explained in the notice of privacy practices. All complaints or issues raised by plan members with respect to the use of their PHI must be submitted in writing to the Privacy Officer.

Craig Rowe

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Newport Beach, CA 92660

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A response will be provided within a reasonable period of time, including time to investigate and resolve any issues, after the receipt of the written complaint. The Privacy Officer has full discretion in resolving the complaint and making any required interpretations and factual determinations. The decision of the Privacy Officer will be final and be given full deference by all parties.

Nondiscrimination Policy

This plan will not discriminate against any individual based on race, color, religion, national origin, disability, gender, sexual orientation, or age. This plan will not establish rules for eligibility based on health status, medical condition, claims experience, receipt of healthcare, medical history, evidence of insurability, genetic information, or disability.

This plan intends to be nondiscriminatory and to meet the requirements under applicable provisions of the Internal Revenue Code of 1986. If the plan administrator determines before or during any plan year that this plan may fail to satisfy any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to highly compensated individuals, the plan administrator shall take such action as the plan administrator deems appropriate, under rules uniformly applicable to similarly situated covered employees, to assure compliance with such requirements or limitation.

Newborns' and Mothers' Health Protection Act

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

issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Qualified Medical Child Support Order Procedures

The plan will provide benefits as required by any Qualified Medical Child Support Order (QMCSO), as defined in ERISA Section 609(a) or National Medical Support Notice. For a copy of the plan's QMCSO procedures, please contact Tower Semiconductor's Benefits Team. The healthcare components of the plan will also provide benefits to dependent children placed with you for adoption under the same terms and conditions as apply in the case of dependent children who are your natural children, in accordance with ERISA Section 609(c).

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For more information, please contact Collective Health.

Mental Health Parity and Addiction Equity

Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, as amended, this plan applies its terms uniformly and enforces parity between covered medical/surgical and covered mental health or substance use disorder benefits. Claims that are billed with a primary or principal diagnosis code categorized by the International Statistical Classification of Diseases and Related Health Problems (ICD-10) as a mental health condition, behavioral health condition, or substance use disorder are adjudicated as mental health claims. For further details, please contact Collective Health.

Genetic Information Nondiscrimination Act

This plan will be operated and maintained in a manner consistent with the Genetic Information Nondiscrimination Act, which provides federal protection from genetic discrimination in health insurance and employment.

Affordable Care Act

This section describes some of the applicable provisions of the federal healthcare reform laws (known as the Affordable Care Act). These provisions have been incorporated into the plan.

- You can cover your adult children to age 26.
- You do not need prior authorization to see an in-network OB/GYN provider.
- If your medical coverage requires you to designate a primary care physician, you have the right to designate any in-network primary care physician accepting new patients and may designate an in-network pediatrician for your children.
- You may seek emergency medical services at an in-network or out-of-network provider without having to obtain prior authorization and with the same cost sharing; however, the out-of-network provider may balance bill you for the difference between its charge and the allowed amount paid by the plan.
- Your medical coverage cannot be retroactively cancelled, unless you fail to timely pay premiums or commit intentional misrepresentation or fraud or as otherwise permitted by applicable law. In other circumstances, you will generally be provided advance notice of cancellation.
- There are no pre-existing condition exclusions and no aggregate annual or lifetime limits on essential health benefits.
- You are not required to pay a co-payment or other cost sharing for in-network preventive and wellness services, such as routine exams, immunizations, mammograms, and routine baby care (see www.healthcare.gov for more information).
- The plan provides minimum value and is affordable as required under the Affordable Care Act.
- You may be entitled to external review of certain healthcare claims. More detailed information may be found in Section 9.

Appendix A: Care Outside the United States—Blue Cross Blue Shield Inter-Plan Programs

This information is provided by Anthem Blue Cross of California (“Anthem”) and describes benefits you may receive through the BlueCard program and internationally

Out-of-Area Services

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

When you receive care from non-participating providers, you will receive it from one of two kinds of providers. Most providers (“participating providers”) contract with the local Blue Cross and/or Blue Shield Plan in that geographic area (“Host Blue”). Some providers (“non-participating providers”) do not contract with the Host Blue. We explain below how we pay both kinds of providers.

Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are prescription drugs that you obtain from a pharmacy and most dental or vision benefits.

A. BlueCard[®] Program

Under the BlueCard[®] Program, when you receive covered services within the geographic area served by a Host Blue, Anthem will still facilitate the processing of claims, but, the Host Blue is responsible for: (a) contracting with its providers; and (b) handling its interactions with those providers.

When you receive covered services outside the Anthem service area and the claim is processed through the BlueCard Program, the amount you pay is calculated based on the lower of:

- The billed charges for covered services; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to the provider. Sometimes, it is an estimated price that takes into account special arrangements with that provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average

savings for services provided by similar types of providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price we used for your claim because they will not be applied after a claim has already been paid.

B. Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, Anthem may process your claims for covered services through negotiated arrangements for national accounts.

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

C. Special Cases: Value-Based Programs

BlueCard[®] Program

If you receive covered services under a value-based program inside a Host Blue's Service Area, you will not be responsible for paying any of the provider incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to Anthem through average pricing or fee schedule adjustments. Additional information is available upon request.

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

If Anthem Blue Cross has entered into a negotiated arrangement with a Host Blue to provide value-based programs to your plan on your behalf, Anthem will follow the same procedures for value-based programs administration and care coordinator fees as noted above for the BlueCard Program.

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

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

E. Non-participating Providers Outside Our Service Area

The pricing method used for nonparticipating provider claims is described in Section 3 of this SPD.

F. Blue Cross Blue Shield Global Core[®] Program

Benefits for services received outside of the United States are different from services received in the United States. Your plan only covers emergency, including ambulance, services outside of the United States. Remember to take an up to date health ID card with you.

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

Keep in mind, if you need emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

How Claims Are Paid with Blue Cross Blue Shield Global Core

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

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

- Physician services;
- Inpatient hospital care not arranged through Blue Cross Blue Shield Global Core; and
- Outpatient services.

You will need to file a claim form for any payments made up front with Collective Health.

Appendix B: Pharmacy Benefit Exclusions

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Medications Requiring Prior Authorization for Medical Necessity

Below is a list of medicines by drug class that will not be covered without a prior authorization for medical necessity. If you continue using one of these drugs without prior approval for medical necessity, you may be required to pay the full cost.

If you are currently using one of the drugs requiring prior authorization for medical necessity, ask your doctor to choose one of the generic or brand formulary options listed below.

Category Drug Class	Drugs Requiring Prior Authorization for Medical Necessity ¹	Formulary Options
Acromegaly	SANDOSTATIN LAR SIGNIFOR LAR SOMAVERT	SOMATULINE DEPOT
Allergies Antihistamines	dexchlorpheniramine Diphen Elixir RyClora CARBINOXAMINE TABLET 6 MG	levocetirizine
Allergies Nasal Steroids / Combinations	BECONASE AQ OMNARIS QNASL ZETONNA	flunisolide spray, fluticasone spray, mometasone spray, DYMISTA
Anticonvulsants	ZONEGRAN	carbamazepine, carbamazepine ext-rel, divalproex sodium, divalproex sodium ext-rel, gabapentin, lamotrigine, lamotrigine ext-rel, levetiracetam, levetiracetam ext-rel, oxcarbazepine, phenobarbital, phenytoin, phenytoin sodium extended, primidone, tiagabine, topiramate, valproic acid, zonisamide, FYCOMPA, OXTELLAR XR, TROKENDI XR, VIMPAT, XCOPRI
	ONFI	clobazam, lamotrigine, topiramate, TROKENDI XR
	SABRIL	vigabatrin
Anti-infectives, Antibacterials Erythromycins / Macrolides	E.E.S. GRANULES ERYPED	erythromycins
Anti-infectives, Antibacterials Tetracyclines	CoreMino doxycycline hyclate delayed-rel tablet 200 mg doxycycline hyclate tablet 50 mg (NDC* 72143021160 only) doxycycline hyclate tablet 75 mg doxycycline hyclate tablet 150 mg doxycycline monohydrate capsule 75 mg doxycycline monohydrate capsule 150 mg minocycline ext-rel Mondoxine NL capsule 75 mg ACTICLATE DORYX DORYX MPC MINOCIN TARGADOX	doxycycline hyclate 20 mg, doxycycline hyclate capsule, minocycline, tetracycline
Anti-infectives, Antibacterials Miscellaneous	MACRODANTIN	nitrofurantoin
Anti-infectives, Antifungals	flucytosine capsule 500 mg	fluconazole
	posaconazole delayed-rel tablet	fluconazole, itraconazole
Anti-infectives, Antivirals Cytomegalovirus *	VALCYTE	valganciclovir
Anti-infectives, Antivirals Hepatitis B *	BARACLUDE TABLET	entecavir, lamivudine, VEMLIDY



Category Drug Class	Drugs Requiring Prior Authorization for Medical Necessity ¹	Formulary Options
Anti-infectives, Antivirals Hepatitis C *	MAVYRET	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6), VOSEVI ²
	VIEKIRA PAK ZEPATIER	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6), HARVONI (genotypes 1, 4, 5, 6)
Anti-infectives, Antivirals Herpes *	acyclovir cream VALTREX	acyclovir capsule, acyclovir tablet, valacyclovir
Anti-infectives Miscellaneous	DARAPRIM	pyrimethamine
Antiobesity	CONTRAVE QSYMIA	SAXENDA
Anxiety * Benzodiazepines	XANAX XANAX XR	alprazolam, clonazepam, diazepam, lorazepam, oxazepam
Asthma * Beta Agonists, Short-Acting	PROAIR HFA PROAIR RESPICLICK PROVENTIL HFA VENTOLIN HFA XOPENEX HFA	albuterol sulfate CFC-free aerosol, levalbuterol tartrate CFC-free aerosol
Asthma * Leukotriene Modulators	SINGULAIR	montelukast, zafirlukast, zileuton ext-rel
Asthma * Steroid Inhalants	ALVESCO ASMANEX ASMANEX HFA	ARNUITY ELLIPTA, FLOVENT DISKUS, FLOVENT HFA, PULMICORT FLEXHALER, QVAR REDIHALER
Asthma * or Chronic Obstructive Pulmonary Disease (COPD) * Steroid / Beta Agonist Combinations	DULERA	ADVAIR DISKUS, ADVAIR HFA, BREO ELLIPTA, SYMBICORT
Attention Deficit Hyperactivity Disorder *	ADZENYS ER ADZENYS XR-ODT APTENSIO XR DAYTRANA	amphetamine-dextroamphetamine mixed salts ext-rel [†] , methylphenidate ext-rel [†] , MYDAYIS, VYVANSE
	EVEKEO	amphetamine-dextroamphetamine mixed salts, methylphenidate
Autoimmune Conditions	INTUNIV	amphetamine-dextroamphetamine mixed salts ext-rel [†] , atomoxetine, guanfacine ext-rel, methylphenidate ext-rel [†] , MYDAYIS, VYVANSE
	ACTEMRA	ENBREL, HUMIRA, RINVOQ, XELJANZ, XELJANZ XR
	CIMZIA	COSENTYX, ENBREL, HUMIRA, OTEZLA, RINVOQ, SKYRIZI, STELARA SUBCUTANEOUS, TREMFYA, XELJANZ, XELJANZ XR
	ENTYVIO	HUMIRA, STELARA SUBCUTANEOUS, XELJANZ, XELJANZ XR
	KINERET	ENBREL, HUMIRA, RINVOQ, XELJANZ, XELJANZ XR
	ORENCIA CLICKJECT ORENCIA INTRAVENOUS ORENCIA SUBCUTANEOUS	COSENTYX, ENBREL, HUMIRA, OTEZLA, RINVOQ, STELARA SUBCUTANEOUS, XELJANZ, XELJANZ XR
	SIMPONI	COSENTYX, ENBREL, HUMIRA, OTEZLA, RINVOQ, STELARA SUBCUTANEOUS, XELJANZ, XELJANZ XR
	TALTZ	COSENTYX, ENBREL, HUMIRA, OTEZLA, SKYRIZI, STELARA SUBCUTANEOUS, TREMFYA, XELJANZ, XELJANZ XR
Cancer Chronic Myelogenous Leukemia *	GLEEVEC TASIGNA	imatinib mesylate, BOSULIF, SPRYCEL



Category Drug Class	Drugs Requiring Prior Authorization for Medical Necessity ¹	Formulary Options
<i>Cancer</i> Multiple Myeloma * Proteasome Inhibitors	BORTEZOMIB KYPROLIS	NINLARO, VELCADE
<i>Cancer</i> PI3K Inhibitors for Follicular Lymphoma *	ALIQUOPA ZYDELIG	COPIKTRA
<i>Cancer</i> Prostate * Hormonal Agents, Antiandrogens	NILANDRON ZYTIGA	<i>abiraterone, bicalutamide, XTANDI, YONSA</i>
<i>Cardiovascular</i> Antiarrhythmics	BETAPACE BETAPACE AF	<i>sotalol</i>
<i>Cardiovascular</i> Antilipemics Cholesterol Absorption Inhibitors	ZETIA	<i>ezetimibe</i>
<i>Cardiovascular</i> Antilipemics Fibrates	<i>fenofibrate tablet 120 mg</i> FENOGLIDE TABLET 120 MG TRICOR	<i>fenofibrate (except fenofibrate tablet 120 mg), fenofibric acid delayed-rel</i>
<i>Cardiovascular</i> Antilipemics HMG-CoA Reductase Inhibitors (HMGs or Statins) / Combinations ³	ALTOPREV CRESTOR LESCOL XL LIPITOR LIVALO	<i>atorvastatin, ezetimibe-simvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, simvastatin</i>
<i>Cardiovascular</i> Antilipemics Niacins	<i>niacin tablet 500 mg</i> <i>Niacor</i>	<i>niacin ext-rel</i>
<i>Cardiovascular</i> Antilipemics PCSK9 Inhibitors	REPATHA	PRALUENT
<i>Cardiovascular</i> Digitalis Glycosides	LANOXIN TABLET (125 MCG and 250 MCG only)	<i>digoxin</i>
<i>Cardiovascular</i> Diuretics	DYRENIUM	<i>amiloride, triamterene</i>
<i>Cardiovascular</i> Nitrates	<i>isosorbide dinitrate 40 mg</i>	<i>isosorbide dinitrate (except isosorbide dinitrate 40 mg), isosorbide mononitrate</i>
<i>Cardiovascular</i> Pulmonary Arterial Hypertension Endothelin Receptor Antagonists	LETAIRIS TRACLEER	<i>ambrisentan, bosentan, OPSUMIT</i>
<i>Carnitine Deficiency</i>	CARNITOR CARNITOR SF	<i>levocarnitine</i>
<i>Chronic Obstructive Pulmonary Disease (COPD) *</i> Anticholinergics	INCRUSE ELLIPTA TUDORZA	SPIRIVA, YUPELRI



Category Drug Class	Drugs Requiring Prior Authorization for Medical Necessity ¹	Formulary Options
<i>Chronic Obstructive Pulmonary Disease (COPD) *</i> Anticholinergic / Beta Agonist Combinations Long Acting	BEVESPI AEROSPHERE	ANORO ELLIPTA, STIOLTO RESPIMAT
<i>Contraceptives Monophasic</i>	BEYAZ MINASTRIN 24 FE TAYTULLA YAZ	<i>ethinyl estradiol-drospirenone, ethinyl estradiol-drospirenone-levomefolate, ethinyl estradiol-norethindrone acetate, ethinyl estradiol-norethindrone acetate-iron</i>
<i>Contraceptives Four Phase</i>	NATAZIA	<i>ethinyl estradiol-drospirenone, ethinyl estradiol-drospirenone-levomefolate, ethinyl estradiol-levonorgestrel, ethinyl estradiol-norethindrone acetate, ethinyl estradiol-norethindrone acetate-iron, ethinyl estradiol-norgestimate, LO LOESTRIN FE</i>
<i>Contraceptives Vaginal</i>	NUVARING	<i>ethinyl estradiol-etonogestrel, ANNOVERA</i>
<i>Cystic Fibrosis *</i> Inhaled Antibiotics	TOBI TOBI PODHALER	<i>tobramycin inhalation solution, BETHKIS</i>
<i>Dental Cavity/Caries Prevention</i>	PREVIDENT	Consult doctor
<i>Depression *</i> Antidepressants, Selective Serotonin Reuptake Inhibitors (SSRIs)	<i>fluoxetine tablet 60 mg</i> LEXAPRO PAXIL PAXIL CR PEXEVA PROZAC VIIBRYD	<i>citalopram, escitalopram, fluoxetine (except fluoxetine tablet 60 mg, fluoxetine tablet [generics for SARAFEM]), paroxetine HCl, paroxetine HCl ext-rel, sertraline, TRINTELLIX</i>
<i>Depression *</i> Antidepressants, Serotonin Norepinephrine Reuptake Inhibitors (SNRIs)	<i>venlafaxine ext-rel tablet (except 225 mg)</i> CYMBALTA EFFEXOR XR PRISTIQ	<i>desvenlafaxine ext-rel, duloxetine, venlafaxine, venlafaxine ext-rel capsule</i>
<i>Depression *</i> Antidepressants, Miscellaneous Agents	<i>bupropion ext-rel tablet 450 mg</i> APLENZIN OLEPTRO	<i>bupropion, bupropion ext-rel (except bupropion ext-rel tablet 450 mg)</i> <i>trazodone</i>
<i>Depression and/or Schizophrenia *</i> Antipsychotics, Atypicals	ABILIFY FANAPT SEROQUEL XR	<i>aripiprazole, clozapine, olanzapine, quetiapine, quetiapine ext-rel, risperidone, ziprasidone, LATUDA, VRAYLAR</i>
<i>Dermatology Acne *</i>	<i>clindamycin gel (NDC* 68682046275 only)</i> Vanoxide-HC ACANYA AZELEX BENZACLIN DIFFERIN LOTION FABIOR TAZORAC VELTIN ZIANA	<i>adapalene, benzoyl peroxide, clindamycin gel (except NDC* 68682046275), clindamycin solution, clindamycin-benzoyl peroxide, erythromycin solution, erythromycin-benzoyl peroxide, tretinoin, EPIDUO, ONEXTON</i>
<i>Dermatology Actinic Keratosis *</i>	<i>fluorouracil cream 0.5%</i> CARAC	<i>fluorouracil cream 5%, fluorouracil solution, imiquimod, PICATO, TOLAK, ZYCLARA</i>
<i>Dermatology Antibiotics</i>	<i>mupirocin cream</i>	<i>gentamicin, mupirocin ointment</i>



Category Drug Class	Drugs Requiring Prior Authorization for Medical Necessity ¹	Formulary Options
Dermatology Antipsoriatics	calcipotriene cream calcitriol ointment SORILUX TAZORAC VECTICAL	calcipotriene ointment, calcipotriene solution
	calcipotriene-betamethasone	calcipotriene ointment or calcipotriene solution WITH desoximetasone, fluocinonide (except fluocinonide cream 0.1%) or BRYHALI
Dermatology Atopic Dermatitis *	doxepin cream	desonide, hydrocortisone, pimecrolimus, tacrolimus, EUGRISA
Dermatology Rosacea *	doxycycline monohydrate delayed-rel capsule	ORACEA
	FINACEA GEL MIRVASO NORITATE	azelaic acid gel, metronidazole, FINACEA FOAM, SOOLANTRA
Dermatology Scars	BEAU RX CICATRACE POLYTOZA RECEDO SCARSILK PAD SIL-K PAD SILVEX SILTREX	Consult doctor
Dermatology Seborrheic Dermatitis *	ketoconazole foam 2% Ketodan	ketoconazole shampoo 2%, selenium sulfide lotion 2.5%
	XOLEGEL	ciclopirox, ketoconazole cream 2%
Dermatology Skin Inflammation and Hives * Corticosteroids	clobetasol spray CLOBEX SPRAY OLUX-E	clobetasol foam
	fluocinonide cream 0.1%	clobetasol cream
	flurandrenolide lotion (NDC [^] 24470092112 only)	desonide, hydrocortisone
	flurandrenolide ointment hydrocortisone butyrate lipophilic cream 0.1% triamcinolone acetonide aerosol 0.2% CORDRAN OINTMENT	hydrocortisone butyrate cream, hydrocortisone butyrate lotion, hydrocortisone butyrate ointment, hydrocortisone butyrate solution, mometasone, triamcinolone cream, triamcinolone lotion, triamcinolone ointment
	diflorasone cream diflorasone ointment APEXICON E PSORCON	desoximetasone, fluocinonide (except fluocinonide cream 0.1%), BRYHALI
Dermatology Warts	VEREGEN	imiquimod
Dermatology Wound Care Products	ALEVICYN GEL ALEVICYN SG ALEVICYN SOLUTION	desonide, hydrocortisone
Dermatology Miscellaneous Skin Conditions	ALCORTIN A ATOPADERM BENSAL HP EPIKERAM KAMDROY NOVACORT SYNERDERM	desonide, hydrocortisone
	oxiconazole (NDCs [^] 00168035830, 51672135902 only)	ciclopirox, clotrimazole, econazole, ketoconazole cream 2%, luliconazole



Category Drug Class	Drugs Requiring Prior Authorization for Medical Necessity ¹	Formulary Options
<i>Diabetes</i> * Biguanides	<i>metformin ext-rel</i> (generics for FORTAMET and GLUMETZA only) FORTAMET GLUMETZA RIOMET	<i>metformin</i> , <i>metformin ext-rel</i> (except generics for FORTAMET and GLUMETZA)
<i>Diabetes</i> * Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	NESINA ONGLYZA TRADJENTA	JANUVIA
<i>Diabetes</i> * Dipeptidyl Peptidase-4 (DPP-4) Inhibitor Combinations	JENTADUETO JENTADUETO XR KAZANO KOMBIGLYZE XR	JANUMET, JANUMET XR
	OSENI	JANUMET, JANUMET XR, JANUVIA WITH <i>pioglitazone</i>
<i>Diabetes</i> * Injectable Incretin Mimetics	BYDUREON BYETTA	OZEMPIC, RYBELSUS, TRULICITY, VICTOZA
<i>Diabetes</i> * Insulins	APIDRA HUMALOG	FIASP, NOVOLOG
	HUMALOG MIX 50/50	NOVOLOG MIX 70/30
	HUMALOG MIX 75/25	NOVOLOG MIX 70/30
	HUMULIN 70/30 ⁴	NOVOLIN 70/30 ⁴
	HUMULIN N ⁴	NOVOLIN N ⁴
	HUMULIN R ⁴	NOVOLIN R ⁴
	NOTE: <i>Humulin R U-500</i> concentrate will not be subject to prior authorization and will continue to be covered.	
	<i>Diabetes</i> * Long Acting Insulins ⁵	LANTUS
<i>Diabetes</i> * Insulin Sensitizers	ACTOS	<i>pioglitazone</i>
<i>Diabetes</i> * Sodium-Glucose Co-transporter 2 (SGLT2) Inhibitors	INVOKANA	FARXIGA, JARDIANCE
<i>Diabetes</i> * Sodium-Glucose Co-transporter 2 (SGLT2) Inhibitor / Biguanide Combinations	INVOKAMET INVOKAMET XR	SYNJARDY, SYNJARDY XR, XIGDUO XR
	QTERN	GLYXAMBI
<i>Diabetes</i> * Supplies, Needles ⁶	NOVO NORDISK NEEDLES OWEN MUMFORD NEEDLES PERRIGO NEEDLES ULTIMED NEEDLES All other insulin needles that are not BD ULTRAFINE brand	BD ULTRAFINE NEEDLES



Category Drug Class	Drugs Requiring Prior Authorization for Medical Necessity ¹	Formulary Options
<i>Diabetes</i> * Supplies, Syringes ⁶	ALLISON MEDICAL INSULIN SYRINGES TRIVIDIA INSULIN SYRINGES ULTIMED INSULIN SYRINGES All other insulin syringes that are not BD ULTRAFINE brand	BD ULTRAFINE INSULIN SYRINGES
<i>Diabetes</i> * Supplies, Test Strips and Kits ^{7,8}	ACCU-CHEK AVIVA PLUS STRIPS AND KITS ACCU-CHEK COMPACT PLUS STRIPS AND KITS ACCU-CHEK GUIDE STRIPS AND KITS ACCU-CHEK SMARTVIEW STRIPS AND KITS BREEZE 2 STRIPS AND KITS CONTOUR NEXT STRIPS AND KITS CONTOUR STRIPS AND KITS FREESTYLE STRIPS AND KITS All other test strips that are not ONETOUCH brand	ONETOUCH ULTRA STRIPS AND KITS ⁷ , ONETOUCH VERIO STRIPS AND KITS ⁷
<i>Dietary Supplements</i>	ENLITE CONTINUOUS GLUCOSE MONITORING SYSTEM EVERSENSE CONTINUOUS GLUCOSE MONITORING SYSTEM FREESTYLE LIBRE CONTINUOUS GLUCOSE MONITORING SYSTEM GUARDIAN CONNECT CONTINUOUS GLUCOSE MONITORING SYSTEM	DEXCOM CONTINUOUS GLUCOSE MONITORING SYSTEM
	FOSTEUM FOSTEUM PLUS	<i>alendronate, ibandronate, risedronate</i>
	<i>Activite</i> <i>DaVite</i> <i>Dextol</i> <i>Folvik-D</i> <i>Folvite-D</i> <i>Genicin Vita-S</i> <i>HylaVite</i> <i>Lorid</i> <i>TronVite</i> <i>Vitasure</i> <i>Xvite</i> FERIVA 21/7 FOLIC-K NICADAN NICAPRIN NICAZEL NICAZEL FORTE NICOMIDE OMNIVEX ORTHO D ORTHO DF RHEUMATE RIBOZEL TALIVA XYZBAC ZYVIT	<i>folic acid</i>
<i>Erectile Dysfunction</i> * Phosphodiesterase Inhibitors	CIALIS STENDRA VIAGRA	<i>sildenafil, tadalafil</i>
<i>Estrogen Replacement</i> *	MINIVELLE VIVELLE-DOT	<i>estradiol, DIVIGEL, EVAMIST</i>



Category Drug Class	Drugs Requiring Prior Authorization for Medical Necessity ¹	Formulary Options
<i>Fertility Regulators</i> Follicle-Stimulating Hormones	FOLLISTIM AQ	GONAL-F
<i>Gastrointestinal</i> Anticholinergics	<i>chlordiazepoxide-clidinium</i> (NDC^ 42494040901 only) GLYCOPYRROLATE TABLET 1.5 MG	<i>dicyclomine</i>
<i>Gastrointestinal</i> Antidiarrheals	ENTERAGAM	<i>alosetron, VIBERZI, XIFAXAN 550 MG</i>
<i>Gastrointestinal</i> Antiemetics	MYTESI	<i>diphenoxylate-atropine, loperamide</i>
<i>Gastrointestinal</i> Irritable Bowel Syndrome	TRANSDERM SCOP	<i>meclizine, scopolamine transdermal</i>
	ZUPLENZ	<i>granisetron, ondansetron, SANCUSO</i>
	AMITIZA	LINZESS, MOVANTI, SYMPROIC
	TRULANCE	LINZESS
<i>Gastrointestinal</i> Laxatives	LACTULOSE PAK	<i>lactulose solution</i>
	GOLYTELY MOVIPREP OSMOPREP SUPREP	<i>peg 3350-electrolytes, CLENPIQ</i>
<i>Gastrointestinal</i> Probiotics	PROVAD ZELAC	Consult doctor
<i>Gastrointestinal</i> Proton Pump Inhibitors (PPIs)	<i>omeprazole-sodium bicarbonate</i> ACIPHEX ACIPHEX SPRINKLE NEXIUM PREVACID PROTONIX ZEGERID	<i>esomeprazole, lansoprazole, omeprazole, pantoprazole, DEXILANT</i>
<i>Gastrointestinal</i> Ulcer Treatment	<i>sucralfate suspension</i> CARAFATE	<i>sucralfate tablet</i>
<i>Gaucher Disease</i>	ELELYSO	CERDELGA, CERZYME
<i>Genitourinary</i> Interstitial Cystitis	RIMSO-50	Consult doctor
<i>Gout *</i>	COLCRYS	<i>colchicine tablet</i>
<i>Growth Hormones</i>	HUMATROPE NUTROPIN AQ OMNITROPE SAIZEN	GENOTROPIN, NORDITROPIN
<i>Hematologic</i> Anticoagulants (oral)	PRADAXA	<i>warfarin, ELIQUIS, XARELTO</i>
<i>Hematologic</i> Erythropoiesis-Stimulating Agents	EPOGEN PROCRIT	ARANESP, RETACRIT
<i>Hematologic</i> Hemophilia A	ELOCTATE	ADYNOVATE, JIVI, KOGENATE FS, KOVALTRY, NOVOEIGHT, NUWIQ
<i>Hematologic</i> Hemophilia B	ALPROLIX	Consult doctor



Category Drug Class	Drugs Requiring Prior Authorization for Medical Necessity ¹	Formulary Options
<i>Hematologic</i> Neutropenia Colony Stimulating Factors	FULPHILA NEULASTA NEULASTA ONPRO UDENYCA	ZIEXTENZO
	GRANIX NEUPOGEN ZARXIO	NIVESTYM
<i>Hematologic</i> Platelet Aggregation Inhibitors	PLAVIX	<i>clopidogrel, prasugrel, BRIILINTA</i>
	ZONTIVITY	Consult doctor
<i>High Blood Pressure *</i> Angiotensin II Receptor Antagonists	ATACAND BENICAR DIOVAN EDARBI	<i>candesartan, irbesartan, losartan, olmesartan, telmisartan, valsartan</i>
<i>High Blood Pressure *</i> Angiotensin II Receptor Antagonist / Diuretic Combinations	ATACAND HCT BENICAR HCT DIOVAN HCT EDARBYCLOR	<i>candesartan-hydrochlorothiazide, irbesartan-hydrochlorothiazide, losartan-hydrochlorothiazide, olmesartan-hydrochlorothiazide, telmisartan-hydrochlorothiazide, valsartan-hydrochlorothiazide</i>
<i>High Blood Pressure *</i> Angiotensin II Receptor Antagonist / Calcium Channel Blocker Combinations	EXFORGE	<i>amlodipine-olmesartan, amlodipine-telmisartan, amlodipine-valsartan</i>
<i>High Blood Pressure *</i> Angiotensin II Receptor Antagonist / Calcium Channel Blocker / Diuretic Combinations	EXFORGE HCT	<i>amlodipine-valsartan-hydrochlorothiazide, olmesartan-amlodipine-hydrochlorothiazide</i>
<i>High Blood Pressure *</i> Beta-blockers	INDERAL LA INDERAL XL INNOPRAN XL TOPROL-XL	<i>atenolol, carvedilol, carvedilol phosphate ext-rel, metoprolol succinate ext-rel, metoprolol tartrate, nadolol, pindolol, propranolol, propranolol ext-rel, BYSTOLIC</i>
<i>High Blood Pressure *</i> Beta-blocker Combinations	DUTOPROL	<i>metoprolol succinate ext-rel WITH hydrochlorothiazide</i>
<i>High Blood Pressure *</i> Calcium Channel Blockers	NORVASC	<i>amlodipine</i>
	<i>diltiazem ext-rel</i> (generics for CARDIZEM LA only) Matzim LA CARDIZEM CARDIZEM CD CARDIZEM LA	<i>diltiazem ext-rel</i> (except generics for CARDIZEM LA)
<i>High Blood Pressure *</i> Calcium Channel Blocker / Nonsteroidal Anti-inflammatory Drugs (NSAIDs) Combinations	CONSENSI	<i>amlodipine WITH celecoxib</i>
<i>Huntington's Disease</i>	XENAZINE	<i>tetrabenazine, AUSTEDO</i>
<i>Immunology</i> Hereditary Angioedema	BERINERT	FIRAZYR, RUCONEST
<i>Immunology</i> Rapamycin Derivatives	ZORTRESS	<i>everolimus</i>



Category Drug Class	Drugs Requiring Prior Authorization for Medical Necessity ¹	Formulary Options
Inflammatory Bowel Disease (IBD) Ulcerative Colitis * Aminosaliclates	ASACOL HD DELZICOL LIALDA	balsalazide, mesalamine delayed-rel, mesalamine ext-rel, sulfasalazine, sulfasalazine delayed-rel, PENTASA
	COLAZAL	balsalazide
Kidney Disease * Phosphate Binders	lanthanum carbonate FOSRENOL	calcium acetate, sevelamer carbonate, PHOSLYRA, VELPHORO
Multiple Sclerosis	AVONEX EXTAVIA PLEGRIDY TECFIDERA	dimethyl fumarate delayed-rel, glatiramer, AUBAGIO, BETASERON, COPAXONE, GILENYA, KESIMPTA, MAYZENT, OGREVUS, REBIF, TYSABRI, VUMERITY, ZEPOSIA
Musculoskeletal	chlorzoxazone 375 mg chlorzoxazone 500 mg (NDC [^] 73007001303 only) chlorzoxazone 750 mg cyclobenzaprine ext-rel capsule cyclobenzaprine tablet 7.5 mg Fexmid Lorzone metaxalone 400 mg methocarbamol 500 mg (NDC [^] 69036091010 only) methocarbamol 750 mg (NDCs [^] 69036093090, 70868090190 only) orphenadrine-aspirin-caffeine Orphenesic: Forte AMRIX CHLORZOXAZONE 250 MG NORGESIC FORTE	cyclobenzaprine (except cyclobenzaprine tablet 7.5 mg)
Narcolepsy Wakefulness Promoters	NUVIGIL	armodafinil, SUNOSI
Ophthalmic Allergies	ALREX BEPREVE	azelastine, cromolyn sodium, olopatadine, LASTACAPT, PAZEO
Ophthalmic Anti-infective / Anti-inflammatory	ZYLET	neomycin-polymyxin B-bacitracin-hydrocortisone, neomycin-polymyxin B-dexamethasone, tobramycin-dexamethasone, TOBRADEX OINTMENT, TOBRADEX ST
Ophthalmic Anti-inflammatory, Nonsteroidal	PROLENSA	bromfenac, diclofenac, ketorolac, ACUVAIL, ILEVRO, NEVANAC
Ophthalmic Anti-inflammatory, Steroidal	FML LIQUIFILM LOTEMAX LOTEMAX SM PRED FORTE	dexamethasone, loteprednol, prednisolone acetate 1%, DUREZOL, FML FORTE, FML S.O.P., MAXIDEX, PRED MILD
Ophthalmic Antivirals	ZIRGAN	trifluridine
Ophthalmic Artificial Tears	LACRISERT	RESTASIS, XIIDRA
Ophthalmic Glaucoma	bimatoprost solution 0.03%	latanoprost, travoprost, LUMIGAN, ZIOPTAN
	TIMOPTIC OCUDOSE	timolol maleate solution, BETIMOL, BETOPTIC S
Ophthalmic Miscellaneous	AVENOVA	Consult doctor
Opioid Dependency	SUBOXONE	buprenorphine-naloxone sublingual, ZUBSOLV
Opioid Reversal	EVZIO	naloxone injection, NARCAN NASAL SPRAY



Category Drug Class	Drugs Requiring Prior Authorization for Medical Necessity ¹	Formulary Options
<i>Osteoarthritis</i> * Viscosupplements	GEL-ONE HYALGAN MONOVISC ORTHOVISC SYNVISC SYNVISC-ONE VISCO-3	DUROLANE, EUFLEXXA, GELSYN-3, SUPARTZ FX
<i>Osteoporosis</i> * Calcium Regulators	MIACALCIN INJECTION	<i>alendronate, calcitonin-salmon, ibandronate, risedronate, FORTEO, PROLIA, TYMLOS</i>
	MIACALCIN NASAL SPRAY	<i>calcitonin-salmon</i>
<i>Otic</i> Anti-infective / Anti-inflammatory	CIPRO HC CIPRODEX	<i>ciprofloxacin-dexamethasone, ofloxacin otic</i>
<i>Overactive Bladder / Incontinence</i> * Urinary Antispasmodics	DETROL LA ENABLEX OXYTROL	<i>darifenacin ext-rel, oxybutynin ext-rel, solifenacin, tolterodine, tolterodine ext-rel, trospium, trospium ext-rel, MYRBETRIQ, TOVIAZ</i>
<i>Pain</i> Headache *	<i>Bupap</i> <i>butalbital-acetaminophen tablet 50-300 mg</i> <i>butalbital-acetaminophen-caffeine capsule</i> <i>Vanadol LQ</i> <i>Vanadol S</i> BUTALBITAL-ACETAMINOPHEN (NDC [^] 69499034230 only) CAMBIA FIORICET CAPSULE	<i>diclofenac sodium, ibuprofen, naproxen (except naproxen CR or naproxen suspension)</i>
	<i>dihydroergotamine spray</i> <i>ergotamine-caffeine</i> <i>Migergot</i> CAFERGOT	<i>eletriptan, naratriptan, rizatriptan, sumatriptan, zolmitriptan, NURTEC ODT, ONZETRA XSAIL, REYVOW, UBRELVY, ZEMBRACE SYMTOUCH, ZOMIG NASAL SPRAY</i>
	<i>sumatriptan-naproxen</i> TREXIMET	<i>diclofenac sodium, ibuprofen or naproxen (except naproxen CR or naproxen suspension) WITH eletriptan, naratriptan, rizatriptan, sumatriptan, zolmitriptan, NURTEC ODT, ONZETRA XSAIL, REYVOW, UBRELVY, ZEMBRACE SYMTOUCH or ZOMIG NASAL SPRAY</i>
<i>Pain</i> Opioid Analgesics	BUTRANS	<i>buprenorphine transdermal, BELBUCA</i>
	LAZANDA	<i>fentanyl transmucosal lozenge, SUBSYS</i>
	<i>levorphanol</i> <i>oxycodone ext-rel</i> HYSINGLA ER OXYCONTIN ZOHYDRO ER	<i>fentanyl transdermal, hydrocodone ext-rel, hydromorphone ext-rel, methadone, morphine ext-rel, NUCYNTA ER, XTAMPZA ER</i>
	PERCOCET PRIMLEV	<i>hydrocodone-acetaminophen, hydromorphone, morphine, oxycodone-acetaminophen, NUCYNTA</i>
	<i>tramadol (NDC[^] 52817019610 only)</i>	<i>tramadol (except NDC[^] 52817019610), tramadol ext-rel</i>
<i>Pain</i> Topical Local Anesthetics	LIDOCAINE-TETRACAINE CREAM (NDC [^] 71800063115 only) LIDOTREX	<i>lidocaine-prilocaine</i>
<i>Pain and Inflammation</i> * Corticosteroids	MILLIPRED RAYOS	<i>dexamethasone, hydrocortisone, methylprednisolone, prednisolone solution, prednisone</i>



Category Drug Class	Drugs Requiring Prior Authorization for Medical Necessity ¹	Formulary Options
Pain and Inflammation * Nonsteroidal Anti-inflammatory Drugs (NSAIDs) / Combinations	ARTHROTEC	celecoxib, diclofenac sodium, ibuprofen, meloxicam or naproxen (except naproxen CR or naproxen suspension) WITH esomeprazole, lansoprazole, omeprazole, pantoprazole or DEXILANT
	Dicloflex DC (NDC [^] 51021037201 only) Diclofenac Inflammacin NuDiclo SoluPak NuDiclo TabPak PENNSAID	diclofenac sodium, diclofenac sodium gel 1%, diclofenac sodium solution, ibuprofen, meloxicam, naproxen (except naproxen CR or naproxen suspension)
	fenoprofen indomethacin capsule 20 mg ketoprofen capsule 25 mg ketoprofen ext-rel capsule mefenamic acid (NDC [^] 69336012830 only) naproxen CR naproxen suspension FENOPROFEN CAPSULE INDOCIN NAPRELAN SPRIX ZORVOLEX	diclofenac sodium, ibuprofen, meloxicam, naproxen (except naproxen CR or naproxen suspension)
	naproxen-esomeprazole	diclofenac sodium, ibuprofen, meloxicam or naproxen (except naproxen CR or naproxen suspension) WITH esomeprazole, lansoprazole, omeprazole, pantoprazole or DEXILANT
Parkinson's Disease	APOKYN	INBRUJA
Postherpetic Neuralgia	HORIZANT	gabapentin, GRALISE
Prostate Condition Benign Prostatic Hyperplasia *	JALYN	dutasteride-tamsulosin, dutasteride or finasteride WITH alluzosin ext-rel, doxazosin, silodosin, tamsulosin or terazosin
	RAPAFLO UROXATRAL	alluzosin ext-rel, doxazosin, silodosin, tamsulosin, terazosin
Respiratory Alpha-1 Antitrypsin Deficiency	ARALAST NP GLASSIA ZEMAIRA	PROLASTIN-C
Respiratory Cough	benzonatate (NDCs [^] 69336012615, 69499032915 only)	benzonatate (except NDCs [^] 69336012615, 69499032915)
Sleep Disorder Hypnotics, Non-benzodiazepines	quazepam INTERMEZZO LUNESTA ROZEREM ZOLPIMIST	doxepin, eszopiclone, ramelteon, zolpidem, zolpidem ext-rel, zolpidem sublingual, BELSOMIRA
Testosterone Replacement * Androgens	testosterone gel 1% (authorized generics for TESTIM and VOGELXO only) ANDROGEL 1% FORTESTA NATESTO TESTIM VOGELXO	testosterone gel (except authorized generics for TESTIM and VOGELXO), testosterone solution, ANDRODERM
Thyroid Supplements	TIROSINT	levothyroxine, SYNTHROID
Women's Health Menopausal Symptom Agents Oral	MENEST OSPHENA PREMARIN	estradiol



Category Drug Class	Drugs Requiring Prior Authorization for Medical Necessity ¹	Formulary Options
Women's Health Menopausal Symptom Agents Vaginal	ESTRING FEMRING INTRAROSA PREMARIN CREAM	estradiol, IMVEXXY
Women's Health Premenstrual Dysphoric Disorder (PMDD)	fluoxetine tablet (generics for SARAFEM only)	fluoxetine (except fluoxetine tablet 60 mg, fluoxetine tablet [generics for SARAFEM]), paroxetine HCl ext-rel, sertraline
Women's Health Prenatal Vitamins	AZESCO ZALVIT	prenatal vitamins, CITRANATAL

Category Drug Class	Other Considerations
All Drugs	On a quarterly basis, new and existing products - including limited source generics, products with significant cost inflation, and specially and non-specially products - may be re-evaluated to determine appropriate formulary placement. These evaluations will assess whether clinically appropriate and cost-effective options remain available on the formulary and may result in additional products not covered without a medical exception, addition or deletion of a product.
Autoimmune and Hepatitis C *	For some clients, an Indication-Based Formulary will be utilized for products in these classes and may result in additional products not covered for certain conditions without a medical exception.
Drugs for Infusion Into Spaces Other Than the Blood	A drug that must be infused into a space other than the blood will generally not be covered under the prescription drug benefit.
New-to-Market Agents ¹	New-to-market products and new variations of products already in the marketplace will not be added to the formulary immediately. Each product will be evaluated for clinical appropriateness and cost-effectiveness. Recommended additions to the formulary will be presented to the CVS Caremark® National Pharmacy and Therapeutics Committee (or other appropriate reviewing body) for review and approval.

The listed formulary options are subject to change.

List of Drugs Requiring Prior Authorization for Medical Necessity

ABILIFY	APOKYN	Bupap
ACANYA	APTENSIO XR	bupropion ext-rel tablet 450 mg
ACCU-CHEK AVIVA PLUS STRIPS AND KITS ⁸	ARALAST NP	butalbital-acetaminophen tablet 50-300 mg
ACCU-CHEK COMPACT PLUS STRIPS AND KITS ⁸	ARTHROTEC	BUTALBITAL-ACETAMINOPHEN
ACCU-CHEK GUIDE STRIPS AND KITS ⁸	ASACOL HD	(NDC ⁴ 69499034230 only)
ACCU-CHEK SMARTVIEW STRIPS AND KITS ⁸	ASMANEX	butalbital-acetaminophen-caffeine capsule
ACIPHEX	ASMANEX HFA	BUTRANS
ACIPHEX SPRINKLE	ATAGAND	BYDUREON
ACTEMRA	ATAGAND HCT	BYETTA
ACTICLATE	ATOPADERM	CAFERGOT
ActiVite	AVENOVA	calcipotriene cream
ACTOS	AVONEX	calcipotriene-betamethasone
acyclovir cream	AZELEX	calcitriol ointment
ADZENYS ER	AZESCO	CAMBIA
ADZENYS XR-ODT	BARACLUDE TABLET	CARAC
ALCORTIN A	BEAU RX	CARAFATE
ALEVICYN GEL	BECONASE AQ	CARBINOXAMINE TABLET 6 MG
ALEVICYN SG	BENICAR	CARDIZEM
ALEVICYN SOLUTION	BENICAR HCT	CARDIZEM CD
ALIQOPA	BENSAL HP	CARDIZEM LA
ALLISON MEDICAL INSULIN SYRINGES ⁵	BENZACLIN	CARNITOR
ALPROLIX	benzonatate (NDCs ⁴ 69336012615, 69499032915 only)	CARNITOR SF
ALREX	BEPREVE	chlordiazepoxide-cikidinium (NDC ⁴ 42494040901 only)
ALTOPREV	BERINERT	CHLORZOXAZONE 250 MG
ALVESCO	BETAPACE	chlorzoxazone 375 mg
AMITIZA	BETAPACE AF	chlorzoxazone 500 mg (NDC ⁴ 73007001303 only)
AMRIX	BEVESPIAEROSPHERE	chlorzoxazone 750 mg
ANDROGEL 1%	BEYAZ	CIALIS
APEXICONE	bimatoprost solution 0.03%	CICATRACE
APIDRA	BORTEZOMIB	CIMZIA
APLENZIN	BREEZE 2 STRIPS AND KITS ⁸	CIPRO HC



CIPRODEX
clindamycin gel (NDC[^] 68682046275 only)
clobetasol spray
 CLOBEX SPRAY
 COLAZAL
 COLCRYS
 CONSENSI
 CONTOUR NEXT STRIPS AND KITS ⁵
 CONTOUR STRIPS AND KITS ⁸
 CONTRAVE
 CORDRAN OINTMENT
CoreMino
 CRESTOR
cyclobenzaprine ext-rel capsule
cyclobenzaprine tablet 7.5 mg
 CYMBALTA
 DARAPRIM
DaVite
 DAYTRANA
 DELZICOL
 DETROL LA
dexchlorpheniramine
Dexitol
Dicloflex DC (NDC[^] 51021037201 only)
Diclocaicin
 DIFFERIN LOTION
diflorasone cream
diflorasone ointment
dihydroergotamine spray
diltiazem ext-rel (genetics for CARDIZEM LA only)
 DIOVAN
 DIOVAN HCT
Diphen Elixir
 DORYX
 DORYX MPC
doxepin cream
doxycycline hyclate delayed-rel tablet 200 mg
doxycycline hyclate tablet 50 mg
 (NDC[^] 72143021160 only)
doxycycline hyclate tablet 75 mg
doxycycline hyclate tablet 150 mg
doxycycline monohydrate capsule 75 mg
doxycycline monohydrate capsule 150 mg
doxycycline monohydrate delayed-rel capsule
 DULERA
 DUTOPROL
 DYRENIUM
 EDARBI
 EDARBYCLOR
 E.E.S. GRANULES
 EFFEXOR XR
 ELELYSO
 ELOCTATE
 ENABLEX
 ENLITE CONTINUOUS
 GLUCOSE MONITORING SYSTEM
 ENTERAGAM
 ENTYVIO
 EPICERAM
 EPOGEN
ergotamine-caffeine
 ERYPED
 ESTRING
 EVEKEO
 EVERSENSE CONTINUOUS
 GLUCOSE MONITORING SYSTEM
 EVZIO
 EXFORGE
 EXFORGE HCT
 EXTAVIA
 FABIOR
 FANAPT
 FEMRING
fenofibrate tablet 120 mg
 FENOGLIDE TABLET 120 MG
fenoprolen
 FENOPROFEN CAPSULE
 FERIVA 21/7

Fexmid
 FINACEA GEL
 FIORICET CAPSULE
flucytosine capsule 500 mg
fluocinonide cream 0.1%
fluorouracil cream 0.5%
fluoxetine tablet (genetics for SARAFEM only)
fluoxetine tablet 60 mg
flurandrenolide lotion (NDC[^] 24470092112 only)
flurandrenolide ointment
 FML LIQUIFILM
 FOLIC-K
 FOLLISTIM AQ
Folvik-D
Folvite-D
 FORTAMET
 FORTESTA
 FOSRENOL
 FOSTEUM
 FOSTEUM PLUS
 FREESTYLE LIBRE CONTINUOUS
 GLUCOSE MONITORING SYSTEM
 FREESTYLE STRIPS AND KITS ⁸
 FULPHILA
 GEL-ONE
Genicin Vita-S
 GLASSIA
 GLEEVEC
 GLUMETZA
 GLYCOPYRROLATE TABLET 1.5 MG
 GOLYTELY
 GRANIX
 GUARDIAN CONNECT CONTINUOUS
 GLUCOSE MONITORING SYSTEM
 HORIZANT
 HUMALOG
 HUMALOG MIX 50/50
 HUMALOG MIX 75/25
 HUMATROPE
 HUMULIN 70/30 ⁴
 HUMULIN N ⁴
 HUMULIN R ⁴
 HYALGAN
hydrocortisone butyrate lipophilic cream 0.1%
HylaVite
 HYSINGLA ER
 INCRUSE ELLIPTA
 INDERAL LA
 INDERAL XL
 INDOCIN
indomethacin capsule 20 mg
Inflammacin
 INNOPRAN XL
 INTERMEZZO
 INTRAROSA
 INTUNIV
 INVOKAMET
 INVOKAMET XR
 INVOKANA
isosorbide dinitrate 40 mg
 JALYN
 JENTADUETO
 JENTADUETO XR
 KAMDQY
 KAZANO
ketocoazole foam 2%
Kelodan
ketoprofen capsule 25 mg
ketoprofen ext-rel capsule
 KINERET
 KOMBIGLYZE XR
 KYPROLIS
 LACRISERT
 LACTULOSE PAK
 LANOXIN TABLET (125 MCG and 250 MCG only)
lanthanum carbonate
 LANTUS
 LAZANDA

LESCOL XL
 LETAIRIS
levorphanol
 LEXAPRO
 LIALDA
 LIDOCAINE-TETRACAINE CREAM
 (NDC[^] 71800063115 only)
 LIDOTREX
 LIPIITOR
 LIVALO
Lorid
Lorzone
 LOTEMAX
 LOTEMAX SM
 LUNESTA
 MACRODANTIN
Matzim LA
 MAVYRET
mefenamic acid (NDC[^] 69336012830 only)
 MENEST
metaxalone 400 mg
metformin ext-rel
 (genetics for FORTAMET and GLUMETZA only)
methocarbamol 500 mg (NDC[^] 69036091010 only)
methocarbamol 750 mg
 (NDCs[^] 69036093090, 70868090190 only)
 MIACALCIN INJECTION
 MIACALCIN NASAL SPRAY
Migergot
 MILLIPRED
 MINASTRIN 24 FE
 MINIVELLE
 MINOCIN
minocycline ext-rel
 MIRVASO
Mondoxyme NL capsule 75 mg
 MONOVISC
 MOVIPREP
MultiPro
mupirocin cream
 MYTESI
 NAPRELAN
naproxen-esomeprazole
naproxen CR
naproxen suspension
 NATAZIA
 NATESTO
 NESINA
 NEULASTA
 NEULASTA ONPRO
 NEUPOGEN
 NEXIUM
niacin tablet 500 mg
Niacor
 NICADAN
 NICAPRIN
 NICAZEL
 NICAZEL FORTE
 NICOMIDE
 NILANDRON
 NORGESIC FORTE
 NORITATE
 NORVASC
 NOVACORT
 NOVO NORDISK NEEDLES ⁶
NuDico SoluPak
NuDico TabPak
 NUTROPIN AQ
 NUVARING
 NUVIGIL
 OLEPTRO
 OLUX-E
omeprazole-sodium bicarbonate
 OMNARIS
 OMNITROPE
 OMNIVEX
 ONFI
 ONGLYZA



ORENCIA CLICKJECT	RIBOZEL	UDENYCA
ORENCIA INTRAVENOUS	RIMSO-50	ULTIMED INSULIN SYRINGES ⁶
ORENCIA SUBCUTANEOUS	RIOMET	ULTIMED NEEDLES ⁶
<i>orphenadrine-aspirin-cafeine</i>	ROZEREM	UROXATRAL
<i>Orphenesic Forte</i>	<i>RyClora</i>	VALCYTE
ORTHO D	SABRIL	VALTREX
ORTHO DF	SAIZEN	<i>Vanatol LQ</i>
ORTHOVISC	SANDOSTATIN LAR	<i>Vanatol S</i>
OSENI	SCARSILK PAD	<i>Vanoxide-HC</i>
OSMOPREP	SEROQUEL XR	VASCULERA
OSPHENA	SIGNIFOR LAR	VECTICAL
OWEN MUMFORD NEEDLES ⁶	SIL-K PAD	VELTIN
<i>oxiconazole (NDCs⁶ 00168035830, 51672135902 only)</i>	SILVEX	<i>venlafaxine ext-rel tablet (except 225 mg)</i>
OXYCONTIN	SILTREX	VENTOLIN HFA
<i>oxymorphone ext-rel</i>	SIMPONI	VEREGEN
OXYTROL	SINGULAIR	VIAGRA
PAXIL	SOMAVERT	VIEKIRA PAK
PAXIL CR	SORILUX	VIIBRYD
PENNSAID	SPRIX	VISCO-3
PERCOCET	STENDRA	<i>Vilasure</i>
PERRIGO NEEDLES ⁶	SUBOXONE	VIVELLE-DOT
PEXEVA	<i>sucralate suspension</i>	VOGELXO
PLAVIX	<i>sumatriptan-naproxen</i>	XANAX
PLEGRIDY	SUPREP	XANAX XR
POLYTOZA	SYNERDERM	XENAZINE
<i>posaconazole delayed-rel tablet</i>	SYNVISC	XOLEGEL
PRADAXA	SYNVISC-ONE	XOPENEX HFA
PRED FORTE	TALIVA	<i>Xvite</i>
PREMARIN	TALTZ	XYZBAC
PREMARIN CREAM	TARGADOX	YAZ
PREVACID	TASIGNA	ZALVIT
PREVIDENT	TAYTULLA	ZARXIO
PRIMLEV	TAZORAC	ZEGERID
PRISTIQ	TECFIDERA	ZELAC
PROAIR HFA	TESTIM	ZEMAIRA
PROAIR RESPICLICK	<i>testosterone gel 1%</i>	ZEPATIER
PROCRIT	(authorized generics for TESTIM and VOGELXO only)	ZETIA
PRODIGEN	TIMOPTIC OCULOSE	ZETONNA
PROLENSA	TIROSINT	ZIANA
PROTONIX	TOBI	ZIRGAN
PROVAD	TOBI PODHALER	ZOHYDRO ER
PROVENTIL HFA	TOPROL XL	ZOLPIMIST
PROZAC	TRACLEER	ZONEGRAN
PSORCON	TRADJENTA	ZONTIVITY
QNASL	<i>tramadol (NDC⁶ 52817019610 only)</i>	ZORTRESS
QSYMIA	TRANSDERM SCOP	ZORVOLEX
QTERN	TREXIMET	ZUPLENZ
<i>quazepam</i>	<i>triamcinolone acetonide aerosol 0.2%</i>	ZYDELIG
RAPAFLO	TRICOR	ZYLET
RAYOS	TRIVIDIA INSULIN SYRINGES ⁶	ZYTIGA
RECEDO	<i>TronVite</i>	ZYVIT
REPATHA	TRULANCE	
RHEUMATE	TUDORZA	



There may be additional drugs subject to prior authorization or other plan design restrictions. Please consult your plan for further information.

This list represents brand products in CAPS, branded generics in upper- and lowercase *Italics*, and generic products in lowercase *italics*. This is not an all-inclusive list of available drug options. Log in to [Caremark.com](https://www.caremark.com) to check coverage and copay information for a specific drug. Discuss this information with your doctor or health care provider. This information is not a substitute for medical advice or treatment. Talk to your doctor or health care provider about this information and any health-related questions you have. CVS Caremark assumes no liability whatsoever for the information provided or for any diagnosis or treatment made as a result of this information. This list is subject to change.

Subject to applicable laws and regulations.

* This list indicates the common uses for which the drug is prescribed. Some drugs are prescribed for more than one condition.

¹ Listing does not include certain NDCs^A.

^A Drug products are identified by unique numerical product identifiers, called National Drug Codes (NDC), which identify the manufacturer, strength, dosage form, formulation and package size.

¹ If your doctor believes you have a specific clinical need for one of these products, he or she should contact the Prior Authorization department at: 1-855-240-0536.

² For use in patients previously treated with an HCV regimen containing an NS5A inhibitor (for genotypes 1-6) or sofosbuvir without an NS5A inhibitor (for genotypes 1a or 3).

³ If approved for coverage and prescribed for primary prevention of cardiovascular disease, may be covered without cost sharing through an exceptions process.

⁴ Rebranded or private label formulations are not covered without a prior authorization for medical necessity (i.e., RELION).

⁵ Long Acting Insulins - First Generation.

⁶ BD ULTRAFINE syringes and needles are the only preferred options.

⁷ A ONETOUCH blood glucose meter may be provided at no charge by the manufacturer to those individuals currently using a meter other than ONETOUCH. For more information on how to obtain a blood glucose meter, call: 1-877-418-4746.

⁸ ONETOUCH brand test strips are the only preferred options.

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Summary of Extended Deadlines and COVID-19 Coverage

How can I get in touch with Collective Health?

For any questions, Collective Health Member Advocates are available from 4 am to 6 pm PT, Monday through Friday, and 7 am to 11 am PT on Saturdays. To send any messages, documents, or appeals to Collective Health, sign into your Collective Health account and use Messages to ensure the fastest response.

What plan deadlines are extended and for how long?

You have additional time to meet plan deadlines for COBRA coverage, enroll in coverage after a life event, and submit claims, appeals, and requests for external review. The extension impacts plan deadlines that normally would have occurred between March 1, 2020, and 60 days after the announced end of the National Emergency Order for the COVID-19 outbreak.

If you have had a claim or appeal denied after March 1, 2020 for failure to meet a plan deadline, contact Collective Health.

How will COVID-19 related services be covered by my plan?

The table below provides an overview of your coverage for any COVID-19 related care.

Service	Description	What You Pay
COVID-19 Screening and Diagnosis	<p>COVID-19 testing and any additional services you receive as part of your testing will be covered whether in a doctor's office, urgent care, emergency room, or at other points of care when ordered or administered by a licensed healthcare provider.</p> <p>This applies to all tests for the purpose of individualized diagnosis or treatment of COVID-19, including all items and services for COVID-19 diagnostic testing and for evaluation to determine the need for COVID-19 diagnostic testing.</p>	<p>In-network: Fully covered (the plan pays 100%). You don't have to meet a deductible first.</p> <p>Out-of-network: Fully covered (the plan pays 100% of the allowed amount). You don't have to meet a deductible first.</p>
COVID-19 Telemedicine	If you're experiencing flu-like symptoms (e.g., cough, shortness of breath, fever) and think you may have COVID-19, a virtual visit with any provider will be covered by your plan.	<p>In-network: Fully covered (the plan pays 100%). You don't have to meet a deductible first.</p> <p>Out-of-network: Fully covered (the plan pays 100% of the allowed amount). You don't have to meet a deductible first.</p>
COVID-19 Treatment	Treatment related to a COVID-19 diagnosis.	Covered based on where you receive your treatment (for example, in a doctor's office or in a hospital) and the type of care received. Prior authorization may be required depending on the service. See Section 5 for more information.
COVID-19 Vaccine	COVID-19 vaccines, vaccine administration, and items and services integral to the furnishing of a COVID-19 vaccine. This may not include additional items or services not related to the COVID-19 vaccine or administration that are received during the vaccine visit.	<p>In-network: Fully covered (the plan pays 100%). You don't have to meet a deductible first.</p> <p>Out-of-network: Fully covered (the plan pays 100% of the allowed amount). You don't have to meet a deductible first.</p>

<p>Other Telemedicine Coverage</p>	<p>See "Telemedicine" in Section 5 for more information on coverage.</p> <p>For rehabilitative services (for example, physical therapy), your coverage is based on the type of care you receive. Your plan's telemedicine restrictions and session limits will apply (<i>if applicable</i>).</p>
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