Employee Assistance Program

Combined Evidence of Coverage and Disclosure Form

Anthem Blue Cross
PO Box 4310

Woodland Hills CA 91365

800/999-7222

Multi Union Security Trust (MUST)

This Combined Evidence of Coverage and Disclosure Form (EOC) constitutes only a summary of your Assistance Program plan. Consult the Agreement to determine the exact terms and conditions of coverage.

The meanings of capitalized words and phrases are defined in the DEFINITIONS section of this EOC.

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Get Help in Your Language

Anthem BlueCross

Language Assistance Services

Curious to know what all this says? We would be too. Here's the English version:
IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD: 711)

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

Spanish
IMPORTANTE: ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

Arabic
مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم1-888-254-2721 .(TTY/TDD:711)

Armenian
ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

Chinese
重要事項：您能看懂這封信函嗎？如果您看不懂，我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助，請立即撥打1-888-254-2721。(TTY/TDD: 711)

Farsi

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید.(TTY/TDD:711)

Hindi

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

Hmong

TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Japanese

重要：この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。1-888-254-2721 (TTY/TDD: 711)

Khmer

សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចឲ្យនរណាម្នាក់អានវាជូនអ្នក។ អ្នកក៏អាចទទួលលិខិតនេះដោយសរសេរជាភាសារបស់អ្នកផងដែរ។
ដើម្បីទទួលជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅលេខ 1-888-254-2721។ (TTY/TDD: 711)

Korean

중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오. (TTY/TDD: 711)

Punjabi

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵਬੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਫੌਰਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian
ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog
MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai
หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้ เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้
ท่านยังอาจให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย
หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่หมายเลข 1-888-254-2721 (TTY/TDD: 711)

Vietnamese
QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (TTY/TDD: 711)

It's Important We Treat You Fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the EAP toll free number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279 or by email to compliance.coordinator@anthem.com. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf . Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Notice of Non-Discrimination Required by California Law

Anthem does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender identity, sexual orientation, age or disability. For people with disabilities, We offer free aids and services, and information in alternate formats, free of charge and in a timely manner, when necessary to ensure an equal opportunity to participate.

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If You have grievance against Anthem, You should first call Anthem at 1-800-999-7222 (TDD: 1-866-333-4823) and use Anthem's grievance process before contacting the DMHC. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to You.

If You need help filing a grievance, call Anthem at 1-800-999-7222. If You need help with a grievance involving an Emergency, a grievance not satisfactorily resolved by Anthem, or a grievance unresolved for more than thirty (30) days, call the DMHC for assistance. The DMHC also has a toll-free number (1-888-466-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The DMHC's internet website www.dmhc.ca.gov has complaint forms online.

Program Services

Counseling sessions provide confidential, professional assessment, consultation, brief counseling and necessary referral regarding any problems that may affect your life or work. Typical problems include parenting, relationships, stress, anxiety, depression, legal and financial, alcohol or drug abuse, or work related concerns. These services are provided without any cost to you. Covered Services must be obtained from a Practitioner who is a licensed, certified, or otherwise qualified mental health professional under contract with us to perform assessment, brief counseling, and referral.

Many people who use Covered Services are able to resolve their problems with the number of sessions provided under this Plan. If your problem requires more lengthy or specialized treatment than this Plan provides, a consultant will refer you to a resource in the community or suggest that you obtain professional help outside of the Plan.

Covered Services are designed to work in conjunction with benefits provided under your Group's health plan, if available. Coverage for services provided by physicians, hospitals, mental health, and substance abuse providers is determined by your group or individual health plan.

How to Obtain Covered Services

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS COVERED SERVICES MAY BE OBTAINED

Covered Services must be obtained from an authorized Practitioner by calling us or by accessing the applicable Anthem website and registering in the Member Center.

Access to Covered Services is available twenty-four hours a day/seven days per week.

When you contact us, if it is apparent that you are experiencing an emergency or urgent situation, you will be immediately referred to a consultant for a telephonic assessment. The consultant may provide crisis intervention over the telephone or assist you in obtaining more intensive, acute care services through your health plan.

Contact Us

We are here to help you. Call us if:

- You have a question or problem.
- You need a Practitioner.
- You want to know about Covered Services available to you.

☏ 1-800-999-7222
✉ Anthem EAP, PO Box 4310, Woodland Hills CA 91365 www.anthemeap.com

Information specific to your Plan is available by calling your dedicated toll free number or the number on the Anthem Blue Cross EAP web site, above. Our privacy statement can also be viewed on our website.

Confidential Communication of Medical Information

Any Member, including an adult or a minor who can consent to a health care service without the consent of a parent or legal guardian, pursuant to State or federal law, may request confidential communication, either in writing or electronically. A request for confidential communication can be sent in writing to Anthem EAP; PO Box 4310 Woodland Hills CA 91365. An electronic request can be made by sending an e-mail to: infoeapbhrc@anthem.com. Members may also call us at 1-800-999-7222.

The confidential communication request will apply to all communications that disclose medical information or a Provider's name and address related to the medical services received by the individual requesting the confidential communication.

A confidential communication request will be valid until either a revocation of the request is received from the Member who initially requested the confidential communication, or a new confidential communication request is received.

Anthem will implement the confidential communication request within seven (7) calendar days of receiving an electronic request or a request by phone, or within fourteen (14) calendar days from the date We receive a written request by first-class mail. We will also acknowledge that We received the request and will provide status if the Member contacts Us.

Second Opinions

If you have a question about your condition or about a plan of treatment which your Practitioner has recommended, you may receive a second opinion from another Practitioner. This second opinion visit will be provided according to the benefits, limitations and exclusions of this Plan. If you wish to receive a second opinion, call us at the number provided in the CONTACT US section to obtain a referral to another Practitioner.

Services that are Covered

Subject to the exclusions and limitations listed in the SERVICES THAT ARE NOT COVERED section, following are the Covered Services that are covered by this Plan when authorized and obtained from a Practitioner. We will not cover any services that are not listed in this section.

1. Counseling Sessions: Up to 12 counseling sessions per unique presenting problem, per 12-month period, per initial term and per renewal term, per Participant. Counseling sessions shall be per unique presenting problem for issues or concerns directly impacting the Participant. Counseling sessions are provided when the assessment reveals that the presenting problem has a reasonable and likely chance of improving as a result of short-term, counseling that is focused on problem resolution. Notwithstanding any provision to the contrary, Covered Services do not include any counseling sessions beyond the limit noted above.

2. Referral to appropriate healthcare benefit and/or clinical resources in the community in situations where the Participant's presenting problem warrants long-term treatment, hospitalization or a more specialized level of care.

3. 24 hours per day, 7 days per week, 365 days per year, toll-free telephone access to a licensed Consultant.

4. Legal Referrals & Discounted Fees: 30-minute telephone or in-person consultation with a licensed attorney.

5. Financial Consultation: Unlimited telephone consultations with an appropriate Financial Consultant.

6. Identify Theft Recovery: Telephone consultation to help recover from and minimize the impact of a breach of identity.

7. Tobacco Cessation: Unlimited access to the Anthem website's online educational tools and information; as well as links to SmokeFree.gov- a comprehensive website offering tools and tips related to tobacco cessation. Access to a chat feature and information on the toll-free Quit Line available in every state.

8. Work/Life Resources and Information: If you wish to speak with a childcare, adult dependent care, elder care, adoption, or parenting consultant regarding consultations, educational materials, or referrals for any of these services, please call your toll-free number. You also have unlimited access to web-based information and resources about childcare, adult dependent care, elder care, adoption, and parenting on the Anthem website. Instructions regarding how to access the websites and obtain the information therein contained are part of the program materials furnished by Anthem.

Services that are Not Covered

Covered Services do not include any of the items below. We do not cover any services beyond Services as listed in SERVICES THAT ARE COVERED section of this EOC. We do not cover unauthorized services.

1. Counseling and legal consultation for the same problem or situation more than once within a 12-month period following the initial date of service.

2. Any services or benefits covered under the Participant's group health benefit/insurance plan.

3. Any hospital, medical, surgical, or any other health care services provided for any condition.

4. Prescription or non-prescription drugs or medications, cosmetics, dietary supplements, health, or beauty aids.

5. Evaluations or reports for a legal proceeding.

6. Fitness-for-Duty evaluations, unless otherwise purchased by Group.

7. Authorizations for an employee to take a leave of absence or time off from the workplace.

8. Counseling mandated by a court of law or government agency.

9. Specialized treatment or evaluations required as a condition of parole, probation, custody, visitation, or forensic evaluations.

10. Determinations or reports related to the Family Medical Leave Act or Short/Long Term Disability.

11. Any onsite service where the safety of the provider would be considered at risk.

12. Expenses related to US Department of Transportation Substance Abuse Professional (SAP) services, unless otherwise purchased by Group.

Your Financial Responsibility

Prepayment Fee
Your Group is responsible for paying the charges for your coverage.

No Separate Charge
There is no member cost sharing or financial liability due from Participants provided you obtain Covered Services which are authorized and from a Practitioner.

Important Note: When a Practitioner recommends a service or resource it does not mean or imply that the service is a covered expense. Call us if you have any questions regarding whether services are covered.

How Coverage Begins

Participants eligible on the day the Agreement begins will be able to obtain Covered Services on the Effective Date. The ability to obtain Covered Services under this Plan will terminate at 11:59 P.M. on the last day of a Participant's eligibility or termination of the Agreement, whichever occurs first.

In order for you to be entitled to benefits under this Plan, both the Agreement and your coverage under this Plan must be in effect on the date you obtain services.

This Plan is subject to amendment, modification, or termination according to the provisions of the Agreement without your consent or concurrence.

Group shall be responsible for determining eligibility of Participants and any Eligible Household Participants if applicable. Any disputes or inquiries regarding eligibility (including renewal and reinstatement) shall be referred to the Group, which shall advise us of its determination.

Eligibility under this Agreement shall be limited to residents of the United States, including any U.S. Territories.

We shall have the sole right to terminate eligibility of any Participant who uses threatening or aggressive behavior.

How Coverage Ends

Your eligibility ends when you are no longer an eligible Participant, upon your termination of employment, or when your Group's Agreement is terminated as a result of nonpayment of fees or otherwise. If fees are not paid according to the Agreement, termination is effective fifteen days after notice of termination is mailed to your Group, as of midnight of the last day of the month for which fees were last received and accepted. If applicable, Your Eligible Household Participants are covered during the same time you are. Upon termination of your employment, please contact your Group to determine whether you and/or your eligible Household Participants may be eligible to continue coverage under COBRA.

Continuation of Care

If you began visits with a Practitioner and have not completed the maximum allowable visits in the time period specified under SERVICES THAT ARE COVERED by the date your coverage under this Plan ends, you may be able to complete the remaining visits. Please contact us for more information.

If you began visits with a Practitioner whose contract is terminated, your remaining visits may continue as covered services if: 1) you are under the care of the Practitioner at the time the provider's contract terminates; and 2) the terminated provider agrees in writing to continue providing visits to you in accordance with the rates, terms and conditions of his or her previous contract with us. If the provider was terminated for reasons of disciplinary cause or reason, fraud, or other criminal activity, or does not agree with these contractual terms and conditions, we are not required to continue the provider's services beyond the provider's contract termination date. Please contact us for more information.

General Provisions

Providing Care. We are not responsible for providing any type of medical or similar care, nor are we responsible for the quality of any such care received. Our relationship with the Practitioner is that of an independent contractor who is not our agent or employee, nor are we, or any of our employees, an employee or agent of any Practitioner. We are not responsible for any damages or injuries as a result of receiving services from a Practitioner.

Provider Reimbursement. Practitioners are paid directly by us. It is not necessary that you file claims for Covered Services you receive under this Plan. You will not be required to pay any Practitioner any amounts we owe to that provider, even in the unlikely event that we fail to pay that provider. You will be liable, however, to pay any provider who is not a Practitioner for any services they provide and for any services that are not covered by this Plan.

Limited Coverage. This Plan provides limited benefits as described in SERVICES THAT ARE COVERED section. In those situations where the Participant's needs are beyond the scope of the Covered Services under this Plan, the Participant may be referred to a local resource or the Group's group health plan or health benefit/insurance plan, if available.

Benefits Not Transferable. Only eligible Participants are entitled to receive Covered Services under this Plan. The right to receive Covered Services cannot be transferred.

Plan Administrator - COBRA and ERISA. In no event will we be plan administrator for the purposes of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) or the Employee Retirement Income Security Act (ERISA). The term "plan administrator" refers either to the Group or to a person or entity other than us, engaged by the Group to perform or assist in performing administrative tasks in connection with the Group's health plan. The Group is responsible for satisfaction of notice, disclosure, and other obligations of administrators under ERISA. In providing notices and otherwise performing under the Agreement, the Group is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as your agent.

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

Public Policy Participation. We have established a Public Policy Committee (that we call our Consumer Relations Committee) to advise our Board of Directors. This Committee advises the Board about how to assure the comfort, dignity, and convenience of the people we cover. The Committee consists of members covered by our health plan, participating providers, and a member of our Board of Directors. The Committee may review our financial information and information about the nature, volume, and resolution of the complaints we receive. The Consumer Relations Committee reports directly to our Board.

Conformity with Laws. Any provision of the plan which, on its effective date, is in conflict with the laws of the governing jurisdiction is hereby amended to conform to the minimum requirements of such laws.

Renewal Provisions. The Agreement is subject to renewal at certain intervals. This Plan renews when the Agreement is renewed and continues in effect unless notice of termination is served within the time specified or as otherwise provided in the Agreement.

Confidentiality and Release of Information. We make every effort to preserve confidentiality of Participants' information. Information may be released only with the written consent of the Participant or as permitted by law. It must be signed, dated, and must specify the nature of the

information and to which persons and organizations it may be disclosed. Participants may access their own records.

Grievance Procedures

If you are dissatisfied about any aspect of this Plan, you may file a grievance verbally by contacting Anthem at its toll-free telephone number provided in the CONTACT US section of this document or in writing to Anthem EAP, 9655 Granite Ridge Dr., 6th Floor, San Diego, California 92123. Also, you may access the company web site at www.anthemEAP.com. All grievances will result in investigation and response. You may file a grievance up to 180 days following any incident or action that is the subject of your dissatisfaction. If you need assistance filing a grievance, please let your consultant or customer service representative know.

Grievance resolution may involve review of your records, which, if needed will be requested by the Grievance and Appeals analyst, or consultant, utilizing mail, fax or secure email. Grievances will be resolved within thirty (30) calendar days from Anthem's receipt of your expression of dissatisfaction.

If you are dissatisfied with the resolution of your grievance, or if your grievance has not been resolved for more than 30 calendar days, you may submit your grievance to the California Department of Managed Health Care for review (see DEPARTMENT OF MANAGED HEALTH CARE). If your case involves an imminent threat to your health, you are not required to complete our grievance process, but may immediately submit your grievance to the Department of Managed Health Care for review.

Information on filing a complaint regarding discrimination based on race, color, national origin, age, disability, or sex can be found in the Language Assistance Services section of this Agreement.

Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at the telephone number listed on your identification card and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's Internet Web site (**http://www.hmohelp.ca.gov**) has complaint forms, IMR applications forms and instructions online.

BINDING ARBITRATION

ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICES UNDER THE POLICY/PLAN OR ANY OTHER ISSUES RELATED TO THE POLICY/PLAN AND CLAIMS OF MEDICAL MALPRACTICE MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. It is understood that any dispute including disputes relating to the delivery of services under the Plan or any other issues related to the Plan, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. YOU AND ANTHEM BLUE CROSS AGREE TO BE BOUND BY THIS ARBITRATION PROVISION AND ACKNOWLEDGE THAT THE RIGHT TO A JURY TRIAL OR TO PARTICIPATE IN A CLASS ACTION IS WAIVED FOR BOTH DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN AND MEDICAL MALPRACTICE CLAIMS.

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

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

The arbitration is initiated by the Participant making a written demand on Anthem Blue Cross. The arbitration will be conducted by a single neutral arbitrator from Judicial Arbitration and Mediation Services ("JAMS"), according to JAMS' applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by a single neutral arbitrator from another neutral arbitration entity, by agreement of the Participant and Anthem Blue Cross, or by order of the court, if the Participant and Anthem Blue Cross cannot agree. If the parties cannot agree on the individual neutral arbitrator, the arbitrator will be selected in accordance with JAMS Rule 15 (or any successor rule).

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. Unless you, or Anthem Blue Cross agree otherwise, the arbitrator may not consolidate more than one person's claims, and may not otherwise preside over any form of a representative or class proceeding.

Definitions

Agreement means the contract entered into between us and your Group to provide Covered Services to Participants.

Participant(s) means as determined by Group, an Eligible [Employee][Member][Student] and any Eligible Household Participants who [is][are] entitled to Covered Services under this Plan and for whom Participant Fees are paid by your Group.

Practitioner means, with regard to any counseling and referral services provided under this Plan, an appropriately licensed health care professional who has agreed to provide Covered Services to Participants. In limited situations involving counseling services, Practitioner can also include licensed health care professionals who are not participating in the applicable network, but who have been approved by us and have agreed to perform a one-time or set number of Covered Services for a particular Participant. For non-health-related services provided under this Plan, including but not limited to legal consultations, financial consultations, and concierge or convenience services, Practitioner means an appropriately trained and/or licensed professional approved by and/or with an agreement us to provide a one-time or set number of Covered Services to a Participant.

Covered Services means those services listed in the SERVICES THAT ARE COVERED section of this EOC that a Participant is entitled to receive under this Plan.

Eligible Employee(s) means the Group's eligible employees as determined and specified by the Group. Eligible Employee(s) may also include other employees, as otherwise agreed upon by Group.

Eligible Household Participant(s) means the spouse, domestic partner, dependents, and others whose place of residence is the same as the Eligible Employee, and/or those dependents who do not share the same residence as the Eligible Employee but due to applicable state law or court order are required to be covered under this Plan. Any person who is permanently residing in your

household is eligible, as are individuals who are qualified as your dependents for federal income tax purposes.

Group means any Employer, Labor Union or Labor Management Trust Fund, Association, or other Group to which the Agreement was issued.

Plan means the entire set of benefits, conditions, exclusions and limitations that make up your coverage. It consists of this EOC, the Agreement, and any attachments.