

**LOS ANGELES COUNTY EMPLOYEES
RETIREMENT ASSOCIATION (LACERA)**

July 1, 2012

Plan II, In-State

Prudent Buyer®

**COMBINED EVIDENCE OF COVERAGE
AND DISCLOSURE FORM**

**Anthem Blue Cross
21555 Oxnard Street
Woodland Hills, California 91367**

This Combined Evidence of Coverage and Disclosure (Evidence of Coverage) Form is a summary of the important terms of your health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage. If you have special health care needs, you should read those sections of the Evidence of Coverage that apply to those needs. LACERA will provide you with a copy of the health plan contract upon request.

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TYPES OF PROVIDERS

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

Participating Providers. We have established a network of various types of "Participating Providers". These providers are called "participating" because they have agreed to participate in our preferred provider organization program (PPO), which we call the Prudent Buyer Plan. They have agreed to provide our members with health care at a special low cost. The amount of benefits payable under this *plan* will be different for *non-participating providers* than for *participating providers*. See the definition of "Participating Providers" in the DEFINITIONS section for a complete list of the types of providers which may be *participating providers*.

We publish a directory of Participating Providers. You may request a directory of Participating Providers by contacting the LACERA dedicated customer service number, 1-800-284-1110. The directory lists all *participating providers* in your area, including health care facilities such as *hospitals* and *skilled nursing facilities*, *physicians*, laboratories, and diagnostic x-ray and imaging providers. You may call us at the customer service number listed on your ID card or you may write to us and ask us to send you a directory. You may also search for a *participating provider* using the "Find a Doctor" function on our website at www.anthem.com/ca. The listings include the credentials of our *participating providers* such as specialty designations and board certification.

Non-Participating Providers. *Non-participating providers* are providers which have not agreed to participate in our Prudent Buyer Plan network. They have not agreed to the reimbursement rates and other provisions of a Prudent Buyer Plan contract.

Physicians. "Physician" means more than an M.D. Certain other practitioners are included in this term as it is used throughout the *plan*. This doesn't mean they can provide every service that a medical doctor could; it just means that we'll cover expense you incur from them when they're practicing within their specialty the same as we would if the care were provided by a medical doctor. As with the other terms, be sure to read the definition of "Physician" to determine which providers' services are covered. Only providers listed in the definition are covered as *physicians*. Please note also that certain providers' services are covered only upon referral of an M.D. (medical doctor) or D.O. (doctor of

osteopathy). Providers for whom referral is required are indicated in the definition of "physician" by an asterisk (*).

Other Health Care Providers. "Other Health Care Providers" are neither *physicians* nor *hospitals*. They are mostly free-standing facilities or service organizations, such as ambulance companies. See the definition of "Other Health Care Providers" in the DEFINITIONS section for a complete list of those providers. *Other health care providers* are not part of our Prudent Buyer Plan provider network.

Reproductive Health Care Services. Some *hospitals* and other providers do not provide one or more of the following services that may be covered under your *plan* contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective *physician* or clinic, or call us at the customer service telephone number listed on your ID card to ensure that you can obtain the health care services that you need.

Care Outside the United States—BlueCard Worldwide

Prior to travel outside the United States, call the customer service telephone number listed on your ID card to find out if your plan has BlueCard Worldwide benefits. Your coverage outside the United States is limited and we recommend:

- Before you leave home, call the customer service number on your ID card for coverage details. **You have coverage for services and supplies furnished in connection only with urgent care or an emergency when travelling outside the United States.**
- Always carry your current ID card.
- In an emergency, seek medical treatment immediately.
- **The BlueCard Worldwide Service Center is available 24 hours a day, seven days a week toll-free at (800) 810-BLUE (2583) or by calling collect at (804) 673-1177.** An assistance coordinator, along with a medical professional, will arrange a *physician* appointment or hospitalization, if needed.

Payment Information

- **Participating BlueCard Worldwide hospitals.** In most cases, you should not have to pay upfront for inpatient care at participating BlueCard Worldwide *hospitals* except for the out-of-pocket costs you

normally pay (noncovered services, deductible, copays, and coinsurance). The *hospital* should submit your claim on your behalf.

- **Doctors and/or non-participating hospitals.** You will have to pay upfront for outpatient services, care received from a *physician*, and inpatient care from a *hospital* that is not a participating BlueCard Worldwide *hospital*. Then you can complete a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim Filing

- **Participating BlueCard Worldwide hospitals will file your claim on your behalf.** You will have to pay the *hospital* for the out-of-pocket costs you normally pay.
- **You must file the claim** for outpatient and *physician* care, or inpatient *hospital* care not provided by a participating BlueCard Worldwide *hospital*. You will need to pay the health care provider and subsequently send an international claim form with the original bills to us.

Claim Forms

- International claim forms are available from us, from the BlueCard Worldwide Service Center, or online at:

www.bcbs.com/bluecardworldwide.

The address for submitting claims is on the form.

SUMMARY OF BENEFITS

THE BENEFITS OF THIS PLAN ARE PROVIDED ONLY FOR THOSE SERVICES THAT WE DETERMINE TO BE MEDICALLY NECESSARY. THE FACT THAT A PHYSICIAN PRESCRIBES OR ORDERS A SERVICE DOES NOT, IN ITSELF, MEAN THAT THE SERVICE IS MEDICALLY NECESSARY OR THAT THE SERVICE COVERED UNDER THIS PLAN. CONSULT THIS BOOKLET OR TELEPHONE US AT THE NUMBER SHOWN ON YOUR IDENTIFICATION CARD IF YOU HAVE ANY QUESTIONS REGARDING WHETHER SERVICES ARE COVERED.

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

For your convenience, this summary provides a brief outline of your benefits. You need to refer to the entire Combined Evidence of Coverage and Disclosure (Evidence of Coverage) Form for more complete information, and you must consult LACERA's health plan contract with us to determine the exact terms and conditions of your coverage.

Second Opinions. If you have a question about your condition or about a plan of treatment which your *physician* has recommended, you may receive a second medical opinion from another *physician*. This second opinion visit will be provided according to the benefits, limitations, and exclusions of this *plan*. If you wish to receive a second medical opinion, remember that greater benefits are provided when you choose a *participating provider*. You may also ask your *physician* to refer you to a *participating provider* to receive a second opinion.

Triage or Screening Services. If you have questions about a particular health condition or if you need someone to help you determine whether or not care is needed, triage or screening services are available to you from us by telephone. Triage or screening services are the evaluation of your health by a *physician* or a nurse who is trained to screen for the purpose of determining the urgency of your need for care. Please contact the 24/7 NurseLine at the telephone number listed on your identification card 24 hours a day, 7 days a week.

Care After Hours. If you need care after your *physician's* normal office hours and you do not have an *emergency* medical condition or need *urgent care*, please call your *physician's* office for instructions.

Telehealth. This *plan* provides benefits for covered services that are appropriately provided through telehealth, subject to the terms and conditions of the *plan*. In-person contact between a health care provider and the patient is not required for these services, and the type of setting where these services are provided is not limited. “Telehealth” is the means of providing health care services using information and communication technologies in the consultation, diagnosis, treatment, education, and management of the patient’s health care when the patient is located at a distance from the health care provider. Telehealth does not include consultations between the patient and the health care provider, or between health care providers, by telephone, facsimile machine, or electronic mail.

All benefits are subject to coordination with benefits under certain other plans.

The benefits of this <i>plan</i> are subject to the REIMBURSEMENT FOR ACTS OF THIRD PARTIES section.
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MEDICAL BENEFITS

DEDUCTIBLES

Calendar Year Deductibles

- Member Deductible..... **\$500**
- Family Deductible **\$1,500**

Additional Deductibles

- Non-Certification Deductible..... **\$200**

Exceptions: In certain circumstances, one or more of these deductibles may not apply, as described below:

- The Calendar Year Deductible will not apply to the following services provided by a *participating provider*: (a) *physician's* services for routine examinations and immunizations under the Well Baby and Well Child Care benefit; (b) Hepatitis B and Varicella Zoster immunizations for dependent children ages 7 through 18, and (c) preventive care. **Preventive Care services provided by a *non-participating provider* are not covered.**
- The Calendar Year Deductible will not apply to facility charges when surgery is performed on an outpatient basis in an *ambulatory surgical center*.
- The Calendar Year Deductible will not apply to services of the surgeon when surgery is performed on an outpatient basis in either an *ambulatory surgical center*, in a *physician's* office or in the outpatient department of a *hospital*.
- The Calendar Year Deductible will not apply to routine radiology and laboratory exams performed within seven days prior to surgery. The exams must be needed for the illness, injury or condition necessitating the surgery, and must be provided and billed by the hospital or ambulatory surgical center where the surgery is to take place.
- The Calendar Year Deductible will not apply to services provided under *home health* and *hospice* care benefits.
- The Calendar Year Deductible will not apply to transplant travel expenses in connection with an authorized transplant procedure.
- The Non-Certification Deductible will not apply to *emergency* admissions or services, nor to the services provided by a *participating provider*. See UTILIZATION REVIEW PROGRAM.

CO-PAYMENTS

Co-Payments.* After you have met your Calendar Year Deductible, and any other applicable deductible, you will be responsible for the following percentages of the *maximum allowed amount*:

For other than inpatient *hospital* services:

- *Participating Providers*.....**20%**
- *Other Health Care Providers***20%**
- *Non-Participating Providers*.....**20%**

For inpatient *hospital* services:

- *Participating Providers*.....**10%**
- *Non-Participating Providers*.....**20%**

Note: In addition to the Co-Payment shown above, you will be required to pay any amount in excess of the *maximum allowed amount* for the services of an *other health care provider* or *non-participating provider*.

***Exceptions:**

- Your Co-Payment for services provided by a *participating provider* under the Acupuncture benefit will be **30%**. Your Co-Payment for services provided by a *non-participating provider* under the Acupuncture benefit will be **50%**.
- Your Co-Payment for services provided by a *participating provider* under the Skilled Nursing Facility benefit will be **30%**. Your Co-Payment for services provided by a *non-participating provider* under the Skilled Nursing Facility benefit will be **50%**.
- There will be no Co-Payment for Hepatitis B and Varicella Zoster (chickenpox) immunizations for dependent children ages 7 through 18. For *non-participating providers* only, we will pay a maximum of **\$12** for each immunization. The calendar year deductible will not apply to these services when they are provided by a *participating provider*.

- Your Co-Payment for preventive care services provided by a *participating provider* will be **\$25**.
- Your Co-Payment for *non-participating providers* will be the same as for *participating providers* for the following services. You may be responsible for charges which exceed the *maximum allowed amount*.
 - a. All *emergency services*;
 - b. An *authorized referral* from a *physician* who is a *participating provider* to a *non-participating provider*;
 - c. Charges by a type of *physician* not represented in the Prudent Buyer Plan network (for example, an audiologist); or
 - d. Cancer Clinical Trials.
- No Co-Payment will be required for the transplant travel expenses authorized by us.
- No Co-Payment will be required for the following services:
 - a. Services provided under *home health care*.
 - b. Services provided under *hospice care*.
 - c. Services in connection with a surgery performed on an outpatient basis in either an *ambulatory surgical center* or in a *physician's office*.
 - d. Services of the surgeon in connection with a surgery performed on an outpatient basis in the *hospital*, an *ambulatory surgical center* or in a *physician's office*.
 - e. Well Baby and Well Child Care services when provided by *participating providers* for dependent children under age 17, after a **\$25** Co-Payment is made for routine examinations.
 - f. Services provided by *participating providers* under the Preventive Care benefit, after a **\$25** Co-Payment is made for routine examinations.
 - g. Routine radiology and laboratory exams performed within seven days prior to surgery. The exams must be needed for the illness, injury or condition necessitating the surgery, and must be provided and billed by the hospital or *ambulatory surgical center* where the surgery is to take place.
- Your Co-Payments for prescription drug benefits are listed in the section entitled YOUR PRESCRIPTION DRUG BENEFITS.

Specialty drugs that are not administered at a provider's office must be filled through the mail order program with CVS Caremark.

Out-of-Pocket Amount*. After you have incurred **\$2,500** in total out-of-pocket payments for covered charges during a *calendar year*, you will not have to make any more Co-Payments. However, you will remain responsible for costs in excess of the *maximum allowed amount*.

MEDICAL BENEFIT MAXIMUMS

We will pay, for the following services and supplies, up to the maximum amounts, or for the maximum number of days or visits shown below:

Skilled Nursing Facility

- For covered *skilled nursing facility* care..... **100 days**
per *calendar year*

Well Baby and Well Child Care (Dependent Children Under Age 7)

- For *physician's* services for each routine examination..... **\$20***
- For each immunization **\$12***

**Non-participating providers only*

Hepatitis B and Varicella Zoster Immunizations (Dependent Children Ages 7 Through 18)

- For each immunization (*non-participating providers only*)..... **\$12**

Preventive Care (Members Age 7 and Over)

- For all covered services and supplies when provided by a *participating provider**..... **\$250**
per *calendar year*

***Note:** Services are covered only when provided by a *participating provider*.

Acupuncture

- For all covered services..... **\$30**
per visit, for up to 50 visits
per *calendar year*

Lifetime Maximum

- Transplant Travel Expense.....**\$10,000**
during your lifetime
- For all medical benefits.....**\$1,000,000**
during your lifetime

Up to **\$2,500** in comprehensive benefits received are automatically restored each January 1.

YOUR MEDICAL BENEFITS

MAXIMUM ALLOWED AMOUNT

General

This section describes the term “*maximum allowed amount*” as used in this Combined Evidence of Coverage and Disclosure Form, and what the term means to you when obtaining covered services under this plan. The *maximum allowed amount* is the total reimbursement payable under your plan for covered services you receive from *participating* and *non-participating providers*. It is our payment towards the services billed by your provider combined with any Deductible or Co-Payment owed by you. In some cases, you may be required to pay the entire *maximum allowed amount*. For instance, if you have not met your Deductible under this plan, then you could be responsible for paying the entire *maximum allowed amount* for covered services. In addition, if these services are received from a *non-participating provider*, you may be billed by the provider for the difference between their charges and our *maximum allowed amount*. In many situations, this difference could be significant.

We have provided two examples below, which illustrate how the *maximum allowed amount* works. These examples are for illustration purposes only.

Example: The plan has a *member* Co-Payment of 30% for *participating provider* services after the Deductible has been met.

- The *member* receives services from a *participating* surgeon. The charge is \$2,000. The *maximum allowed amount* under the plan for the surgery is \$1,000. The *member's* Co-Payment responsibility when a *participating* surgeon is used is 30% of \$1,000, or \$300. This is what the *member* pays. We pay 70% of \$1,000, or \$700. The *participating* surgeon accepts the total of \$1,000 as reimbursement for the surgery regardless of the charges.

Example: The plan has a *member* Co-Payment of 50% for *non-participating provider* services after the Deductible has been met.

- The *member* receives services from a *non-participating* surgeon. The charge is \$2,000. The *maximum allowed amount* under the plan for the surgery is \$1,000. The *member's* Co-Payment responsibility when a *non-participating* surgeon is used is 50% of \$1,000, or \$500. We pay the remaining 50% of \$1,000, or \$500. In addition, the *non-participating* surgeon could bill the *member* the difference between \$2,000 and \$1,000. So the *member's* total out-of-pocket charge would be \$500 plus an additional \$1,000, for a total of \$1,500.

When you receive covered services, we will, to the extent applicable, apply claim processing rules to the claim submitted. We use these rules to evaluate the claim information and determine the accuracy and appropriateness of the procedure and diagnosis codes included in the submitted claim. Applying these rules may affect the *maximum allowed amount* if we determine that the procedure and/or diagnosis codes used were inconsistent with procedure coding rules and/or reimbursement policies. For example, if your provider submits a claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed, the *maximum allowed amount* will be based on the single procedure code.

Provider Network Status

The *maximum allowed amount* may vary depending upon whether the provider is a *participating provider*, a *non-participating provider* or *other health care provider*.

Participating Providers. For covered services performed by a *participating provider* the *maximum allowed amount* for this *plan* will be the rate the *participating provider* has agreed with us to accept as reimbursement for the covered services. Because *participating providers* have agreed to accept the *maximum allowed amount* as payment in full for those covered services, they should not send you a bill or collect for amounts above the *maximum allowed amount*. However, you may receive a bill or be asked to pay all or a portion of the *maximum allowed amount* to the extent you have not met your Deductible or have a Co-Payment. Please call the customer service telephone number on your ID card for help in finding a *participating provider* or visit www.anthem.com/ca.

If you go to a *hospital* which is a *participating provider*, you should not assume all providers in that *hospital* are also *participating providers*. To receive the greater benefits afforded when covered services are provided by a *participating provider*, you should request that all your provider services (such as services by an anesthesiologist) be performed by *participating providers* whenever you enter a *hospital*.

If you are planning to have outpatient surgery, you should first find out if the facility where the surgery is to be performed is an *ambulatory surgical center*. An *ambulatory surgical center* is licensed as a separate facility even though it may be located on the same grounds as a *hospital* (although this is not always the case). If the center is licensed separately, you should find out if the facility is a *participating provider* before undergoing the surgery.

Non-Participating Providers and Other Health Care Providers.*

Providers who are not in our Prudent Buyer network are *non-participating providers* or *other health care providers*, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers. For covered services you receive from a *non-participating provider* or *other health care provider* the *maximum allowed amount* will be based on the applicable Anthem Blue Cross *non-participating provider* rate or fee schedule for this plan, an amount negotiated by us or a third party vendor which has been agreed to by the *non-participating provider*, an amount derived from the total charges billed by the *non-participating provider*, an amount based on information provided by a third party vendor, or an amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services (“CMS”). When basing the *maximum allowed amount* upon the level or method of reimbursement used by CMS, Anthem Blue Cross will update such information, which is unadjusted for geographic locality, no less than annually.

Unlike *participating providers*, *non-participating providers* and *other health care providers* may send you a bill and collect for the amount of the *non-participating provider's* or *other health care provider's* charge that exceeds our *maximum allowed amount under this plan*. You may be responsible for paying the difference between the *maximum allowed amount* and the amount the *non-participating provider* or *other health care provider* charges. This amount can be significant. Choosing a *participating provider* will likely result in lower out of pocket costs to you. Please call the customer service number on your ID card for help in finding a *participating provider* or visit our website at www.anthem.com/ca. Customer service is also available to assist you in determining this *plan's maximum allowed amount* for a particular *covered service* from a *non-participating provider* or *other health care provider*.

Please see the “Out of Area Services” section in the Part entitled “GENERAL PROVISIONS” for additional information.

***Exceptions:**

– Emergency Services Provided by Non-Participating Providers

For *emergency services* provided by *non-participating providers* or at *non-contracting hospitals*, reimbursement is based on the *reasonable and customary value*. You will not be responsible for any amounts in excess of the *reasonable and customary value* for *emergency services rendered within California*.

- **Cancer Clinical Trials.** The *maximum allowed amount* for services and supplies provided in connection with Cancer Clinical Trials will be the lesser of the billed charge or the amount that ordinarily applies when services are provided by a *participating provider*.
- **If Medicare is the primary payor, the *maximum allowed amount* does not include any charge:**
 1. By a *hospital*, in excess of the approved amount as determined by Medicare; or
 2. By a *physician* who is a *participating provider* who accepts Medicare assignment, in excess of the approved amount as determined by Medicare; or
 3. By a *physician* who is a *non-participating provider* or *other health care provider* who accepts Medicare assignment, in excess of the lesser of *maximum allowed amount* stated above, or the approved amount as determined by Medicare; or
 4. By a *physician* or *other health care provider* who does not accept Medicare assignment, in excess of the lesser of the *maximum allowed amount* stated above, or the limiting charge as determined by Medicare.

Member Cost Share

For certain covered services, and depending on your plan design, you may be required to pay all or a part of the *maximum allowed amount* as your cost share amount (Deductibles or Co-Payments). Your cost share amount and the Out-Of-Pocket Amounts may be different depending on whether you received covered services from a *participating provider* or *non-participating provider*. Specifically, you may be required to pay higher cost-sharing amounts or may have limits on your benefits when using *non-participating providers*. Please see the SUMMARY OF BENEFITS section for your cost share responsibilities and limitations, or call the customer service telephone number on your ID card to learn how this *plan's* benefits or cost share amount may vary by the type of provider you use.

Anthem Blue Cross will not provide any reimbursement for non-covered services. You may be responsible for the total amount billed by your provider for non-covered services, regardless of whether such services are performed by a *participating provider* or *non-participating provider*. Non-covered services include services specifically excluded from coverage by the terms of your plan and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, Medical Benefit Maximums or day/visit limits.

In some instances you may only be asked to pay the lower *participating provider* cost share percentage when you use a *non-participating provider*. For example, if you go to a *participating* hospital or facility and receive covered services from a *non-participating provider* such as a radiologist, anesthesiologist or pathologist providing services at the hospital or facility, you will pay the *participating provider* cost share percentage of the *maximum allowed amount* for those covered services. However, you also may be liable for the difference between the *maximum allowed amount* and the *non-participating provider's* charge.

Authorized Referrals

In some circumstances we may authorize *participating provider* cost share amounts (Deductibles or Co-Payments) to apply to a claim for a covered service you receive from a *non-participating provider*. In such circumstance, you or your *physician* must contact us in advance of obtaining the covered service. It is your responsibility to ensure that we have been contacted. If we authorize a *participating provider* cost share amount to apply to a covered service received from a *non-participating provider*, you also may still be liable for the difference between the *maximum allowed amount* and the *non-participating provider's* charge. Please call the customer service telephone number on your ID card for *authorized referral* information or to request authorization.

DEDUCTIBLES, CO-PAYMENTS AND MEDICAL BENEFIT MAXIMUMS

After we subtract any applicable deductible and your Co-Payment, we will pay benefits up to the *maximum allowed amount*, (or the *reasonable and customary value* for *emergency services* provided by a *non-participating provider*), not to exceed any applicable Medical Benefit Maximum. The Deductible amounts, Co-Payments, Out-Of-Pocket Amounts and Medical Benefit Maximums are set forth in the SUMMARY OF BENEFITS.

DEDUCTIBLES

Each deductible under this *plan* is separate and distinct from the other. Only the covered charges that make up the *maximum allowed amount* (or the *reasonable and customary value* for *emergency services* provided by a *non-participating provider*) will apply toward the satisfaction of any deductible except as specifically indicated in this booklet.

Calendar Year Deductible. Each *year*, you will be responsible for satisfying the *member's* Calendar Year Deductible before we begin to pay benefits. If members of an enrolled family pay deductible expense in a year equal to the Family Deductible, the Calendar Year Deductible for all family members will be considered to have been met.

Covered charges incurred from October through December and applied toward the Calendar Year Deductible for that *year* also count toward the Calendar Year Deductible for the next year.

Prior Plan Calendar Year Deductibles. If you were covered under the *prior plan* any amount paid during the same *calendar year* toward your Calendar Year Deductible under the *prior plan*, will be applied toward your Calendar Year Deductible under this *plan*; provided that, such payments were for charges that would be covered under this *plan*.

Additional Deductible

Each time you are admitted to a *hospital* or *residential treatment center* or have outpatient surgery at an *ambulatory surgical center* without properly obtaining certification, you are responsible for paying the Non-Certification Deductible. This deductible will not apply to an *emergency* admission or procedure, nor to services provided at a *participating provider*. Certification is explained in UTILIZATION REVIEW PROGRAM.

CO-PAYMENTS

After you have satisfied any applicable deductible, we will subtract your Co-Payment from the *maximum allowed amount* remaining (or from the amount of *reasonable and customary value* remaining for *emergency services* provided by a *non-participating provider*).

If your Co-Payment is a percentage, we will apply the applicable percentage to the *maximum allowed amount* remaining after any deductible has been met. This will determine the dollar amount of your Co-Payment.

MEDICAL BENEFIT MAXIMUMS

We do not make benefit payments for any *member* in excess of any of the Medical Benefit Maximums. Your Lifetime Maximum under this *plan* will be reduced by any benefits we paid to you or on your behalf under any other health plan provided by Anthem, or any of its affiliates, which is sponsored by the *group*.

Prior Plan Maximum Benefits. If you were covered under the *prior plan*, any benefits paid to you under the *prior plan* will reduce any maximum amounts you are eligible for under this *plan* which apply to the same benefit.

CONDITIONS OF COVERAGE

The following conditions of coverage must be met for expense incurred for services or supplies to be covered under this plan.

1. You must incur this expense while you are covered under this *plan*. Expense is incurred on the date you receive the service or supply for which the charge is made.
2. The expense must be for a medical service or supply furnished to you as a result of illness or injury or pregnancy, unless a specific exception is made.
3. The expense must be for a medical service or supply included in MEDICAL CARE THAT IS COVERED. Additional limits on covered charges are included under specific benefits and in the SUMMARY OF BENEFITS.
4. The expense must not be for a medical service or supply listed in MEDICAL CARE THAT IS NOT COVERED. If the service or supply is partially excluded, then only that portion which is not excluded will be covered under this plan.
5. The expense must not exceed any of the maximum benefits or limitations of this *plan*.
6. Any services received must be those which are regularly provided and billed by the provider. In addition, those services must be consistent with the illness, injury, degree of disability and your medical needs. Benefits are provided only for the number of days required to treat your illness or injury.
7. All services and supplies must be ordered by a *physician*.

MEDICAL CARE THAT IS COVERED

Subject to the Medical Benefit Maximums in the SUMMARY OF BENEFITS, the requirements set forth under CONDITIONS OF COVERAGE and the exclusions or limitations listed under MEDICAL CARE THAT IS NOT COVERED, we will provide benefits for the following services and supplies:

Hospital

1. Inpatient services and supplies, provided by a *hospital*. The *maximum allowed amount* will not include charges in excess of the *hospital's* prevailing two-bed room rate unless there is a negotiated per diem rate between us and the *hospital*, or unless your *physician* orders, and we authorize, a private room as *medically necessary*.
2. Services in *special care units*. The *maximum allowed amount* will not include charges in excess of two and one half times the

hospital's most common charge for its standard semi-private room accommodations.

3. Outpatient services and supplies provided by a *hospital*, including outpatient surgery.

Hospital services are subject to pre-service review to determine medical necessity. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

Skilled Nursing Facility. Inpatient services and supplies provided by a *skilled nursing facility*, for up to 100 days per *calendar year*. The amount by which your room charge exceeds the prevailing two-bed room rate of the *skilled nursing facility* is not considered covered under this plan.

Home Health Care. The following services provided by a *home health agency*:

1. Services of a registered nurse or licensed vocational nurse under the supervision of a registered nurse or a *physician*.
2. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy, or respiratory therapy.
3. Services of a medical social service worker.
4. Services of a health aide who is employed by (or who contracts with) a *home health agency*. Services must be ordered and supervised by a registered nurse employed by the *home health agency* as professional coordinator. These services are covered only if you are also receiving the services listed in 1 or 2 above.
5. *Medically necessary* supplies provided by the *home health agency*.

A visit of four hours or less by a home health aide shall be considered as one home health visit.

Home health care services are not covered if received while you are receiving benefits under the "Hospice Care" provision of this section.

Hospice Care. The services and supplies listed below are covered when provided by a *hospice* for the palliative treatment of pain and other symptoms associated with a terminal disease. You must be suffering from a terminal illness for which the prognosis of life expectancy is one year or less, as certified by your *physician* and submitted to us. Covered services are available on a 24-hour basis for the management of your condition.

1. Interdisciplinary team care with the development and maintenance of an appropriate plan of care.
2. Short-term inpatient *hospital* care when required in periods of crisis or as respite care. Coverage of inpatient respite care is provided on an occasional basis and is limited to a maximum of five consecutive days per admission.
3. Skilled nursing services provided by or under the supervision of a registered nurse. Certified home health aide services and homemaker services provided under the supervision of a registered nurse.
4. Social services and counseling services provided by a qualified social worker.
5. Dietary and nutritional guidance. Nutritional support such as intravenous feeding or hyperalimentation.
6. Physical therapy, occupational therapy, speech therapy, and respiratory therapy provided by a licensed therapist.
7. Volunteer services provided by trained *hospice* volunteers under the direction of a *hospice* staff member.
8. Pharmaceuticals, medical equipment, and supplies necessary for the management of your condition. Oxygen and related respiratory therapy supplies.
9. Bereavement services, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following the *subscriber's* or the *family member's* death. Bereavement services are available to surviving members of the immediate family for a period of one year after the death. Your immediate family means your spouse, children, step-children, parents, and siblings.
10. Palliative care (care which controls pain and relieves symptoms, but does not cure) which is appropriate for the illness.

Your *physician* must consent to your care by the *hospice* and must be consulted in the development of your treatment plan. The *hospice* must submit a written treatment plan to us every 30 days.

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

1. Medication, ancillary medical supplies and supply delivery, (not to exceed a 14-day supply); however, medication which is delivered but not administered is not covered;
2. Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications;
3. *Hospital* and home clinical visits related to the administration of infusion therapy, including skilled nursing services including those provided for: (a) patient or alternative caregiver training; and (b) visits to monitor the therapy;
4. Rental and purchase charges for durable medical equipment (as shown below); maintenance and repair charges for such equipment;
5. Laboratory services to monitor the patient's response to therapy regimen.

Home infusion therapy provider services are subject to pre-service review to determine medical necessity. See UTILIZATION REVIEW PROGRAM for details.

Ambulatory Surgical Center. Services and supplies provided by an *ambulatory surgical center* in connection with outpatient surgery.

Professional Services

1. Services of a *physician*.
2. Services of an anesthetist (M.D. or C.R.N.A.).

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

Reconstructive Surgery. Reconstructive surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or creating a normal appearance. This includes *medically necessary* dental or orthodontic services that are an integral part of reconstructive

surgery for cleft palate procedures. "Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

Ambulance. The following ambulance services:

1. Base charge, mileage and non-reusable supplies of a licensed ambulance company for ground service to transport you to and from a *hospital*.
2. Emergency services or transportation services that are provided to you by a licensed ambulance company as a result of a "911" emergency response system* request for assistance if you believe you have an *emergency* medical condition requiring such assistance.
3. Base charge, mileage and non-reusable supplies of a licensed air ambulance company to transport you from the area where you are first disabled to the nearest *hospital* where appropriate treatment is provided if, and only if, such services are *medically necessary* and ground ambulance service is inadequate.
4. Monitoring, electrocardiograms (EKGs; ECGs), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriately licensed person must render the services.

* If you have an *emergency* medical condition that requires an emergency response, please call the "911" emergency response system if you are in an area where the system is established and operating.

Transportation. Travel expense incurred for transportation within the United States or Canada by railroad or scheduled commercial airline to but not from a *hospital* equipped to furnish special treatment for an illness or injury.

Diagnostic Services. Outpatient diagnostic imaging and laboratory services.

Radiation Therapy

Chemotherapy

Hemodialysis Treatment

Prosthetic Devices

1. Breast prostheses following a mastectomy.
2. *Prosthetic devices* to restore a method of speaking when required as a result of a covered *medically necessary* laryngectomy.

3. We will pay for other *medically necessary prosthetic devices*, including:
 - a. Surgical implants;
 - b. Artificial limbs or eyes;
 - c. The first pair of contact lenses or eye glasses when required as a result of a covered *medically necessary* eye surgery;
 - d. Therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications; and
 - e. For members with diabetes, orthopedic footwear used as an integral part of a brace; shoe inserts that are custom molded to the patient.

Durable Medical Equipment. Rental or purchase of dialysis equipment; dialysis supplies. Rental or purchase of other medical equipment and supplies which are:

1. Of no further use when medical needs end (but not disposable);
2. For the exclusive use of the patient;
3. Not primarily for comfort or hygiene;
4. Not for environmental control or for exercise; and
5. Manufactured specifically for medical use.

We will determine whether the item satisfies the conditions above.

Pediatric Asthma Equipment and Supplies. The following items and services when required for the *medically necessary* treatment of asthma in a dependent *child*:

1. Nebulizers, including face masks and tubing, inhaler spacers, and peak flow meters. These items are covered under the *plan's* medical benefits and are not subject to any limitations or maximums that apply to coverage for durable medical equipment (see "Durable Medical Equipment").
2. Education for pediatric asthma, including education to enable the *child* to properly use the items listed above. This education will be covered under the *plan's* benefits for office visits to a *physician*.

Blood. Blood transfusions, including blood processing and the cost of unreplaced blood and blood products. Charges for the collection, processing and storage of self-donated blood are covered, but only when specifically collected for a planned and covered surgical procedure.

Dental Care

1. **Admissions for Dental Care.** Listed inpatient *hospital* services for up to three days during a *hospital stay*, when such *stay* is required for dental treatment and has been ordered by a *physician* (M.D.) and a dentist (D.D.S. or D.M.D.). We will make the final determination as to whether the dental treatment could have been safely rendered in another setting due to the nature of the procedure or your medical condition. *Hospital stays* for the purpose of administering general anesthesia are not considered necessary and are not covered except as specified in #2, below.
2. **General Anesthesia.** General anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a *hospital* or *ambulatory surgical center*. This applies only if (a) the *member* is less than seven years old, (b) the *member* is developmentally disabled, or (c) the *member's* health is compromised and general anesthesia is *medically necessary*. Charges for the dental procedure itself, including professional fees of a dentist, are not covered.
3. **Dental Injury.** Services of a *physician* (M.D.) or dentist (D.D.S. or D.M.D.) solely to treat an *accidental injury* to natural teeth. Coverage shall be limited to only such services that are *medically necessary* to repair the damage done by *accidental injury* and/or restore function lost as a direct result of the *accidental injury*. Damage to natural teeth due to chewing or biting is not *accidental injury*.
4. **Cleft Palate.** *Medically necessary* dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. "Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

Important: If you decide to receive dental services that are not covered under this *plan*, a *participating provider* who is a dentist may charge you his or her usual and customary rate for those services. Prior to providing you with dental services that are not a covered benefit, the dentist should provide a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about the dental services that are covered under this *plan*, please call us at the customer service telephone number listed on your ID card. To fully understand your coverage under this *plan*, please carefully review this Evidence of Coverage document.

Pregnancy and Maternity Care

1. All medical benefits for an enrolled *member* when provided for pregnancy or maternity care, including the following services:
 - a. Prenatal and postnatal care;
 - b. Ambulatory care services (including ultrasounds, fetal non-stress tests, *physician* office visits, and other *medically necessary* maternity services performed outside of a *hospital*);
 - c. Involuntary complications of pregnancy;
 - d. Diagnosis of genetic disorders in cases of high-risk pregnancy; and
 - e. Inpatient *hospital* care including labor and delivery.

Inpatient *hospital* benefits in connection with childbirth will be provided for at least 48 hours following a normal delivery or 96 hours following a cesarean section, unless the mother and her *physician* decide on an earlier discharge. Please see the section entitled FOR YOUR INFORMATION for a statement of your rights under federal law regarding these services.

2. Medical *hospital* benefits for routine nursery care of a newborn *child*, if the *child's* natural mother is an enrolled *member*. Routine nursery care of a newborn child includes screening of a newborn for genetic diseases, congenital conditions, and other health conditions provided through a program established by law or regulation.
3. Certain services are covered under the "Preventive Care Services" benefit. Please see that provision for further details.

Organ and Tissue Transplants. Services provided in connection with a non-investigative organ or tissue transplant, if you are:

1. The organ or tissue recipient; or
2. The organ or tissue donor.

If you are the recipient, an organ or tissue donor who is not an enrolled *member* is also eligible for services as described. Benefits are reduced by any amounts paid or payable by that donor's own coverage.

Covered charges do not include charges for services received without first obtaining our prior authorization, or which are provided at a facility other than a transplant center approved by us. See UTILIZATION REVIEW PROGRAM for details.

Transplant Travel Expense. Benefits are paid for transportation, lodging and necessary living expenses for you or your *family member* and one companion if you or your *family member* is referred by a Personal Case Manager to a facility for an organ or tissue transplant. Your companion must be a *spouse, family member* or guardian of you or your *family member*.

Necessary living expenses will not include items such as meals, child care, house sitting charges, kennel boarding or reimbursement of any wages lost by the companion during your or your *family member's* stay in the referred facility.

We will pay up to a lifetime maximum of **\$10,000**.

Mental or Nervous Disorders or Substance Abuse. Covered services shown below for the *medically necessary* treatment of *mental or nervous disorders* or substance abuse, or to prevent the deterioration of chronic conditions.

1. Inpatient *hospital* services as stated in the "Hospital" provision of this section, services from a *residential treatment center*, and visits to a *day treatment center*.
2. *Physician* visits during a covered inpatient *stay*.
3. *Physician* visits for outpatient psychotherapy or psychological testing for the treatment of *mental or nervous disorders* or substance abuse.
4. Behavioral health treatment for pervasive developmental disorder or autism. See the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM for a description of the services that are covered. **Note:** You must obtain pre-service review for all behavioral health treatment services for the treatment of pervasive developmental disorder or autism in order for these services to be covered by this *plan* (see UTILIZATION REVIEW PROGRAM for details). No benefits are payable for these services if pre-service review is not obtained.

Treatment for substance abuse does not include smoking cessation programs, nor treatment for nicotine dependency or tobacco use.

Well Baby and Well Child Care. The following services for a dependent *child* under 17 years of age:

1. A *physician's* services for routine physical examinations. For *participating providers*, you must pay a **\$25** co-payment for each examination. For *non-participating providers* only, we will pay up to a maximum of **\$20** for each examination.

2. Immunizations given as standard medical practice for children. For *non-participating providers* only, we will pay up to a maximum of **\$12** for each immunization.
3. Radiology and laboratory services in connection with routine physical examinations.

Screening For Blood Lead Levels. Services and supplies provided in connection with screening for blood lead levels if your dependent *child* is at risk for lead poisoning, as determined by your *physician*, when the screening is prescribed by your *physician*.

Hepatitis B and Varicella Zoster Immunizations. Hepatitis B and Varicella Zoster (chickenpox) immunizations for dependent children ages 7 through 18. For *non-participating providers* only, we will pay a maximum of **\$12** for each immunization.

Preventive Care (Members Age 7 and Over). We will pay up to **\$250** during a *calendar year* for the following services when provided for *members* age 7 and over by a *participating provider*.

1. A *physician's* services for routine physical examinations. You must pay a **\$25** co-payment for each examination.
2. Immunizations given as standard medical practice.
3. Radiology and laboratory services and tests ordered by the examining *physician* in connection with a routine physical examination.
4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
 - a. Women's contraceptives, sterilization procedures, and counseling. This includes generic and *single source brand drugs* as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUD)s, and implants are also covered.
 - b. Breast feeding support, supplies, and counseling. One breast pump will be covered per calendar year under this benefit.
 - c. Gestational diabetes screening.

Preventive Care services are covered only if provided by a participating provider. Hepatitis B and Varicella Zoster Immunizations, Prostate Cancer Screenings, Cervical Cancer Screenings including human papillomavirus (HPV) screening and Breast Cancer screenings are not provided under these preventive care benefits but are provided under other benefits specifically stated under this section.

Prostate Cancer Screening. Services and supplies provided in connection with routine tests to detect prostate cancer.

Cervical Cancer Screening. Services and supplies provided in connection with a routine test to detect cervical cancer, including pap smears and any cervical cancer screening test, including human papillomavirus (HPV) screening, approved by the federal Food and Drug Administration upon referral by your *physician*.

Breast Cancer. Services and supplies provided in connection with the screening for, diagnosis of, and treatment for breast cancer, including:

1. Routine and diagnostic mammogram examinations.
2. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.
3. Reconstructive surgery of both breasts performed to restore and achieve symmetry following a *medically necessary* mastectomy.
4. Breast prostheses following a mastectomy (see "Prosthetic Devices").

Other Cancer Screening Tests. Services and supplies provided in connection with all generally medically accepted cancer screening tests. This coverage is provided according to the terms and conditions of this *plan* that apply to all other medical conditions.

Cancer Clinical Trials. Coverage is provided for services and supplies for routine patient care costs, as defined below, in connection with phase I, phase II, phase III and phase IV cancer clinical trials, if all the following conditions are met:

1. The treatment provided in a clinical trial must either:
 - a. Involve a *drug* that is exempt under federal regulations from a new drug application, or
 - b. Be approved by (i) one of the National Institutes of Health, (ii) the federal Food and Drug Administration in the form of an investigational new drug application, (iii) the United States Department of Defense, or (iv) the United States Veteran's Administration.

2. You must be diagnosed with cancer to be eligible for participation in these clinical trials.
3. Participation in such clinical trials must be recommended by your *physician* after determining participation has a meaningful potential to benefit the *member*.
4. For the purpose of this provision, a clinical trial must have a therapeutic intent. Clinical trials to just test toxicity are not included in this coverage.

Routine patient care costs means the costs associated with the provision of services, including drugs, items, devices and services which would otherwise be covered under the *plan*, including health care services which are:

1. Typically provided absent a clinical trial.
2. Required solely for the provision of the investigational drug, item, device or service.
3. Clinically appropriate monitoring of the investigational item or service.
4. Prevention of complications arising from the provision of the investigational drug, item, device, or service.
5. Reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

Routine patient care costs do not include the costs associated with any of the following:

1. *Drugs* or devices not approved by the federal Food and Drug Administration that are associated with the clinical trial.
2. Services other than health care services, such as travel, housing, companion expenses and other nonclinical expenses that you may require as a result of the treatment provided for the purposes of the clinical trial.
3. Any item or service provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient.
4. Health care services that, except for the fact they are provided in a clinical trial, are otherwise specifically excluded from the *plan*.
5. Health care services customarily provided by the research sponsors free of charge to *members* enrolled in the trial.

Note: You will be financially responsible for the costs associated with non-covered services.

Disagreements regarding the coverage or medical necessity of possible clinical trial services may be subject to Independent Medical Review as described in GRIEVANCE PROCEDURES.

Physical Therapy, Physical Medicine and Occupational Therapy.

The following services provided by a *physician* under a treatment plan:

1. Physical therapy and physical medicine provided on an outpatient basis for the treatment of illness or injury including the therapeutic use of heat, cold, exercise, electricity, ultra violet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care which are customarily provided by chiropractors, physical therapists and osteopaths.)
2. Occupational therapy provided on an outpatient basis when the ability to perform daily life tasks has been lost or reduced by, or has not been developed due to, illness or injury including programs which are designed to rehabilitate mentally, physically or emotionally handicapped persons. Occupational therapy programs are designed to maximize or improve a patient's upper extremity function, perceptual motor skills and ability to function in daily living activities.

Benefits are not payable for care provided to relieve general soreness or for conditions that may be expected to improve without treatment. For the purposes of this benefit, the term "visit" shall include any visit by a *physician* in that *physician's* office, or in any other outpatient setting, during which one or more of the services covered under this limited benefit are rendered, even if other services are provided during the same visit.

Contraceptives. Services and supplies provided in connection with the following methods of contraception:

- Injectable drugs and implants for birth control, administered in a *physician's* office, if *medically necessary*.
- Intrauterine contraceptive devices (IUDs) and diaphragms, dispensed by a *physician* if *medically necessary*.
- Professional services of a *physician* in connection with the prescribing, fitting, and insertion of intrauterine contraceptive devices or diaphragms.

If your *physician* determines that none of these contraceptive methods are appropriate for you based on your medical or personal history,

coverage will be provided for another prescription contraceptive method that is approved by the Food and Drug Administration (FDA) and prescribed by your *physician*.

Certain contraceptives are covered under the "Preventive Care Services" benefit. Please see that provision for further details.

HIV Testing. Human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis. This coverage is provided according to the terms and conditions of this *plan* that apply to all other medical conditions.

Outpatient Speech Therapy. Outpatient speech therapy following injury or organic disease.

Acupuncture. The services of a *physician* for acupuncture treatment to treat a disease, illness or injury, including a patient history visit, physical examination, treatment planning and treatment evaluation, electroacupuncture, cupping and moxibustion. We will pay for up to 50 visits during a *calendar year*, and for up to a maximum of **\$30** for all covered services rendered during each visit.

Foot Care. The services of a *physician* for diagnosis and treatment for (a) weak, strained or flat feet or instability or imbalance of the feet; (b) any tarsalgia, metatarsalgia or bunion other than operations involving the exposure of bones, tendons or ligaments; or (c) toe nail (other than the removal of nail matrix or root) or the removal by cutting or any other method of superficial lesions of the feet including corns, callouses and hyperkeratosis.

Diabetes. Services and supplies provided for the treatment of diabetes, including:

1. The following equipment and supplies:
 - a. Blood glucose monitors, including monitors designed to assist the visually impaired, and blood glucose testing strips.
 - b. Insulin pumps.
 - c. Pen delivery systems for insulin administration (non-disposable).
 - d. Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin.
 - e. Podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes-related complications.

Items a through d above are covered under your *plan's* benefits for durable medical equipment (see "Durable Medical Equipment"). Item e above is covered under your *plan's* benefits for prosthetic devices (see "Prosthetic Devices").

2. Diabetes education program which:
 - a. Is designed to teach a *member* who is a patient and covered members of the patient's family about the disease process and the daily management of diabetic therapy;
 - b. Includes self-management training, education, and medical nutrition therapy to enable the *member* to properly use the equipment, supplies, and medications necessary to manage the disease; and
 - c. Is supervised by a *physician*.

Diabetes education services are covered under *plan* benefits for office visits to *physicians*.

3. The following items are covered as medical supplies:
 - a. Insulin syringes, disposable pen delivery systems for insulin administration. Charges for insulin and other prescriptive medications are not covered as a medical supply. Please refer to the pharmacy benefits.
 - b. Testing strips, lancets, and alcohol swabs.
4. Screenings for gestational diabetes are covered under your Preventive Care Services benefit. Please see that provision for further details.

Jaw Joint Disorders. We will pay for splint therapy or surgical treatment for disorders or conditions of the joints linking the jawbones and the skull (the temporomandibular joints), including the complex of muscles, nerves and other tissues related to those joints.

Special Food Products. Special food products and formulas that are part of a diet prescribed by a *physician* for the treatment of phenylketonuria (PKU). Most formulas used in the treatment of PKU are obtained from a *pharmacy* and are covered under your *plan's* *prescription drug* benefits (see YOUR PRESCRIPTION DRUG BENEFITS). Special food products that are not available from a *pharmacy* are covered as medical supplies under your *plan's* medical benefits.

Accidental Injury. The following are provided if in connection with an *accidental injury* and expense incurred is within two years of the injury date; routine eye or hearing exams, eye refractions, eye glasses, contact lens, hearing aids or any type of external appliances used to improve visual or hearing acuity and their fittings.

Prescription Drug for Abortion. Mifepristone is covered when provided under the Food and Drug Administration (FDA) approved treatment regimen.

MEDICAL CARE THAT IS NOT COVERED

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

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

Experimental or Investigative. Any *experimental* or *investigative* procedure or medication. But, if you are denied benefits because it is determined that the requested treatment is *experimental* or *investigative*, you may request an independent medical review as described in GRIEVANCE PROCEDURES.

Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with *urgent care* or an *emergency*.

Crime or Nuclear Energy. Conditions that result from: (1) your commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy.

Not Covered. Services received before your *effective date* or after your coverage ends, except as specifically stated under EXTENSION OF BENEFITS.

Non-Licensed Providers. Treatment or services rendered by non-licensed health care providers and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed provider under the supervision of a licensed *physician*, except as specifically provided or arranged by us. This exclusion does not apply to the *medically necessary* treatment of pervasive developmental disorder or autism, to the extent stated in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.

Excess Amounts. Any amounts in excess of *maximum allowed amounts* or the Lifetime Maximum.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if you do not claim those benefits.

If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, benefits will be provided subject to our right of recovery and reimbursement under California Labor Code Section 4903, and as described in REIMBURSEMENT FOR ACTS OF THIRD PARTIES.

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

Services of Relatives. Professional services received from a person who lives in your home or who is related to you by blood or marriage, except as specifically stated in the "Home Infusion Therapy" provision of MEDICAL CARE THAT IS COVERED.

Voluntary Payment. Services for which you have no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research *hospital*. Such a *hospital* must meet the following guidelines:

1. It must be internationally known as being devoted mainly to medical research;
2. At least **10%** of its yearly budget must be spent on research not directly related to patient care;

3. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. It must accept patients who are unable to pay; and
5. Two-thirds of its patients must have conditions directly related to the *hospital's* research.

Not Specifically Listed. Services not specifically listed in this *plan* as covered services.

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

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a *hospital stay* primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use. Smoking cessation *drugs*.

Orthodontia. Braces and other orthodontic appliances or services, except as specifically stated in the "Reconstructive Surgery" or "Dental Care" provisions of MEDICAL CARE THAT IS COVERED.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth, or treatment to the teeth or gums, or treatment to or for any disorders for the jaw joint, except as specifically stated in the "Reconstructive Surgery", "Dental Care" or "Jaw Joint Disorders" provisions of MEDICAL CARE THAT IS COVERED. Cosmetic dental surgery or other dental services for beautification.

Hearing Aids or Tests. Hearing aids. Routine hearing tests, except as specifically provided under the "Accidental Injury" and "Preventive Care (Members Age 7 and Over)" provisions of MEDICAL CARE THAT IS COVERED.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, except as specifically provided under the "Accidental Injury" and "Preventive Care (Members Age 7 and Over)" provisions of MEDICAL CARE THAT IS COVERED. Eyeglasses or contact lenses, except as specifically stated in the "Accidental Injury" and "Prosthetic Devices" provisions of MEDICAL CARE THAT IS COVERED.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a *home health agency, hospice or home infusion therapy provider* as specifically stated in the "Home Health Care", "Hospice

Care", "Home Infusion Therapy", or "Physical Therapy, Physical Medicine And Occupational Therapy" provisions of MEDICAL CARE THAT IS COVERED. This exclusion also does not apply to the *medically necessary* treatment of *severe mental disorders*, or to the *medically necessary* treatment of pervasive developmental disorder or autism, to the extent stated in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.

Outpatient Speech Therapy. Outpatient speech therapy except as stated in the "Outpatient Speech Therapy" provision of MEDICAL CARE THAT IS COVERED. This exclusion also does not apply to the *medically necessary* treatment of *severe mental disorders*, or to the *medically necessary* treatment of pervasive developmental disorder or autism, to the extent stated in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

Weight Alteration Programs (Inpatient and Outpatient). Weight loss or weight gain programs including, but not limited to, dietary evaluations and counseling, exercise programs, behavioral modification programs, surgery, laboratory tests, food and food supplements, vitamins and other nutritional supplements associated with weight loss or weight gain. Dietary evaluations and counseling, and behavioral modification programs are covered for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity will be covered only when criteria are met as recommended by our Medical Policy.

Sex Transformation. Procedures or treatments to change characteristics of the body to those of the opposite sex.

Sterilization Reversal. Reversal of sterilization.

Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of *infertility*, including, but not limited to, diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal, and gamete intrafallopian transfer.

Orthopedic Supplies. Orthopedic shoes (other than shoes joined to braces) or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications as specifically stated in the "Prosthetic Devices" provision of MEDICAL CARE THAT IS COVERED.

Air Conditioners. Air purifiers, air conditioners, or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a *hospital stay* primarily for environmental change or physical therapy. *Custodial care* or rest cures, except as specifically provided under the "Hospice Care" or "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a *skilled nursing facility*, except as specifically stated in the "Skilled Nursing Facility" provision of MEDICAL CARE THAT IS COVERED.

Chronic Pain. Treatment of chronic pain, except as specifically provided under the "Hospice Care" or "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED.

Exercise Equipment. Exercise equipment, or any charges for activities, instrumentalities, or facilities normally intended or used for developing or maintaining physical fitness, including, but not limited to, charges from a physical fitness instructor, health club or gym, even if ordered by a *physician*.

Personal Items. Any supplies for comfort, hygiene or beautification.

Educational or Academic Services. This plan does not cover:

1. Educational or academic counseling, remediation, or other services that are designed to increase academic knowledge or skills.
2. Educational or academic counseling, remediation, or other services that are designed to increase socialization, adaptive, or communication skills.
3. Academic or educational testing.
4. Teaching skills for employment or vocational purposes.
5. Teaching art, dance, horseback riding, music, play, swimming, or any similar activities.
6. Teaching manners and etiquette or any other social skills.

7. Teaching and support services to develop planning and organizational skills such as daily activity planning and project or task planning.

This exclusion does not apply to the *medically necessary* treatment of pervasive developmental disorder or autism, to the extent stated in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.

Food or Dietary Supplements. Nutritional and/or dietary supplements and counseling, except as provided in this *plan* or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specifically stated in the "Well Baby and Well Child Care", "Preventive Care (Members Age 7 and Over)", "Cervical Cancer Screening", "Breast Cancer", "Prostate Cancer Screening", "Screening For Blood Lead Levels", or "Hepatitis B and Varicella Zoster Immunizations" provisions of MEDICAL CARE THAT IS COVERED.

Acupuncture. Acupuncture treatment except as specifically stated in the "Acupuncture" provision of MEDICAL CARE THAT IS COVERED. Acupressure, or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Physical Therapy or Physical Medicine. Services of a *physician* for physical therapy or physical medicine, except when provided during a covered inpatient confinement, or as specifically stated in the "Home Health Care", "Hospice Care", "Home Infusion Therapy" or "Physical Therapy, Physical Medicine and Occupational Therapy" provisions of MEDICAL CARE THAT IS COVERED. This exclusion also does not apply to the *medically necessary* treatment of *severe mental disorders*, or to the *medically necessary* treatment of pervasive developmental disorder or autism, to the extent stated in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specifically stated in the "Home Infusion Therapy" and "Prescription Drug for Abortion" provisions of MEDICAL CARE THAT IS COVERED or under YOUR PRESCRIPTION DRUG BENEFITS sections. Non-prescription, over-the-counter patent or proprietary drugs or medicines. Cosmetics, health or beauty aids.

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specifically stated in the "Contraceptives" provision in MEDICAL CARE THAT IS COVERED.

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by us.

Clinical Trials. Services and supplies in connection with clinical trials, except as specifically stated in the "Cancer Clinical Trials" provision under the section MEDICAL CARE THAT IS COVERED.

BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM

This *plan* provides coverage for behavioral health treatment for Pervasive Developmental Disorder or autism. This coverage is provided according to the terms and conditions of this *plan* that apply to all other medical conditions, except as specifically stated in this section.

You must obtain pre-service review for all behavioral health treatment services for the treatment of Pervasive Developmental Disorder or autism in order for these services to be covered by this *plan* (see UTILIZATION REVIEW PROGRAM for details). No benefits are payable for these services if pre-service review is not obtained.

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

DEFINITIONS

Pervasive Developmental Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, includes Autistic Disorder, Rett's Disorder, Childhood Disintegrative

Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified.

Applied Behavior Analysis (ABA) means the design, implementation, and evaluation of systematic instructional and environmental modifications to promote positive social behaviors and reduce or ameliorate behaviors which interfere with learning and social interaction.

Intensive Behavioral Intervention means any form of Applied Behavioral Analysis that is comprehensive, designed to address all domains of functioning, and provided in multiple settings for no more than 40 hours per week, across all settings, depending on the individual's needs and progress. Interventions can be delivered in a one-to-one ratio or small group format, as appropriate.

Qualified Autism Service Provider is either of the following:

- A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for Pervasive Developmental Disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified; or
- A person licensed as a physician and surgeon (M.D. or D.O.), physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to state law, who designs, supervises, or provides treatment for Pervasive Developmental Disorder or autism, provided the services are within the experience and competence of the licensee.

Our network of *participating providers* is limited to licensed Qualified Autism Service Providers who contract with us and who may supervise and employ Qualified Autism Service Professionals or Qualified Autism Service Paraprofessionals who provide and administer Behavioral Health Treatment.

Qualified Autism Service Professional is a provider who meets all of the following requirements:

- Provides behavioral health treatment,
- Is employed and supervised by a Qualified Autism Service Provider,
- Provides treatment according to a treatment plan developed and approved by the Qualified Autism Service Provider,

- Is a behavioral service provider approved as a vendor by a California regional center to provide services as an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program as defined in state regulation, and
- Has training and experience in providing services for Pervasive Developmental Disorder or autism pursuant to applicable state law.

Qualified Autism Service Paraprofessional is an unlicensed and uncertified individual who meets all of the following requirements:

- Is employed and supervised by a Qualified Autism Service Provider,
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider,
- Meets the criteria set forth in any applicable state regulations adopted pursuant to state law concerning the use of paraprofessionals in group practice provider behavioral intervention services, and
- Has adequate education, training, and experience, as certified by a Qualified Autism Service Provider.

BEHAVIORAL HEALTH TREATMENT SERVICES COVERED

The behavioral health treatment services covered by this *plan* for the treatment of Pervasive Developmental Disorder or autism are limited to those professional services and treatment programs, including Applied Behavior Analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with Pervasive Developmental Disorder or autism and that meet all of the following requirements:

- The treatment must be prescribed by a licensed physician and surgeon (an M.D. or D.O.) or developed by a licensed clinical psychologist,
- The treatment must be provided under a treatment plan prescribed by a Qualified Autism Service Provider and administered by one of the following: (a) Qualified Autism Service Provider, (b) Qualified Autism Service Professional supervised and employed by the Qualified Autism Service Provider, or (c) Qualified Autism Service Paraprofessional supervised and employed by a Qualified Autism Service provider, and

- The treatment plan must have measurable goals over a specific timeline and be developed and approved by the Qualified Autism Service Provider for the specific patient being treated. The treatment plan must be reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate, and must be consistent with applicable state law that imposes requirements on the provision of Applied Behavioral Analysis services and Intensive Behavioral Intervention services to certain persons pursuant to which the Qualified Autism Service Provider does all of the following:
 - ◆ Describes the patient's behavioral health impairments to be treated,
 - ◆ Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the intervention plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported,
 - ◆ Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Pervasive Developmental Disorder or autism,
 - ◆ Discontinues Intensive Behavioral Intervention services when the treatment goals and objectives are achieved or no longer appropriate, and
 - ◆ The treatment plan is not used for purposes of providing or for the reimbursement of respite care, day care, or educational services, and is not used to reimburse a parent for participating in the treatment program. No coverage will be provided for any of these services or costs. The treatment plan must be made available to us upon request.

REIMBURSEMENT FOR ACTS OF THIRD PARTIES

Under some circumstances, a *member* may need services under this *plan* for which a third party may be liable or legally responsible by reason of negligence, an intentional act or breach of any legal obligation. In that event, we will provide the benefits of this *plan* subject to the following:

1. We will automatically have a lien, to the extent of benefits provided, upon any recovery, whether by settlement, judgment or otherwise, that you receive from the third party, the third party's insurer, or the third party's guarantor. The lien will be in the amount of benefits we paid under this *plan* for the treatment of the illness, disease, injury or condition for which the third party is liable.

- If we paid the provider other than on a capitated basis, our lien will not be more than amount we paid for those services.
 - If we paid the provider on a capitated basis, our lien will not be more than 80% of the usual and customary charges for those services in the geographic area in which they were given.
 - If you hired an attorney to gain your recovery from the third party, our lien will not be for more than one-third of the money due you under any final judgment, compromise, or settlement agreement.
 - If you did not hire an attorney, our lien will not be for more than one-half of the money due you under any final judgment, compromise or settlement agreement.
 - If a final judgment includes a special finding by a judge, jury, or arbitrator that you were partially at fault, our lien will be reduced by the same comparative fault percentage by which your recovery was reduced.
 - Our lien is subject to a pro rata reduction equal to your reasonable attorney's fees and costs in line with the common fund doctrine.
2. You must advise us in writing, within 60 days of filing a claim against the third party and take necessary action, furnish such information and assistance, and execute such papers as we may require to facilitate enforcement of our rights. You must not take action which may prejudice our rights or interests under your *plan*. Failure to give us such notice or to cooperate with us, or actions that prejudice our rights or interests will be a material breach of this *plan* and will result in your being personally responsible for reimbursing us.
 3. We will be entitled to collect on our lien even if the amount you or anyone recovered for you (or your estate, parent or legal guardian) from or for the account of such third party as compensation for the injury, illness or condition is less than the actual loss you suffered.

YOUR PRESCRIPTION DRUG BENEFITS

Prescription Drug Benefits are administered through CVS Caremark; please review the following information for details on Retail, Mail Order and Specialty drug coverage.

Contact Information:

For General Inquiries such as: Finding a Network Pharmacy, Obtaining Retail or Mail Order Claim Forms and Drug Coverage Questions	CVS Caremark P.O. Box 65929 San Antonio, TX 78265-9529 www.CVS Caremark.com	(800) 450-3755 FastStart Mail Order: (800) 875-0867
Specialty Pharmacy General Inquiries, Claim Forms and Drug Coverage Questions	CVS Caremark Specialty Pharmacy	(800) 237-2767
Status of Retail Claim, Obtain New ID Card	Anthem Blue Cross www.anthem.com/ca	(800) 284-1110
Appeals	CVS Caremark Appeals Dept MC 109 P.O. Box 52084 Phoenix, AZ 85072-2084	Fax: (866) 689-3092 Physician Only Phone: (866) 443-1183

When You Obtain Your Prescription at a Retail Pharmacy expense is incurred on the date you receive the *drug* for which the charge is made. Prescription drug covered expense is the maximum charge for each covered service or supply that will be accepted by CVS Caremark for each different type of *pharmacy*. It is not necessarily the amount a *pharmacy* bills for the service.

Prescription Drug Covered Expense will always be the lesser of the billed charge or the amount shown below.

Type of Provider	Maximum Prescription Drug Covered Expense is...
Network Pharmacies and Mail Service Program	Prescription Drug Specified Rate
Non-Network Pharmacies	Customary and Reasonable

When you go to a network pharmacy. Provided you have properly identified yourself as a member, a *network pharmacy* will only charge the negotiated rate. CVS Caremark will then transmit the claim to Anthem Blue Cross for processing.

When you go to a non-network pharmacy. If you purchase a *prescription drug* from a *non-network pharmacy*, you will have to pay the full cost of the *drug* and submit a claim directly to CVS Caremark.

Type of Prescription	Your Share of the Cost
Network Retail Pharmacy	20% after Deductible
Non-Network Retail Pharmacy*	40% after Deductible

* If you do not live within a CVS Caremark service area you will be reimbursed 80% of Customary and Reasonable charges after your Deductible has been met.

When You Order Your Prescription Through the Mail. If you take prescription medication on an ongoing basis, you may order up to a 90 day supply by mail through CVS Caremark Prescription Service.

CVS Caremark Prescription Service guarantees that every prescription will be screened and filled by a registered pharmacist and be accurate in quantity and potency. Your prescription will be sent to you in a sealed container for your protection.

When you order by mail, your prescription is reviewed by a pharmacist, checked against your Patient Profile, dispensed and verified by CVS Caremark’s Quality Control Department before it is mailed to you.

To use this service, ask your physician to prescribe needed medication for up to a 90 day supply, plus refills. If you are presently taking medication, ask your doctor for a new prescription. Send a completed Patient Questionnaire, your original prescriptions and the appropriate co-

payment for each prescription to CVS Caremark Prescription Service. Make your check or money order payable to CVS Caremark Prescription Service.

CVS Caremark makes it easier for members to get started with mail service and stay on track with their therapies. Members can fill out and print the form online at Caremark.com by clicking on New Prescriptions. Members can then mail in their form along with prescription and payment. Members can also contact FastStart from 7am to 7pm CT Monday – Friday to get started on their mail order. Member's medications will be delivered within 10 days from the time your order is placed.

Type of Prescription	Your Share of the Cost
Mail Order Generic	\$10 copay
Mail Order Brand Name	\$30 copay
Mail Order Non-Formulary	\$50 copay

Ordering Refills

With your original prescription medication, you will receive a notice showing the number of times it may be refilled. Simply enclose this refill notice along with your co-payment and mail to CVS Caremark Prescription Service in the pre-addressed envelope. (Specialty drugs that are not administered at a provider's office must be filled through the mail order program with CVS Caremark.) To avoid the risk of running out, order your refills two weeks before you need them.

Emergency Situations

If you need medication immediately but will be taking it on an ongoing basis, ask your physician for two prescriptions: the first should be for a 14 day supply that you can have filled at a local pharmacy; the second prescription should be for the balance, up to a 90 day supply. Send the larger prescription with the appropriate co-payment to CVS Caremark Prescription Service. (Specialty drugs that are not administered at a provider's office must be filled through the mail order program with CVS Caremark.)

When You Order Your Prescription Through Specialty Drug Program. You can only order your *prescription* for a *specialty drug* through the specialty drug program unless you are given an exception from the specialty drug program. Specialty Drug Program only fills *specialty drug prescriptions*. Specialty Drug Program will deliver your medication to you by mail or common carrier.

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

You or your *physician* may obtain a list of *specialty drugs* available through Specialty Drug Program or order forms by contacting CVS Caremark Specialty Pharmacy.

Type of Prescription	Your Share of the Cost
Specialty Pharmacy	\$150 copay

If you don't get your *specialty drug* through the specialty drug program or in a physician's office, you will not receive any benefits under this *plan*.

Special Programs

From time to time, we may initiate various programs to encourage you to utilize more cost-effective or clinically-effective *drugs* including, but, not limited to, *generic drugs*, mail service *drugs*, over-the-counter *drugs* or preferred drug products. If we initiate such a program, and we determine that you are taking a *drug* for a medical condition affected by the program, you will be notified in writing of the program and how to participate in it and how it may affect your benefits.

The CVS Caremark Claims and Appeals Process Pre-authorization Review:

CVS Caremark will implement the prescription drug cost containment programs requested by the *group* by comparing member requests for certain medicines and/or other prescription benefits against pre-defined preferred drug lists or formularies before those prescriptions are filled. If CVS Caremark determines that the member's request for pre-authorization cannot be approved, that determination will constitute an Adverse Benefit Determination.

Appeals of Adverse Benefit Determinations:

If an Adverse Benefit Determination is rendered on the member's Claim, the member may file an appeal of that determination. The member's appeal of the Adverse Benefit Determination must be made in writing and submitted to CVS Caremark within 180 days after the member receives notice of the Adverse Benefit Determination. If the Adverse Benefit Determination is rendered with respect to an Urgent Care Claim, the member and/or the member's attending physician may submit an appeal by calling CVS Caremark.

The member's appeal should include the following information:

- Name of the person the appeal is being filed for;
- CVS Caremark Identification Number;
- Date of birth;
- Written statement of the issue(s) being appealed;
- Drug name(s) being requested; and
- Written comments, documents, records or other information relating to the Claim.

The member's appeal and supporting documentation may be mailed or faxed to CVS Caremark.

CVS Caremark will provide the first-level review of appeals of Pre-Service Claims. If the member appeals CVS Caremark's decision, the member can request an additional second-level Medical Necessity review. That review will be conducted by an Independent Review Organization ("IRO").

PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED

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

1. Minoxidil (Rogaine) in compounded lotion form when prescribed for cosmetic purposes.
2. Anorectics (any drug or medicine for the purpose of weight loss).
3. Nicorette (or any other drug or medicine containing nicotine or other smoking deterrent, including but not limited to patches).
4. Non-legend drugs or medicines.
5. Therapeutic devices or appliances and support garments and other non-medical substances, regardless of their intended use.
6. Drugs or medicines delivered or administered by the prescriber.
7. Obsolete drugs or medicines (obsolete drugs or medicines are those drugs or medicines which are no longer being produced or have been taken off the market by the manufacturer).
8. Unit dose drugs or medicines (unit dose drugs or medicines are those drugs or medicines which are individually packaged when the same drug or medicine is available in a multi-dose container).

9. More than a 90 day supply or a 270 unit dose of any one prescription or refill when purchased under the Mail Order Drug Plan.
10. Any charge for the giving of insulin.
11. With respect to drugs and medicines, any refill over the number the physician lists.
12. With respect to drugs and medicines, any refill made more than one year after the date of the original prescription order.
13. Drugs or medicines for which benefits are provided under any other provisions of the Plan.
14. Growth hormones, including the drug Protopin (Somatrem).
15. Retin-A.
16. Any drug not listed on the CVS Caremark Preferred Drug List.

COORDINATION OF BENEFITS

If you are covered by more than one group health plan, your benefits under This Plan will be coordinated with the benefits of those Other Plans. These coordination provisions apply separately to each *insured person*, per *calendar year*, and are largely determined by California law. Any coverage you have for medical or dental benefits, will be coordinated as shown below.

DEFINITIONS

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

Allowable Expense is any necessary, reasonable and customary item of expense which is at least partially covered by at least one Other Plan covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage;
2. Group service plan contract, group practice, group individual practice and other group prepayment coverages;

3. Group coverage under labor-management trustee plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.
4. Medicare. This does not include Medicare when, by law, its benefits are secondary to those of any private insurance program or other non-governmental program.

The term "Other Plan" refers separately to each agreement, policy, contract, or other arrangement for services and benefits, and only to that portion of such agreement, policy, contract, or arrangement which reserves the right to take the services or benefits of other plans into consideration in determining benefits.

Principal Plan is the plan which will have its benefits determined first.

This Plan is that portion of this *plan* which provides benefits subject to this provision.

EFFECT ON BENEFITS

This provision will apply in determining a person's benefits under This Plan for any *calendar year* if the benefits under This Plan and any Other Plans, exceed the Allowable Expenses for that *calendar year*.

1. If This Plan is the Principal Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan.
2. If This Plan is not the Principal Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed Allowable Expense.
3. The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if you were covered under This Plan only.

ORDER OF BENEFITS DETERMINATION

The following rules determine the order in which benefits are payable:

1. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision. This would include Medicare in all cases, except when the law requires that This Plan pays before Medicare.
2. A plan which covers you as a *subscriber* pays before a plan which covers you as a dependent. But, if you are retired and eligible for Medicare, Medicare pays (a) after the plan which covers you as a

dependent of an active employee, but (b) before the plan which covers you as a retired *subscriber*.

For example: You are covered as a retired *subscriber* under this plan and eligible for Medicare (Medicare would normally pay first). You are also covered as a dependent of an active employee under another plan (in which case Medicare would pay second). In this situation, the plan which covers you as a dependent will pay first and the plan which covers you as a retired *subscriber* would pay last.

3. For a dependent *child* covered under plans of two parents, the plan of the parent whose birthday falls earlier in the *calendar year* pays before the plan of the parent whose birthday falls later in the *calendar year*. But if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits.

Exception to rule 3: For a dependent *child* of parents who are divorced or separated, the following rules will be used in place of Rule 3:

- a. If the parent with custody of that *child* for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that *child* as a dependent pays first.
 - b. If the parent with custody of that *child* for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:
 - i. The plan which covers that *child* as a dependent of the parent with custody.
 - ii. The plan which covers that *child* as a dependent of the stepparent (married to the parent with custody).
 - iii. The plan which covers that *child* as a dependent of the parent without custody.
 - iv. The plan which covers that *child* as a dependent of the stepparent (married to the parent without custody).
 - c. Regardless of a and b above, if there is a court decree which establishes a parent's financial responsibility for that *child's* health care coverage, a plan which covers that *child* as a dependent of that parent pays first.
4. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But, if either plan does not have a provision regarding laid-off or retired employees, provision 6 applies.

5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan do not agree under these circumstances with the order of benefit determination provisions of This Plan, this rule will not apply.
6. When the above rules do not establish the order of payment, the plan on which you have been enrolled the longest pays first unless two of the plans have the same effective date. In this case, Allowable Expense is split equally between the two plans.

OUR RIGHTS UNDER THIS PROVISION

Responsibility For Timely Notice. We are not responsible for coordination of benefits unless timely information has been provided by the requesting party regarding the application of this provision.

Reasonable Cash Value. If any Other Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of services provided will be considered Allowable Expense. The reasonable cash value of such service will be considered a benefit paid, and our liability reduced accordingly.

Facility of Payment. If payments which should have been made under This Plan have been made under any Other Plan, we have the right to pay that Other Plan any amount we determine to be warranted to satisfy the intent of this provision. Any such amount will be considered a benefit paid under This Plan, and such payment will fully satisfy our liability under this provision.

Right of Recovery. If payments made under This Plan exceed the maximum payment necessary to satisfy the intent of this provision, we have the right to recover that excess amount from any persons or organizations to or for whom those payments were made, or from any insurance company or service plan.

BENEFITS FOR MEDICARE ELIGIBLE MEMBERS

If you are a *retired employee* or the spouse of a *retired employee* and you are eligible for Medicare Part A because you made the required number of quarterly contributions to the Social Security System, your benefits under this *plan* will be subject to the section entitled COORDINATION OF BENEFITS and the provision “Coordinating Benefits With Medicare”, below.

Coordinating Benefits With Medicare. We will not provide benefits under this *plan* that duplicate any benefits to which you would be entitled under Medicare. This exclusion applies to all parts of Medicare in which you can enroll without paying additional premium. If you are required to pay additional premium for any part of Medicare, this exclusion will apply to that part of Medicare only if you are enrolled in that part.

If you are entitled to Medicare, your Medicare coverage will not affect the services covered under this *plan* except as follows:

1. Medicare must provide benefits first to any services covered both by Medicare and under this *plan*.
2. For services you receive that are covered both by Medicare and under this *plan*, coverage under this *plan* will apply only to Medicare deductibles, coinsurance, and other charges for covered services over and above what Medicare pays.
3. For any given claim, the combination of benefits provided by Medicare and the benefits provided under this *plan* will not exceed the *maximum allowed amount* for the covered services.

We will apply any charges paid by Medicare for services covered under this *plan* toward your *plan* deductible, if any.

UTILIZATION REVIEW PROGRAM

Benefits are provided only for *medically necessary* and appropriate services. Utilization Review is designed to work together with you and your provider to ensure you receive appropriate medical care and avoid unexpected out of pocket expense.

No benefits are payable, however, unless your coverage is in force at the time services are rendered, and the payment of benefits is subject to all the terms and requirements of this *plan*.

Important: The Utilization Review Program requirements described in this section do not apply when coverage under this *plan* is secondary to another plan providing benefits for you or your *family members*.

The utilization review program evaluates the medical necessity and appropriateness of care and the setting in which care is provided. You and your *physician* are advised if we have determined that services can be safely provided in an outpatient setting, or if an inpatient *stay* is recommended. Services that are *medically necessary* and appropriate are certified by us and monitored so that you know when it is no longer *medically necessary* and appropriate to continue those services.

It is your responsibility to see that your *physician* starts the utilization review process before scheduling you for any service subject to the utilization review program. If you receive any such service, and do not follow the procedures set forth in this section, your benefits will be reduced as shown in the "Effect on Benefits".

UTILIZATION REVIEW REQUIREMENTS

Utilization reviews are conducted for the following services:

- All inpatient *hospital stays* and *residential treatment center* admissions.
- *Facility-based care* for the treatment of *mental or nervous disorders* and substance abuse.
- Organ and tissue transplants.
- Home infusion therapy.
- Behavioral health treatment for pervasive developmental disorder or autism, as specified in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.

Exceptions: Utilization review is not required for inpatient *hospital stays* for the following services:

- Maternity care of 48 hours or less following a normal delivery or 96 hours or less following a cesarean section; and
- Mastectomy and lymph node dissection.

The stages of utilization review are:

1. **Pre-service review** determines in advance the medical necessity and appropriateness of certain procedures or admissions and the appropriate length of stay, if applicable. Pre-service review is required for the following services:
 - Scheduled, non-emergency inpatient *hospital stays* and *residential treatment center* admissions (except inpatient *stays* for maternity care or mastectomy and lymph node dissection).
 - *Facility-based care* for the treatment of *mental or nervous disorders* and substance abuse.
 - Organ and tissue transplants.
 - Home infusion therapy.
 - Behavioral health treatment for pervasive developmental disorder or autism, as specified in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.
2. **Concurrent review** determines whether services are *medically necessary* and appropriate when we are notified while service is ongoing, for example, an emergency admission to the hospital.
3. **Retrospective review** is performed to review services that have already been provided. This applies in cases when pre-service or concurrent review was not completed, or in order to evaluate and audit medical documentation subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified.

EFFECT ON BENEFITS

In order for the full benefits of this *plan* to be payable, the following criteria must be met:

1. The appropriate utilization reviews must be performed in accordance with this *plan*. When pre-service review is not performed as required for an inpatient *hospital* or *residential treatment center* admission or

for *facility-based care* for the treatment of *mental or nervous disorders* and substance abuse, the benefits to which you would have been otherwise entitled will be subject to the Non-Certification Deductible shown in the SUMMARY OF BENEFITS.

2. When pre-service review is performed and the admission, procedure or service is determined to be *medically necessary* and appropriate, benefits will be provided for the following:
 - Organ and tissue transplants if the *physicians* on the surgical team and the facility in which the transplant is to take place are approved for the transplant requested.
 - Services of a home infusion therapy provider if the attending *physician* has submitted both a prescription and a plan of treatment before services are rendered.
 - Behavioral health treatment for pervasive developmental disorder or autism, as specified in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.

If you proceed with any services that have been determined to be not *medically necessary* and appropriate at any stage of the utilization review process, benefits will not be provided for those services.

3. Services that are not reviewed prior to or during service delivery will be reviewed retrospectively when the bill is submitted for benefit payment. If that review results in the determination that part or all of the services were not *medically necessary* and appropriate, benefits will not be paid for those services. Remaining benefits will be subject to previously noted reductions that apply when the required reviews are not obtained.

HOW TO OBTAIN UTILIZATION REVIEWS

Remember, it is always your responsibility to confirm that the review has been performed. If the review is not performed your benefits will be reduced as shown in the “Effect on Benefits”.

Pre-service Reviews. Penalties will result for failure to obtain required pre-service review, before receiving scheduled services, as follows:

1. For all scheduled services that are subject to utilization review, you or your *physician* must initiate the pre-service review at least three working days prior to when you are scheduled to receive services.
2. You must tell your *physician* that this *plan* requires pre-service review. *Physicians* who are *participating providers* will initiate the

review on your behalf. A *non-participating provider* may initiate the review for you, or you may call us directly. The toll-free number for pre-service review is printed on your identification card.

3. If you do not receive the reviewed service within 60 days of the certification, or if the nature of the service changes, a new pre-service review must be obtained.
4. We will determine if services are *medically necessary* and appropriate. For inpatient *hospital* and *residential treatment center* stays, we will, if appropriate, specify a specific length of *stay* for services. For *facility-based care* for the treatment of *mental or nervous disorders* and substance abuse we will, if appropriate, specify the type and level of services, as well as their duration. You, your *physician* and the provider of the service will receive a written confirmation showing this information.

Concurrent Reviews

1. If pre-service review was not performed, you, your *physician* or the provider of the service must contact us for concurrent review. For an *emergency* admission or procedure, we must be notified within one working day of the admission or procedure, unless extraordinary circumstances* prevent such notification within that time period.
2. When *participating providers* have been informed of your need for utilization review, they will initiate the review on your behalf. You may ask a *non-participating provider* to call the toll free number printed on your identification card or you may call directly.
3. When we determine that the service is *medically necessary* and appropriate, we will, depending upon the type of treatment or procedure, specify the period of time for which the service is medically appropriate. We will also determine the medically appropriate setting.
4. If we determine that the service is not *medically necessary* and appropriate, your *physician* will be notified by telephone no later than 24 hours following our decision. We will send written notice to you and your *physician* within two business days following our decision. However, care will not be discontinued until your *physician* has been notified and a plan of care that is appropriate for your needs has been agreed upon.

***Extraordinary Circumstances.** In determining "extraordinary circumstances", we may take into account whether or not your condition was severe enough to prevent you from notifying us, or whether or not a member of your family was available to notify us for you. You may have

to prove that such "extraordinary circumstances" were present at the time of the *emergency*.

Retrospective Reviews

1. Retrospective review is performed when we are not notified of the service you received, and are therefore unable to perform the appropriate review prior to your discharge from the *hospital* or completion of outpatient treatment. It is also performed when pre-service or concurrent review has been done, but services continue longer than originally certified.

It may also be performed for the evaluation and audit of medical documentation after services have been provided, whether or not pre-service or concurrent review was performed.

2. Such services which have been retroactively determined to not be *medically necessary* and appropriate will be retrospectively denied certification.

THE MEDICAL NECESSITY REVIEW PROCESS

We work with you and your health care providers to cover *medically necessary* and appropriate care and services. While the types of services requiring review and the timing of the reviews may vary, we are committed to ensuring that reviews are performed in a timely and professional manner. The following information explains our review process.

1. A decision on the medical necessity of a pre-service request will be made no later than 5 business days from receipt of the information reasonably necessary to make the decision, and based on the nature of your medical condition.

When your medical condition is such that you face an imminent and serious threat to your health, including the potential loss of life, limb, or other major bodily function and the normal five day timeframe described above would be detrimental to your life or health or could jeopardize your ability to regain maximum function, a decision on the medical necessity of a pre-service request will be made no later than 72 hours after receipt of the information reasonably necessary to make the decision (or within any shorter period of time required by applicable federal law, rule, or regulation).

2. A decision on the medical necessity of a concurrent request will be made no later than one business day from receipt of the information reasonably necessary to make the decision, and based on the nature of your medical condition. However, care will not be discontinued until your *physician* has been notified and a plan of care that is appropriate for your needs has been agreed upon.
3. A decision on the medical necessity of a retrospective review will be made and communicated in writing no later than 30 days from receipt of the information necessary to make the decision to you and your *physician*.
4. If we do not have the information we need, we will make every attempt to obtain that information from you or your *physician*. If we are unsuccessful, and a delay is anticipated, we will notify you and your *physician* of the delay and what we need to make a decision. We will also inform you of when a decision can be expected following receipt of the needed information.
5. All pre-service, concurrent and retrospective reviews for medical necessity are screened by clinically experienced, licensed personnel (called "Review Coordinators") using pre-established criteria and our medical policy. These criteria and policies are developed and approved by practicing providers not employed by us, and are evaluated at least annually and updated as standards of practice or technology change. Requests satisfying these criteria are certified as *medically necessary*. Review Coordinators are able to approve most requests.
6. A written confirmation including the specific service determined to be *medically necessary* will be sent to you and your provider no later than 2 business days after the decision, and your provider will be initially notified by telephone within 24 hours of the decision for pre-service and concurrent reviews.
7. If the request fails to satisfy these criteria or medical policy, the request is referred to a Peer Clinical Reviewer. Peer Clinical Reviewers are health professionals clinically competent to evaluate the specific clinical aspects of the request and render an opinion specific to the medical condition, procedure and/or treatment under review. Peer Clinical Reviewers are licensed in California with the same license category as the requesting provider. When the Peer Clinical Reviewer is unable to certify the service, the requesting *physician* is contacted by telephone for a discussion of the case. In many cases, services can be certified after this discussion. If the Peer Clinical Reviewer is still unable to certify the service, your provider will be given the option of having the request reviewed by a different Peer Clinical Reviewer.

8. Only the Peer Clinical Reviewer may determine that the proposed services are not *medically necessary* and appropriate. Your *physician* will be notified by telephone within 24 hours of a decision not to certify and will be informed at that time of how to request reconsideration. Written notice will be sent to you and the requesting provider within two business days of the decision. This written notice will include:
 - an explanation of the reason for the decision,
 - reference of the criteria used in the decision to modify or not certify the request,
 - the name and phone number of the Peer Clinical Reviewer making the decision to modify or not certify the request,
 - how to request reconsideration if you or your provider disagree with the decision.
9. Reviewers may be plan employees or an independent third party we choose at our sole and absolute discretion.
10. You or your *physician* may request copies of specific criteria and/or medical policy by writing to the address shown on your plan identification card. We disclose our medical necessity review procedures to health care providers through provider manuals and newsletters.

A determination of medical necessity does not guarantee payment or coverage. The determination that services are *medically necessary* is based on the clinical information provided. Payment is based on the terms of your coverage at the time of service. These terms include certain exclusions, limitations, and other conditions. Payment of benefits could be limited for a number of reasons, including:

- The information submitted with the claim differs from that given by phone;
- The service is excluded from coverage; or
- You are not eligible for coverage when the service is actually provided.

Revoking or modifying an authorization. An authorization for services or care may be revoked or modified prior to the services being rendered for reasons including but not limited to the following:

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

- You reach a benefit maximum that applies to the services in question;
- Your benefits under the *plan* change so that the services in question are no longer covered or are covered in a different way.

PERSONAL CASE MANAGEMENT

The personal case management program enables us to authorize you to obtain medically appropriate care in a more economical, cost-effective and coordinated manner during prolonged periods of intensive medical care. Through a case manager, we have the right to recommend an alternative plan of treatment which may include services not covered under this *plan*. It is not your right to receive personal case management, nor do we have an obligation to provide it; we provide these services at our sole and absolute discretion.

HOW PERSONAL CASE MANAGEMENT WORKS

You may be identified for possible personal case management through the *plan's* utilization review procedures, by the attending *physician*, *hospital* staff, or our claims reports. You or your family may also call us.

Benefits for personal case management will be considered only when all of the following criteria are met:

1. You require extensive long-term treatment;
2. We anticipate that such treatment utilizing services or supplies covered under this *plan* will result in considerable cost;
3. Our cost-benefit analysis determines that the benefits payable under this *plan* for the alternative plan of treatment can be provided at a lower overall cost than the benefits you would otherwise receive under this *plan* while maintaining the same standards of care; and
4. You (or your legal guardian) and your *physician* agree, in a letter of agreement, with our recommended substitution of benefits and with the specific terms and conditions under which alternative benefits are to be provided.

Alternative Treatment Plan. If we determine that your needs could be met more efficiently, an alternative treatment plan may be recommended. This may include providing benefits not otherwise covered under this *plan*. A case manager will review the medical records and discuss your treatment with the attending *physician*, you, and your family.

We make treatment recommendations only; any decision regarding treatment belong to you and your *physician*. The *group* will, in no way, compromise your freedom to make such decisions.

EFFECT ON BENEFITS

1. Any alternative benefits are accumulated toward the Lifetime Maximum.
2. Benefits are provided for an alternative treatment plan on a case-by-case basis only. We have absolute discretion in deciding whether or not to authorize services in lieu of benefits for any *member*, which alternatives may be offered and the terms of the offer.
3. Our authorization of services in lieu of benefits in a particular case in no way commits us to do so in another case or for another *member*.
4. The personal case management program does not prevent us from strictly applying the expressed benefits, exclusions and limitations of this *plan* at any other time or for any other *member*.

Note: We reserve the right to use the services of one or more third parties in the performance of the services outlined in the letter of agreement. No other assignment of any rights or delegation of any duties by either party is valid without the prior written consent of the other party.

DISAGREEMENTS WITH MEDICAL MANAGEMENT DECISIONS

1. If you or your *physician* disagree with a decision, or question how it was reached, you or your *physician* may request reconsideration. Requests for reconsideration (either by telephone or in writing) must be directed to the reviewer making the determination. The address and the telephone number of the reviewer are included on your written notice of determination. Written requests must include medical information that supports the medical necessity of the services.
2. If you, your representative, or your *physician* acting on your behalf find the reconsidered decision still unsatisfactory, a request for an appeal of a reconsidered decision may be submitted in writing to us.
3. If the appeal decision is still unsatisfactory, your remedy may be binding arbitration. (See BINDING ARBITRATION.)

QUALITY ASSURANCE

Utilization review programs are monitored, evaluated, and improved on an ongoing basis to ensure consistency of application of screening criteria and medical policy, consistency and reliability of decisions by reviewers, and compliance with policy and procedure including but not limited to timeframes for decision making, notification and written confirmation. Our Board of Directors is responsible for medical necessity review processes through its oversight committees including the Strategic Planning Committee, Quality Management Committee, and Physician Relations Committee. Oversight includes approval of policies and procedures, review and approval of self-audit tools, procedures, and results. Monthly process audits measure the performance of reviewers and Peer Clinical Reviewers against approved written policies, procedures, and timeframes. Quarterly reports of audit results and, when needed, corrective action plans are reviewed and approved through the committee structure.

HOW COVERAGE BEGINS AND ENDS

HOW COVERAGE BEGINS

ELIGIBLE STATUS

1. **Subscribers.** You are in an eligible status if you are a *retiree*. A *retiree* is retired from active full-time employment from Los Angeles County and eligible to participate in the health plan benefit program administered by the Los Angeles County Employees Retirement Association (LACERA).
2. **Family Members.** The following are eligible to enroll as *family members*: (a) Either the *subscriber's* eligible *spouse* or eligible *domestic partner*; and (b) An eligible unmarried *child*.

Definition of Family Member

1. **Spouse** is the *subscriber's* spouse under a legally valid marriage. Spouse does not include any person who is: (a) covered as a *subscriber*; or (b) in active service in the armed forces.
2. **Domestic partner** is the *subscriber's* domestic partner under a legally registered and valid domestic partnership. Domestic partner does not include any person who is: (a) covered as a *subscriber*; or (b) in active service in the armed forces.
3. **Child** is the *subscriber's*, *spouse's* or *domestic partner's* unmarried natural child, stepchild, or legally adopted child, subject to the following:
 - a. The child depends on the *subscriber*, *spouse* or *domestic partner* for financial support or the *subscriber*, *spouse* or *domestic partner* is legally required to provide group health coverage for the child pursuant to an administrative or court order. A child is considered financially dependent if he or she qualifies as a dependent for federal income tax purposes.
 - b. The unmarried child is under 19 years of age, [or 18 years for surviving children (without a surviving *spouse*)], or if over the age of 19, [or over age 18 for surviving children (without a surviving *spouse*)], that child is eligible until his or her 23rd birthday [or 22nd birthday for surviving children (without a surviving *spouse*)], provided he or she is enrolled as a full-time student in a properly accredited educational institution. Any break in the school calendar will not disqualify a child from coverage under this provision. An unmarried child 19 years of age [or over age 18 for surviving children (without a surviving *spouse*)], but, less than 23 years of age [or 22 years of age for surviving children (without a

surviving *spouse*)], who enters or returns to an eligible status will become eligible for coverage on the first day of the month following the date an enrollment application is filed on their behalf.

- c. The unmarried child is 19 years of age, or more and: (i) was covered under the *prior plan*, or has six or more months of *creditable coverage*, (ii) is chiefly dependent on the *subscriber, spouse or domestic partner* for support and maintenance, and (iii) is incapable of self-sustaining employment due to a physical or mental condition. A *physician* must certify in writing that the child is incapable of self-sustaining employment due to a physical or mental condition. We must receive the certification, at no expense to us, within 60-days of the date the *subscriber* receives our request. We may request proof of continuing dependency and that a physical or mental condition still exists, but not more often than once each year after the initial certification. This exception will last until the child is no longer chiefly dependent on the *subscriber, spouse or domestic partner* for support and maintenance due to a continuing physical or mental condition. A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.
- d. A child who is in the process of being adopted is considered a legally adopted child if we receive legal evidence of both: (i) the intent to adopt; and (ii) that the *subscriber, spouse or domestic partner* have either: (a) the right to control the health care of the child; or (b) assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption.

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

- e. The term "child" does not include: (i) any child for whom the *subscriber, spouse or domestic partner* is the legal guardian, but who is not the *subscriber's, spouse's or domestic partner's* natural child, stepchild or adopted child, or (ii) any person who is in active service in the armed forces.

- f. If both parents are covered as *subscribers*, their children may be covered as the *family members* of both. However, the total amount of benefits we would then pay shall not exceed the *maximum allowed amount*.

ELIGIBILITY DATE

1. For *subscribers*, you become eligible for coverage on the first day of the month coinciding with or following the date subscription charges are paid on your behalf.
2. For *family members*, you become eligible for coverage on the later of: (a) the date the *subscriber* becomes eligible for coverage; or, (b) the date you meet the *family member* definition.

ENROLLMENT

To enroll as a *subscriber*, or to enroll *family members*, the *subscriber* must properly file an application. An application is considered properly filed, only if it is personally signed, dated, and given to the *group* within 60 days from your date of retirement. To enroll a family member after the subscriber has been covered, the family member must be enrolled within 30 days from his or her eligibility date. We must receive this application from the *group* within 90 days. If any of these steps are not followed, your coverage may be denied.

EFFECTIVE DATE

Your effective date of coverage is subject to the timely payment of subscription charges on your behalf. The date you become covered is determined as follows:

1. **Timely Enrollment:** If you enroll for coverage before, on, or within the required number of days after your eligibility date, then your coverage will begin as follows: (a) for *subscribers*, on your eligibility date; and (b) for *family members*, on the later of (i) the date the *subscriber's* coverage begins, or (ii) the first day of the month after the *family member* becomes eligible. If you become eligible before the *agreement* takes effect, coverage begins on the effective date of the *agreement*, provided the enrollment application is on time and in order.
2. **Late Enrollment.** If you file an enrollment application or membership change form with the *group* more than 60 days after your eligibility date for subscribers or add new dependents after 30 days from the date they become eligible, coverage will begin six months following the date the enrollment application is filed.

3. **Disenrollment:** If you voluntarily choose to disenroll from coverage under this *plan*, you will be eligible to reapply for coverage 12 months from the date you disenrolled. You may enroll earlier than the 12 month period if you meet any of the conditions listed under SPECIAL ENROLLMENT PERIODS.

Important Note for Newborn and Newly-Adopted Children. If the *subscriber* (or *spouse* or *domestic partner*, if the *spouse* or *domestic partner* is enrolled) is already covered:(1) any *child* born to the *subscriber*, *spouse* or *domestic partner* will be enrolled from the moment of birth; and (2) any *child* being adopted by the *subscriber*, *spouse* or *domestic partner* will be enrolled from the date on which either: (a) the adoptive *child's* birth parent, or other appropriate legal authority, signs a written document granting the *subscriber*, *spouse* or *domestic partner* the right to control the health care of the *child* (in the absence of a written document, other evidence of the *subscriber's*, *spouse's* or *domestic partner's* right to control the health care of the *child* may be used); or (b) the *subscriber*, *spouse* or *domestic partner* assumed a legal obligation for full or partial financial responsibility for the *child* in anticipation of the *child's* adoption. The written document referred to above includes, but is not limited to, a health facility minor release report, a medical authorization form, or relinquishment form.

In both cases, coverage will be in effect for 31 days. For the *child's* enrollment to continue beyond this 31-day period, the *subscriber* must submit a membership change form to the *group* within the 31-day period. We must then receive the form from the *group* within 90 days.

Special Enrollment Periods

You may enroll without having to satisfy the waiting periods specified in the Late Enrollment and Disenrollment provisions if you are otherwise eligible under any one of the circumstances set forth below:

1. You have met all of the following requirements:
 - a. You were covered as an individual or dependent under either:
 - i. Another employer group health plan or health insurance coverage, including coverage under a COBRA or CalCOBRA continuation; or
 - ii. A state Medicaid plan or under a state child health insurance program (SCHIP), including the Healthy Families Program or the Access for Infants and Mothers (AIM) Program.
 - b. You certified in writing at the time you became eligible for coverage under this *plan* that you were declining coverage under

this *plan* or disenrolling because you were covered under another health plan as stated above and you were given written notice that if you choose to enroll later, you may be required to wait twelve months to do.

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

i. If the other health plan was another employer group health plan or health insurance coverage, including coverage under a COBRA or CalCOBRA continuation, coverage ended because you lost eligibility under the other plan, your coverage under a COBRA or CalCOBRA continuation was exhausted, or employer contributions toward coverage under the other plan terminated. You must properly file an application with the *group* within 31 days after the date your coverage ends or the date employer contributions toward coverage under the other plan terminate.

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

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

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

3. We do not have a written statement from the *group* stating that prior to declining coverage or disenrolling, you received and signed acknowledgment of a written notice specifying that if you do not enroll for coverage within the required number of days after your eligibility date, or if you disenroll, and later file an enrollment

application, your coverage may not begin until the first day of the month following a twelve month period.

4. You have a change in family status through either marriage or domestic partnership, or the birth, adoption, or placement for adoption of a *child*:
 - a. If you are enrolling following marriage or domestic partnership, you and your new *spouse* or *domestic partner* must enroll within 31 days of the date of marriage or domestic partnership. Your new *spouse* or *domestic partner's* children may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above.
 - b. If you are enrolling following the birth, adoption, or placement for adoption of a *child*, your *spouse* (if you are already married) or *domestic partner*, who is eligible but not enrolled, may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above. Application must be made within 31 days of the birth or date of adoption or placement for adoption.
5. You meet or exceed a lifetime limit on all benefits under another health plan. Application must be made within 31 days of the date a claim or a portion of a claim is denied due to your meeting or exceeding the lifetime limit on all benefits under the other plan.
6. You become eligible for assistance, with respect to the cost of coverage under the employer's group *plan*, under a state Medicaid or SCHIP health plan, including any waiver or demonstration project conducted under or in relation to these plans. You must properly file an application with the *group* within 60 days after the date you are determined to be eligible for this assistance.

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

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

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

HOW COVERAGE ENDS

Your coverage ends without notice from us as provided below:

1. If the *agreement* terminates, your coverage ends at the same time. This *agreement* may be canceled or changed without notice to you.
2. If the *group* no longer provides coverage for the class of *insured persons* to which you belong, your coverage ends on the effective date of that change. If this *agreement* is amended to delete coverage for *family members*, a *family member's* coverage ends on the effective date of that change.
3. Coverage for *family members* ends when *subscriber's* coverage ends.
4. Coverage ends at the end of the period for which subscription charges have been paid to us on your behalf when the required subscription charges for the next period are not paid.
5. If you voluntarily cancel coverage at any time, coverage ends on the subscription charge due date coinciding with or following the date of voluntary cancellation, as provided by written notice to us.
6. If you no longer meet the requirements set forth in the "Eligible Status" provision of HOW COVERAGE BEGINS, your coverage ends as of the subscription charge due date coinciding with or following the date you cease to meet such requirements.

Exceptions to item 6:

- a. **Handicapped Children:** If a *child* reaches the age limits shown in the "Eligible Status" provision of this section, the *child* will continue to qualify as a *family member* if he or she is (i) covered under this *plan*, (ii) still chiefly dependent on the *subscriber*, *spouse* or *domestic partner* for support and maintenance, and (iii) incapable of self-sustaining employment due to a physical or mental condition. A *physician* must certify in writing that the *child* has a physical or mental condition that makes the *child* incapable of obtaining self-sustaining employment. We will notify the *subscriber* that the *child's* coverage will end when the *child* reaches the *plan's* upper age limit at least 90-days prior to the date the *child* reaches that age. The *subscriber* must send proof of the *child's* physical or mental condition within 60-days of the date the *subscriber* receives our request. If we do not complete our determination of the *child's* continuing eligibility by the date

the *child* reaches the *plan's* upper age limit, the *child* will remain covered pending our determination. When a period of two years has passed, we may request proof of continuing dependency due to a continuing physical or mental condition, but not more often than once each year. This exception will last until the *child* is no longer chiefly dependent on the *subscriber, spouse* or *domestic partner* for support and maintenance or a physical or mental condition no longer exists. A *child* is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

- b. **Full time students taking a medical leave of absence from school:** If a *child* who is 19 years of age or more [or over age 18 for surviving children (without a surviving *spouse*)], enrolled as a full-time student in a properly accredited properly accredited educational institution, and covered under this *plan* in accordance with the "Eligible Status" provision of this section, the *child* may remain covered under this *plan* for a period not to exceed 12 months or until the date the *child's* coverage would normally end in accordance with the terms and conditions of this *plan*, whichever comes first, during a medical leave of absence from school. This provision applies if the nature of the *child's* health condition does not meet the requirements of the "Handicapped Children" provision, above. The period of coverage during this medical leave of absence will begin on the first day of the leave or on the date a *physician* determines the child's illness, injury, or condition prevented the *child* from attending school, whichever comes first. Any break in the school calendar will not disqualify the *child* from maintaining coverage under this provision. A *physician* must certify in writing that the leave of absence from school is medically necessary. This certification must be submitted to us at least 30 days prior to the date the leave begins if the medical reason for the leave and the leave itself are foreseeable. If the medical reason for the leave and the leave itself are not foreseeable, the certification must be submitted to us within 30 days after the date the leave begins.

Note: If a marriage or domestic partnership terminates, the *subscriber* must give or send to the *group* written notice of the termination. Coverage for a former *spouse* or *domestic partners*, and their dependent *children*, if any, ends according to the "Eligible Status" provisions. If Anthem suffers a loss because of the *subscriber* failing to notify the *group* of the termination of their marriage or domestic partnership, Anthem may seek recovery from the *subscriber* for any actual loss resulting thereby. Failure to provide written notice to the *group* will not delay or prevent termination of the marriage or domestic partnership. If the *subscriber* notifies the *group* in writing to cancel coverage for a

former *spouse* or *domestic partner* and the *children* of the *spouse* or *domestic partner*, if any, immediately upon termination of the *subscriber's* marriage or domestic partnership, such notice will be considered compliance with the requirements of this provision.

You may be entitled to continued benefits under terms which are specified elsewhere under CONTINUATION OF COVERAGE, CALCOBRA CONTINUATION OF COVERAGE, COVERAGE FOR SURVIVING FAMILY MEMBERS; EXTENSION OF BENEFITS and HIPAA COVERAGE AND CONVERSION.

Unfair Termination of Coverage. If you believe that your coverage has been or will be improperly terminated, you may file a grievance with us in accordance with the procedures described in the section entitled GRIEVANCE PROCEDURES. You should file your grievance as soon as possible after you receive notice that your coverage will end. You may also request a review of the matter by the Director of the Department of Managed Health Care. If your coverage is still in effect when you submit a grievance, we will continue to provide coverage to you under the terms of this *plan* until a final determination of your request for review has been made, including any review by the Director of the Department of Managed Health Care (this does not apply if your coverage is cancelled for non-payment of subscription charges). If your coverage is maintained in force pending outcome of the review, subscription charges must still be paid to us on your behalf.

CONTINUATION OF COVERAGE

LACERA is subject to the federal law which governs this provision (Title X of P.L. 99-272), so you may be entitled to continuation of coverage. Check with LACERA for details.

DEFINITIONS

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

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

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

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continuation period, with the exception of newborns and adoptees as specified above; or (b) a *domestic partner*, or a *child of a domestic partner*, if they are eligible under HOW COVERAGE BEGINS AND ENDS.

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

1. **For Retirees and their Family Members.** Cancellation or a substantial reduction of retiree benefits under the *plan* due to the *group's* filing for Chapter 11 bankruptcy, provided that:
 - a. The *agreement* expressly includes coverage for retirees; and
 - b. Such cancellation or reduction of benefits occurs within one year before or after the *group's* filing for bankruptcy.
2. **For Family Members:**
 - a. The death of the *subscriber*;
 - b. The *spouse's* divorce or legal separation from the *subscriber*;
 - c. The end of a *child's* status as a dependent *child*, as defined by the *agreement*; or
 - d. The *subscriber's* entitlement to Medicare.

ELIGIBILITY FOR COBRA CONTINUATION

A *subscriber* or *family member*, **other than a *domestic partner*, and a *child of a domestic partner***, may choose to continue coverage under the *agreement* if your coverage would otherwise end due to a Qualifying Event.

Entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 1.

TERMS OF COBRA CONTINUATION

Notice. The *group* or its administrator (we are not the administrator) will notify either the *subscriber* or *family member* of the right to continue coverage under COBRA, as provided below:

1. For Qualifying Events 1, or 2, the *group* or its administrator will notify the *subscriber* of the right to continue coverage.
2. For Qualifying Events 2(a) or 2(d) above, a *family member* will be notified of the COBRA continuation right.

3. You must inform the *group* within 60 days of Qualifying Events 2(b) or 2(c) above if you wish to continue coverage. The *group* in turn will promptly give you official notice of the COBRA continuation right.

If you choose to continue coverage you must notify the *group* within 60 days of the date you receive notice of your COBRA continuation right. The COBRA continuation coverage may be chosen for all *members* within a family, or only for selected *members*.

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

Notice of continued coverage, along with the initial subscription charge, must be delivered to us by the *group* within 45 days after you elect COBRA continuation coverage.

Additional Family Members. A *spouse* or *child* acquired during the COBRA continuation period is eligible to be enrolled as a *family member*. The standard enrollment provisions of the *agreement* apply to enrollees during the COBRA continuation period.

Cost of Coverage. The *group* may require that you pay the entire cost of your COBRA continuation coverage. This cost, called the "subscription charge", must be remitted to the *group* each month during the COBRA continuation period. We must receive payment of the subscription charge each month from the *group* in order to maintain the coverage in force.

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

1. A *spouse* whose COBRA continuation began due to divorce, separation or death of the *subscriber*;
2. A *child* if neither the *subscriber* nor the *spouse* has enrolled for this COBRA continuation coverage (if more than one *child* is so enrolled, the subscription charge will be the two-party or three-party rate depending on the number of *children* enrolled); and
3. A *child* whose COBRA continuation began due to the person no longer meeting the dependent *child* definition.

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

For example, a *child* may have been originally eligible for this COBRA continuation due to termination of the *subscriber's* employment, and enrolled for this COBRA continuation as a Qualified Beneficiary. If,

during the COBRA continuation period, the *child* reaches the upper age limit of the *plan*, the *child* is eligible for an extended continuation period which would end no later than 36 months from the date of the original Qualifying Event (the termination of employment).

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

For *family members* properly enrolled during the COBRA continuation, coverage begins according to the enrollment provisions of the *agreement*.

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

1. The end of 18 months from the Qualifying Event, if the Qualifying Event was termination of employment or reduction in work hours;*
2. The end of 36 months from the Qualifying Event, if the Qualifying Event was the death of the *subscriber*, divorce or legal separation, or the end of dependent *child* status;*
3. The end of 36 months from the date the *subscriber* became entitled to Medicare, if the Qualifying Event was the *subscriber's* entitlement to Medicare.
4. The date the *agreement* terminates;
5. The end of the period for which subscription charges are last paid;
6. The date, following the election of COBRA, the *member* first becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the *member*, in which case this COBRA continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied; or
7. The date, following the election of COBRA, the *member* first becomes entitled to Medicare.

*For a *member* whose COBRA continuation coverage began under a *prior plan*, this term will be dated from the time of the Qualifying Event under that *prior plan*. Additional note: If your COBRA continuation under this *plan* began on or after January 1, 2003 and ends in accordance with item 1, you may further elect to continue coverage for medical benefits only under CalCOBRA for the balance of 36 months (COBRA and CalCOBRA combined). All COBRA eligibility must be exhausted before you are eligible to further continue coverage under CalCOBRA. Please

see CALCOBRA CONTINUATION OF COVERAGE in this booklet for more information.

Subject to the *agreement* remaining in effect, a retired *subscriber* whose COBRA continuation coverage began due to Qualifying Event 2 may be covered for the remainder of his or her life; that person's covered *family members* may continue coverage for 36 months after the *subscriber's* death. But coverage could terminate prior to such time for either the *subscriber* or *family member* in accordance with items 4, 5 or 6 above.

If your COBRA continuation under this *plan* ends in accordance with items 1, 2 or 3, you may be eligible for medical conversion coverage. If your COBRA continuation under this *plan* ends in accordance with items 1, 2, 3, or 4 you may be eligible for HIPAA coverage. The *group* will provide notice of these options within 180 days prior to your COBRA termination date. Please see HIPAA COVERAGE AND CONVERSION in this booklet for more information.

EXTENSION OF CONTINUATION DURING TOTAL DISABILITY

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

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

1. Satisfy the legal requirements for being totally and permanently disabled under the Social Security Act; and
2. Be determined and certified to be so disabled by the Social Security Administration.

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

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

Cost of Coverage. For the 19th through 29th months that the total disability continues, the *group* must remit the cost for the extended continuation coverage to us. This cost (called the "subscription charge") shall be subject to the following conditions:

1. If the disabled *member* continues coverage during this extension, this charge shall be **150%** of the applicable rate for the length of time the disabled *member* remains covered, depending upon the number of covered dependents. If the disabled *member* does not continue coverage during this extension, this charge shall remain at **102%** of the applicable rate.
2. The cost for extended continuation coverage must be remitted to us by the *group* each month during the period of extended continuation coverage. We must receive timely payment of the subscription charge each month from the *group* in order to maintain the extended continuation coverage in force.
3. The *group* may require that you pay the entire cost of the extended continuation coverage.

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

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

1. The end of the month following a period of 30 days after the Social Security Administration's final determination that you are no longer totally disabled;
2. The end of 29 months from the Qualifying Event*;
3. The date the *agreement* terminates;
4. The end of the period for which subscription charges are last paid;
5. The date, following the election of COBRA, the *member* first becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the *member*, in which case this COBRA extension will end at the end of the period for which the pre-existing condition exclusion or limitation applied; or
6. The date, following the election of COBRA, the *member* first becomes entitled to Medicare. However, entitlement to Medicare will

not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 1.

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

*Note: If your COBRA continuation under this *plan* began on or after January 1, 2003 and ends in accordance with item 2, you may further elect to continue coverage for medical benefits only under CalCOBRA for the balance of 36 months (COBRA and CalCOBRA combined). All COBRA eligibility must be exhausted before you are eligible to further continue coverage under CalCOBRA. Please see CALCOBRA CONTINUATION OF COVERAGE in this booklet for more information.

CALCOBRA CONTINUATION OF COVERAGE

If your continuation coverage under federal COBRA began on or after January 1, 2003, you have the option to further continue coverage under CalCOBRA for medical benefits only if your federal COBRA ended following:

1. 18 months after the qualifying event, if the qualifying event was termination of employment or reduction in work hours; or
2. 29 months after the qualifying event, if you qualified for the extension of COBRA continuation during total disability.

All federal COBRA eligibility must be exhausted before you are eligible to further continue coverage under CalCOBRA. You are not eligible to further continue coverage under CalCOBRA if you (a) are entitled to Medicare; (b) have other coverage or become covered under another group plan, as long as you are not subject to a pre-existing condition limitation under that coverage; or (c) are eligible for or covered under federal COBRA. Coverage under CalCOBRA is available for medical benefits only.

TERMS OF CALCOBRA CONTINUATION

Notice. Within 180 days prior to the date federal COBRA ends, we will notify you of your right to further elect coverage under CalCOBRA. If you choose to elect CalCOBRA coverage, you must notify us in writing within 60 days of the date your coverage under federal COBRA ends or when you are notified of your right to continue coverage under CalCOBRA, whichever is later. If you don't give us written notification within this time period you will not be able to continue your coverage.

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance

typically require a review of your medical history that could result in higher cost or you could be denied coverage entirely.

Additional Family Members. A dependent acquired during the CalCOBRA continuation period is eligible to be enrolled as a *family member*. The standard enrollment provisions of the *agreement* apply to enrollees during the CalCOBRA continuation period.

Cost of Coverage. You will be required to pay the entire cost of your CalCOBRA continuation coverage (this is the “subscription charge”). This cost will be:

1. 110% of the applicable *group* rate if your coverage under federal COBRA ended after 18 months; or
2. 150% of the applicable *group* rate if your coverage under federal COBRA ended after 29 months.

You must make payment to us within the timeframes specified below. We must receive payment of your subscription charge each month to maintain your coverage in force.

Payment Dates. The first payment is due along with your enrollment form within 45 days after you elect continuation coverage. You must make this payment by first-class mail or other reliable means of delivery, in an amount sufficient to pay any required subscription charges and subscription charges due. Failure to submit the correct amount within this 45-day period will disqualify you from receiving continuation coverage under CalCOBRA. Succeeding subscription charges are due on the first day of each following month.

If subscription charges are not received when due, your coverage will be cancelled. We will cancel your coverage only upon sending you written notice of cancellation at least 30 days prior to cancelling your coverage (or any longer period of time required by applicable federal law, rule, or regulation). If you make payment in full within this time period, your coverage will not be cancelled. If you do not make the required payment in full within this time period, your coverage will be cancelled as of 12:00 midnight on the thirtieth day after the date on which the notice of cancellation is sent (or any longer period of time required by applicable federal law, rule, or regulation) and will not be reinstated. Any payment we receive after this time period runs out will be refunded to you within 20 business days. Note: You are still responsible for any unpaid subscription charges that you owe to us, including subscription charges that apply during any grace period.

Change of Subscription Charge. The amounts of the subscription charges may be changed by us as of any subscription charge due date. We will provide you with written notice at least 60 days prior to the date any subscription charge increase goes into effect.

Accuracy of Information. You are responsible for supplying up-to-date eligibility information. We shall rely upon the latest information received as correct without verification; but we maintain the right to verify any eligibility information you provide.

CalCOBRA Continuation Coverage Under the Prior Plan. If you were covered through CalCOBRA continuation under the *prior plan*, your coverage may continue under this *plan* for the balance of the continuation period. However your coverage shall terminate if you do not comply with the enrollment requirements and subscription charge payment requirements of this *plan* within 30 days of receiving notice that your continuation coverage under the *prior plan* will end.

When CalCOBRA Continuation Coverage Begins. When you elect CalCOBRA continuation coverage and pay the subscription charge, coverage is reinstated back to the date federal COBRA ended, so that no break in coverage occurs.

For *family members* properly enrolled during the CalCOBRA continuation, coverage begins according to the enrollment provisions of the *agreement*.

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

1. The date that is 36 months after the date of your qualifying event under federal COBRA*;
2. The date the *agreement* terminates;
3. The date the *group* no longer provides coverage to the class of *members* to which you belong;
4. The end of the period for which subscription charges are last paid (your coverage will be cancelled upon written notification, as explained under "Payment Dates", above);
5. The date you become covered under any other health plan, unless the other health plan contains an exclusion or limitation relating to a pre-existing condition that you have. In this case, this continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied;
6. The date you become entitled to Medicare; or

7. The date you become covered under a federal COBRA continuation.

CalCOBRA continuation will also end if you move out of our service area or if you commit fraud.

*If your CalCOBRA continuation coverage began under a *prior plan*, this term will be dated from the time of the qualifying event under that *prior plan*.

If your CalCOBRA continuation under this *plan* ends in accordance with items 1, 2, or 3, you may be eligible for HIPAA coverage or medical conversion coverage. You will receive notice of these options within 180 days prior to your CalCOBRA termination date. Please see HIPAA COVERAGE AND CONVERSION in this booklet for more information.

COVERAGE FOR SURVIVING FAMILY MEMBERS

If the *subscriber* dies while covered under this *plan*, coverage continues for enrolled *family members* until one of the following occurs; however, in order for the *family members* to be eligible for such coverage, the *spouse's* marriage to the deceased *subscriber* must have occurred more than twelve months prior to the *subscriber's* date of retirement. Coverage for such *family members* continues until one of the following occurs:

1. Subscription charges are not paid to Anthem on the *member's* behalf, or
2. The *group* cancels coverage for the class of *subscribers* to which the *member* belongs, or
3. The agreement between the *group* and Anthem terminates, or
4. The *child* no longer meets all of the conditions of coverage in HOW COVERAGE BEGINS AND ENDS.

Note: The cost of continuing coverage under this provision may be more than the cost of coverage the *group* provides to its retirees or their *family members*. The *member* may be responsible for all or part of the subscription charges.

EXTENSION OF BENEFITS

If you are a *totally disabled subscriber* or a *totally disabled family member* and under the treatment of a *physician* on the date of discontinuance of the *agreement*, your benefits may be continued for treatment of the totally disabling condition. This extension of benefits is not available if you become covered under another group health plan that provides coverage without limitation for your disabling condition. Extension of benefits is subject to the following conditions:

1. If you are confined as an inpatient in a *hospital* or *skilled nursing facility*, you are considered totally disabled as long as the inpatient *stay* is *medically necessary*, and no written certification of the total disability is required. If you are discharged from the *hospital* or *skilled nursing facility*, you may continue your total disability benefits by submitting written certification by your *physician* of the total disability within 90 days of the date of your discharge. Thereafter, we must receive proof of your continuing total disability at least once every 90 days while benefits are extended.
2. If you are not confined as an inpatient but wish to apply for total disability benefits, you must do so by submitting written certification by your *physician* of the total disability. We must receive this certification within 90 days of the date coverage ends under this *plan*. At least once every 90 days while benefits are extended, we must receive proof that your total disability is continuing.
3. Your extension of benefits will end when any one of the following circumstances occurs:
 - a. You are no longer totally disabled.
 - b. The maximum benefits available to you under this *plan* are paid.
 - c. You become covered under another group health plan that provides benefits without limitation for your disabling condition.
 - d. A period of up to 12 months has passed since your extension began.

HIPAA COVERAGE AND CONVERSION

If your coverage for medical benefits under this *plan* ends, you may be eligible to enroll for coverage with any carrier or health plan that offers individual medical coverage. HIPAA coverage and conversion coverage are available upon request if you meet the requirements stated below. Both HIPAA coverage and conversion are available for medical benefits only. Please note that the benefits and cost of these plans will differ from your employer's *plan*.

HIPAA Coverage

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides an option for individual coverage when coverage under the employer's group *plan* ends. To be eligible for HIPAA coverage, you must meet all of the following requirements:

1. You must have a minimum of 18 months of continuous health coverage, most recently under an employer-sponsored health plan, and have had coverage within the last 63 days.
2. Your most recent coverage was not terminated due to nonpayment of subscription charges or fraud.
3. If continuation of coverage under the employer *plan* was available under COBRA, CalCOBRA, or a similar state program, such coverage must have been elected and exhausted.
4. You must not be eligible for Medicare, Medi-Cal, or any group medical coverage and cannot have other medical coverage.

You must apply for HIPAA coverage within 63 days of the date your coverage under the employer's *plan* ends. Any carrier or health plan that offers individual medical coverage must make HIPAA coverage available to qualified persons without regard to health status. If you decide to enroll in HIPAA coverage, you will no longer qualify for conversion coverage.

Conversion Coverage

To apply for a conversion plan, you must submit an application to us and make the first subscription charge payment within 63 days of the date your coverage under the employer's *plan* ends. Under certain circumstances you are not eligible for a conversion plan. They are:

1. You are not eligible if your coverage under this *plan* ends because the *agreement* between the *group* and us terminates and is replaced by another group plan within 15 days.

2. You are not eligible if your coverage under this *plan* ends because subscription charges are not paid when due because you (or the *subscriber* who enrolled you as a dependent) did not contribute your part, if any.
3. You are not eligible for a conversion plan if you are eligible for health coverage under another group plan when your coverage ends.
4. You are not eligible for a conversion plan if you are eligible for Medicare coverage when your coverage under this *plan* ends, whether or not you have actually enrolled in Medicare.
5. You are not eligible for a conversion plan if you are covered under an individual health plan.
6. You are not eligible for a conversion plan if you were not covered for medical benefits under the *plan* for three consecutive months immediately prior to the termination of your coverage.

If you decide to enroll in a conversion plan, you will no longer qualify for HIPAA coverage.

Important: The intention of conversion coverage is not to replace the coverage you have under this *plan*, but to make available to you a specified amount of coverage for medical benefits until you can find a replacement. The conversion plan provides lesser benefits than this *plan* and the provisions and rates differ.

When coverage under your employer's group *plan* ends, you will receive more information about how to apply for HIPAA coverage or conversion, including a postcard for requesting an application and a telephone number to call if you have any questions.

GENERAL PROVISIONS

Providing of Care. We are not responsible for providing any type of *hospital*, medical or similar care, nor are we responsible for the quality of any such care received.

Independent Contractors. Our relationship with providers is that of an independent contractor. *Physicians*, and other health care professionals, *hospitals*, *skilled nursing facilities* and other community agencies are not our agents nor are we, or any of our employees, an employee or agent of any *hospital*, medical group or medical care provider of any type.

Non-Regulation of Providers. The benefits of this *plan* do not regulate the amounts charged by providers of medical care, except to the extent that rates for covered services are regulated with *participating providers*.

Out-of-California Providers. The Blue Cross and Blue Shield Association, of which we are a member, has a program (called the "BlueCard Program") which allows our *members* to have the reciprocal use of participating providers contracted under other states' Blue Cross and/or Blue Shield Licensees. If you are outside of California and require medical care or treatment, you may use a local Blue Cross and/or Blue Shield provider. If you use one of these providers, your out-of-pocket expenses may be lower than those incurred when using a provider that does not participate in the BlueCard Program. The rules for the BlueCard Program, including those described below, are set by The Blue Cross and Blue Shield Association. In order for you to receive access to whatever discounts may be available, we must abide by those rules.

When you obtain covered health care services through the BlueCard Program outside of California, your co-payment for such services, if it is not a flat dollar amount, is usually calculated on the lower of the:

- Billed charges for your covered services, or
- Negotiated price that the on-site Blue Cross and/or Blue Shield Licensee ("Host Blue") passes on to us.

Often, the "negotiated price," referred to above, will consist of a simple discount, which reflects the actual price paid by the Host Blue. But, sometimes it is an estimated price that factors in expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect **average** expected savings with your health care provider or with a specified group of providers. If the negotiated price reflects average expected savings, it may result in greater variation (more or less) from the actual price paid than will the estimated price. The estimated or

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average price may be adjusted in the future to correct for over- or underestimation of past prices. Regardless of how the negotiated price is determined, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating *member* liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate *member* liability calculation methods that differ from the usual BlueCard Program method noted above in the second paragraph of this section, or require a surcharge, we would then calculate your co-payment for any covered health care services using the methods outlined by the applicable state statute in effect at the time you received your care.

Providers available to you through the BlueCard Program have not entered into contracts with Anthem Blue Cross. If you have any questions or complaints about the BlueCard Program, please call us at the customer service telephone number listed on your ID card.

Terms of Coverage

1. In order for you to be entitled to benefits under the *agreement*, both the *agreement* and your coverage under the *agreement* must be in effect on the date the expense giving rise to a claim for benefits is incurred.
2. The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date you receive the service or supply for which the charge is made.
3. The *agreement* is subject to amendment, modification or termination according to the provisions of the *agreement* without your consent or concurrence.

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

Free Choice of Provider. This *plan* in no way interferes with your right as a *member* entitled to *hospital* benefits to select a *hospital*. You may choose any *physician* who holds a valid *physician* and surgeon's certificate and who is a member of, or acceptable to, the attending staff and board of directors of the *hospital* where services are received. You may also choose any other health care professional or facility which provides care covered under this *plan*, and is properly licensed according

to appropriate state and local laws. However, your choice may affect the benefits payable according to this *plan*.

Provider Reimbursement. *Physicians* and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. A participating *physician* may, after notice from us, be subject to a reduced negotiated rate in the event the participating *physician* fails to make routine referrals to *participating providers*, except as otherwise allowed (such as for *emergency services*). *Hospitals* and other health care facilities may be paid either a fixed fee or on a discounted fee-for-service basis.

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

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

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

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

Notice of Claim. You or the provider of service must send properly and fully completed claim forms to us within 90 days of the date you receive the service or supply for which a claim is made. Services received and charges for the services must be itemized, and clearly and accurately described. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 24 months will be allowed. We are not liable for the benefits of the *agreement* if you do not file claims within the required time period. Claim forms must be used; canceled checks or receipts are not acceptable.

Payment to Providers. We will pay the benefits of this *plan* directly to *contracting hospitals*, *participating providers*, COE and medical transportation providers. Also, we will pay *non-contracting hospitals* and other providers of service directly when you assign benefits in writing. If you are a MediCal beneficiary and you assign benefits in writing to the State Department of Health Services, we will pay the benefits of this *plan*

to the State Department of Health Services. These payments will fulfill our obligation to you for those covered services.

Right of Recovery. When the amount we paid exceeds our liability under this *plan*, we have the right to recover the excess amount. This amount may be recovered from you, the person to whom payment was made or any other plan.

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 CONTINUATION OF COVERAGE section of this booklet, the *group* is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as your agent.

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

Prepayment Fees. LACERA is responsible for paying subscription charges to us for all coverage provided to you and your *family members*. LACERA may require that you contribute all or part of the costs of these subscription charges. Please consult LACERA for details.

Liability of Subscriber to Pay Providers. In accordance with California law, you will not be required to pay any *participating provider* or *other health care provider* any amounts we owe to that provider (not including co-payments or deductibles), even in the unlikely event that we fail to pay that provider. You may be liable, however, to pay *non-participating providers* any amounts not paid to them by us.

Renewal Provisions. LACERA's health plan *agreement* with us is subject to renewal at certain intervals. We may change the subscription charges or other terms of the *plan* from time to time.

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.

Financial Arrangements with Providers. Anthem or an affiliate has contracts with certain health care providers and suppliers (hereafter referred to together as “Providers”) for the provision of and payment for health care services rendered to its *subscribers* and *members/insured* persons entitled to health care benefits under individual certificates and group policies or contracts to which Anthem or an affiliate is a party, including all persons covered under the *agreement*.

Under the above-referenced contracts between Providers and Anthem or an affiliate, the negotiated rates paid for certain medical services provided to persons covered under the *agreement* may differ from the rates paid for persons covered by other types of products or programs offered by Anthem or an affiliate for the same medical services. In negotiating the terms of the *agreement*, the *group* was aware that Anthem or its affiliates offer several types of products and programs. The *subscribers*, *family members* and the *group* are entitled to receive the benefits of only those discounts, payments, settlements, incentives, adjustments and/or allowances specifically applicable to Anthem or its affiliates’ agreements for insured group accounts.

Also, under arrangements with some Providers certain discounts, payments, rebates, settlements, incentives, adjustments and/or allowances, including, but not limited to, pharmacy rebates, may be based on aggregate payments made by Anthem or an affiliate in respect to all health care services rendered to all persons who have coverage through a program provided or administered by Anthem or an affiliate. They are not attributed to specific claims or plans and do not inure to the benefit of any covered individual or group, but may be considered by Anthem or an affiliate in determining its fees or subscription charges or premiums.

Confidentiality and Release of Medical Information. We will use reasonable efforts, and take the same care to preserve the confidentiality of the *member’s* medical information. We may use data collected in the course of providing services hereunder for statistical evaluation and research. If such data is ever released to a third party, it shall be released only in aggregate statistical form without identifying the *member*. Medical information may be released only with the written consent of the *member* or as required 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. *Members* may access their own medical records.

We may release your medical information to professional peer review organizations and to the *group* for purposes of reporting claims experience or conducting an audit of our operations, provided the information disclosed is reasonably necessary for the *group* to conduct the review or audit.

A statement describing our policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request.

Medical Policy and Technology Assessment. Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria is used to determine the investigational status or medical necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 physicians from various medical specialties including Anthem's medical directors, physicians in academic medicine and physicians in private practice. Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to *medical necessity* criteria used to determine whether a procedure, service, supply or equipment is covered.

Certificate of Creditable Coverage. Certificates of creditable coverage are issued automatically when your coverage under this *plan* ends. We will also provide a certificate of creditable coverage in response to your request, or to a request made on your behalf, at any time while you are covered under this *plan* and up to 24 months after your coverage under this *plan* ends. The certificate of creditable coverage documents your coverage under this *plan*. To request a certificate of creditable coverage, please call the customer service telephone number listed on your ID card.

Transition Assistance for New Members: Transition Assistance is a process that allows for completion of covered services for new *members* receiving services from a *non-participating provider*. If you are a new *member*, you may request Transition Assistance if any one of the following conditions applies:

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Anthem in consultation with you and the *non-participating provider* and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time you enroll with Anthem.
3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.
4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.
5. The care of a newborn *child* between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the time the *child* enrolls with Anthem.
6. Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the time you enroll with Anthem.

Please contact customer service at the telephone number listed on your ID card to request Transition Assistance or to obtain a copy of the written policy. Eligibility is based on your clinical condition and is not determined by diagnostic classifications. Transition Assistance does not provide coverage for services not otherwise covered under the *plan*.

We will notify you by telephone, and the provider by telephone and fax, as to whether or not your request for Transition Assistance is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the *plan*. Financial arrangements with *non-participating providers* are negotiated on a case-by-case basis. We will request that the *non-participating provider* agree to accept reimbursement and contractual requirements that apply to *participating providers*, including payment terms. If the *non-participating provider* does not agree to accept said reimbursement and contractual requirements, we are not required to continue that provider's services. If you do not meet the criteria for Transition Assistance, you are afforded due process including having a *physician* review the request.

Continuity of Care after Termination of Provider: Subject to the terms and conditions set forth below, Anthem will provide benefits at the *participating provider* level for covered services (subject to applicable copayments, coinsurance, deductibles and other terms) received from a provider at the time the provider's contract with us terminates (unless the provider's contract terminates for reasons of medical disciplinary cause or reason, fraud, or other criminal activity).

You must be under the care of the *participating provider* at the time the provider's contract terminates. The terminated provider must agree in writing to provide services to you in accordance with the terms and conditions of his or her agreement with Anthem prior to termination. The provider must also agree in writing to accept the terms and reimbursement rates under his or her agreement with Anthem prior to termination. If the provider does not agree with these contractual terms and conditions, we are not required to continue the provider's services beyond the contract termination date.

Anthem will provide such benefits for the completion of covered services by a terminated provider only for the following conditions:

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Anthem in consultation with you and the terminated provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.
3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.
4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.

5. The care of a newborn *child* between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.
6. Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the date the provider's contract terminates.

Such benefits will not apply to providers who have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity.

Please contact customer service at the telephone number listed on your ID card to request continuity of care or to obtain a copy of the written policy. Eligibility is based on the *member's* clinical condition and is not determined by diagnostic classifications. Continuity of care does not provide coverage for services not otherwise covered under the *plan*.

We will notify you by telephone, and the provider by telephone and fax, as to whether or not your request for continuity of care is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the *plan*. Financial arrangements with terminated providers are negotiated on a case-by-case basis. We will request that the terminated provider agree to accept reimbursement and contractual requirements that apply to *participating providers*, including payment terms. If the terminated provider does not agree to accept the same reimbursement and contractual requirements, we are not required to continue that provider's services. If you disagree with our determination regarding continuity of care, you may file a grievance with us by following the procedures described in the section entitled GRIEVANCE PROCEDURES.

GRIEVANCE PROCEDURES

If you have a question about your eligibility, (including if you believe your coverage under this *plan* has been or will be improperly terminated), your benefits under this *plan*, or concerning a claim, please call the telephone number listed on your identification card, or you may write to us (please address your correspondence to Anthem Blue Cross, P.O. Box 4310, Woodland Hills, CA 91365-4310 marked to the attention of the Customer Service Department listed on your identification card). Our customer service staff will answer your questions or assist you in resolving your issue.

If you are not satisfied with the resolution based on your initial inquiry, you may request a copy of the Plan Grievance Form from the customer service representative. You may complete and return the form to us, or ask the customer service representative to complete the form for you over the telephone. You may also submit a grievance to us online or print the Plan Grievance Form through the Anthem Blue Cross website at **www.anthem.com/ca**. You must submit your grievance to us no later than 180 days following the date you receive a denial notice from us or any other incident or action with which you are dissatisfied. Your issue will then become part of our formal grievance process and will be resolved accordingly.

All grievances received by us will be acknowledged in writing, together with a description of how we propose to resolve the grievance. After we have reviewed your grievance, we will send you a written statement on its resolution within 30 days. If your case is urgent and involves an imminent threat to your health, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, review of your grievance will be expedited and resolved within three days. You have the right to review all documents that are part of your grievance file and to present evidence and testimony as part of the grievance process.

If you are dissatisfied with the resolution of your grievance, or if your grievance has not been resolved after at least 30 days (or within three days for urgent cases), you may submit your grievance to the California Department of Managed Health Care for review prior to binding arbitration (see DEPARTMENT OF MANAGED HEALTH CARE). If your case is urgent and involves an imminent threat to your health, as described above, you are not required to complete our grievance process or to wait at least 30 days, but may immediately submit your grievance to the Department of Managed Health Care (DMHC) for review. If your grievance concerns the termination of your coverage, you may also immediately submit your grievance to the DMHC if the DMHC determines your grievance requires immediate review.

If your grievance concerns the termination of your coverage and your coverage is still in effect when you submit a grievance, we will continue to provide coverage to you under the terms of this *plan* until a final determination of your request for review has been made, including any review by the Director of the Department of Managed Health Care. (Note: This does not apply if your coverage is cancelled due to non-payment of subscription charges.) If your coverage is maintained in force pending outcome of the review, subscription charges must still be paid to us on your behalf. If your coverage has already ended when you submit the grievance, your coverage will not be maintained. If the Director of the Department of Managed Health Care determines that your coverage should not have been terminated, we will reinstate your coverage back to the date it was terminated. Subscription charges must be paid current to us on your behalf from the date coverage is reinstated.

If at the conclusion of review of your grievance by the Department of Managed Health Care you continue to be dissatisfied with its resolution, or prior to and instead of review of your case by the Department of Managed Health Care, your remedy may be binding arbitration (see BINDING ARBITRATION).

Questions about your prescription drug coverage. If you have outpatient *prescription drug* coverage and you have questions or concerns, you may call the Pharmacy Customer Service number listed on your ID card. If you are dissatisfied with the resolution of your inquiry and want to file a grievance, you may write to us at the address listed above and follow the formal grievance process.

Independent Medical Review of Denials of Experimental or Investigative Treatment

If coverage for a proposed treatment is denied because we determine that the treatment is *experimental* or *investigative*, you may ask that the denial be reviewed by an external independent medical review organization contracting with the Department of Managed Health Care ("DMHC"). Your request for this review may be submitted to the DMHC. You pay no application or processing fees of any kind for this review. You have the right to provide information in support of your request for review. A decision not to participate in this review process may cause you to forfeit any statutory right to pursue legal action against us regarding the disputed health care service. We will send you an application form and an addressed envelope for you to use to request this review with any grievance disposition letter denying coverage for this reason. You may also request an application form by calling us at the telephone number listed on your identification card or write to us at Anthem Blue Cross, P.O. Box 4310, Woodland Hills, CA 91365-4310. To qualify for this review, all of the following conditions must be met:

- You have a life-threatening or seriously debilitating condition, described as follows:
 - ◆ A life-threatening condition is a condition or disease where the likelihood of death is high unless the course of the disease is interrupted or a condition or disease with a potentially fatal outcome where the end point of clinical intervention is the patient's survival.
 - ◆ A seriously debilitating condition is a disease or condition that causes major, irreversible morbidity.
- Your *physician* must certify that either (a) standard treatment has not been effective in improving your condition, (b) standard treatment is not medically appropriate, or (c) there is no more beneficial standard treatment covered by this *plan* than the proposed treatment.
- The proposed treatment must either be:
 - ◆ Recommended by a *participating provider* who certifies in writing that the treatment is likely to be more beneficial than standard treatments, or
 - ◆ Requested by you or by a licensed board certified or board eligible *physician* qualified to treat your condition. The treatment requested must be likely to be more beneficial for you than standard treatments based on two documents of scientific and medical evidence from the following sources:
 - a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized standards;
 - b) Medical literature meeting the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database of Health Services Technology Assessment Research (HSTAR);
 - c) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;
 - d) Either of the following: (i) The American Hospital Formulary Service's Drug Information, or (ii) the American Dental Association Accepted Dental Therapeutics;

- e) Any of the following references, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: (i) the Elsevier Gold Standard's Clinical Pharmacology, (ii) the National Comprehensive Cancer Network Drug and Biologics Compendium, or (iii) the Thomson Micromedex DrugDex;
- f) Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and
- g) Peer reviewed abstracts accepted for presentation at major medical association meetings.

In all cases, the certification must include a statement of the evidence relied upon.

You must request this review within six months of the date you receive a denial notice from us in response to your grievance, or from the end of the 30 day or three day grievance period, whichever applies. This application deadline may be extended by the DMHC for good cause.

Within three business days of receiving notice from the DMHC of your request for review we will send the reviewing panel all relevant medical records and documents in our possession, as well as any additional information submitted by you or your *physician*. Any newly developed or discovered relevant medical records identified by us or by a *participating provider* after the initial documents are sent will be immediately forwarded to the reviewing panel. The external independent review organization will complete its review and render its opinion within 30 days of its receipt of request for review (or within seven days if your *physician* determines that the proposed treatment would be significantly less effective if not provided promptly). This timeframe may be extended by up to three days for any delay in receiving necessary records.

Please note: If you have a terminal illness (an incurable or irreversible condition that has a high probability of causing death within one year or less) and proposed treatment is denied because the treatment is determined to be *experimental*, you may also meet with our review committee to discuss your case as part of the grievance process (see GRIEVANCE PROCEDURES).

Independent Medical Review of Grievances Involving a Disputed Health Care Service

You may request an independent medical review (“IMR”) of disputed health care services from the Department of Managed Health Care (“DMHC”) if you believe that we have improperly denied, modified, or delayed health care services. A "disputed health care service" is any health care service eligible for coverage and payment under your *plan* that has been denied, modified, or delayed by us, in whole or in part because the service is not *medically necessary*.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. We must provide you with an IMR application form and an addressed envelope for you to use to request IMR with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against us regarding the disputed health care service.

Eligibility: The DMHC will review your application for IMR to confirm that:

1. One or more of the following conditions has been met:
 - (a) Your provider has recommended a health care service as *medically necessary*,
 - (b) You have received *urgent care* or *emergency services* that a provider determined was *medically necessary*, or
 - (c) You have been seen by a *participating provider* for the diagnosis or treatment of the medical condition for which you seek independent review;
2. The disputed health care service has been denied, modified, or delayed by us, based in whole or in part on a decision that the health care service is not *medically necessary*; and
3. You have filed a grievance with us and the disputed decision is upheld or the grievance remains unresolved after 30 days. If your grievance requires expedited review you need not participate in our grievance process for more than three days. The DMHC may waive the requirement that you follow our grievance process in extraordinary and compelling cases.

You must apply for IMR within six months of the date you receive a denial notice from us in response to your grievance or from the end of the 30 day or three day grievance period, whichever applies. This application deadline may be extended by the DMHC for good cause.

If your case is eligible for IMR, the dispute will be submitted to a medical specialist or specialists who will make an independent determination of whether or not the care is *medically necessary*. You will receive a copy of the assessment made in your case. If the IMR determines the service is *medically necessary*, we will provide benefits for the health care service.

For non-urgent cases, the IMR organization designated by the DMHC must provide its determination within 30 days of receipt of your application and supporting documents. For urgent cases involving an imminent and serious threat to your health, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of your health, the IMR organization must provide its determination within 3 days.

For more information regarding the IMR process, or to request an application form, please call us at the customer service telephone number listed on your ID card.

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

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

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

The *member* and Anthem agree to be bound by these arbitration provisions and acknowledge that they are giving up their right to trial by jury for both medical malpractice claims and any other disputes.

California Health & Safety Code section 1363.1 requires that any arbitration agreement include the following notice based on California Code of Civil Procedure 1295(a): **It is understood that any dispute as to medical malpractice, that is, 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 and except for disputes regarding a claim for damages within the jurisdictional limits of the small claims court. Both parties to this contract, by entering into it, acknowledge that they are giving up their constitutional right to have any and all disputes, including medical malpractice claims, decided in a court of law before a jury, and instead are accepting the use of arbitration.**

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

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

The arbitration is initiated by the *member* making written demand on Anthem. The arbitration will be conducted by Judicial Arbitration and Mediation Services (“JAMS”), according to its applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by agreement of the *member* and Anthem, or by order of the court, if the *member* and Anthem cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, Anthem will assume all or a portion of the costs of the arbitration.

Please send all Binding Arbitration demands in writing to Anthem Blue Cross, P.O. Box 4310, Woodland Hills, CA 91365-4310 marked to the attention of the Customer Service Department listed on your identification card.

DEFINITIONS

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

Accidental injury is physical harm or disability which is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental injury does not include illness or infection, except infection of a cut or wound.

Agreement is the Group Benefit Agreement issued by us to the *group*.

Ambulatory surgical center is a freestanding outpatient surgical facility. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services. It must also meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations or the Accreditation Association of Ambulatory Health Care.

Anthem Blue Cross (Anthem) is a health care service plan, regulated by the California Department of Managed Health Care.

Authorized referral occurs when you, because of your medical needs, are referred to a *non-participating provider*, but only when:

1. There is no *participating provider* who practices in the appropriate specialty, which provides the required services, or which has the necessary facilities within a 30-mile radius of, or 30 minutes normal travel time from, your residence or place of work;
2. You are referred in writing to the *non-participating provider* by the *physician* who is a *participating provider*; and
3. We have authorized the referral before services are rendered.

You or your *physician* must call the toll-free telephone number printed on your identification card prior to scheduling an admission to, or receiving the services of, a *non-participating provider*.

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

Custodial care is care provided primarily to meet your personal needs. This includes help in walking, bathing or dressing. It also includes: preparing food or special diets; feeding by utensil, tube or gastrostomy; suctioning and administration of medicine which is usually self-administered or any other care which does not require continuing services of medical personnel.

If *medically necessary*, benefits will be provided for feeding (by tube or gastrostomy) and suctioning.

Day treatment center is an outpatient psychiatric facility which is licensed according to state and local laws to provide outpatient programs and treatment of *mental or nervous disorders* or substance abuse under the supervision of *physicians*.

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

Drug (prescription drug) means a prescribed drug approved by the Food and Drug Administration for general use by the public. For the purposes of this *plan*, insulin will be considered a prescription drug.

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

Emergency is a sudden, serious, and unexpected acute illness, injury, or condition (including without limitation sudden and unexpected severe pain), or a *psychiatric emergency medical condition*, which the *member* reasonably perceives, could permanently endanger health if medical treatment is not received immediately. Final determination as to whether services were rendered in connection with an emergency will rest solely with us.

Emergency services are services provided in connection with the initial treatment of a medical or psychiatric *emergency*.

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

Facility-based care is care provided in a *hospital, psychiatric health facility, residential treatment center or day treatment center* for the treatment of *mental or nervous disorders* or substance abuse.

Family member meets the *plan's* eligibility requirements for family members as outlined under HOW COVERAGE BEGINS AND ENDS.

Group refers to the business entity to which we have issued this *agreement*. The name of the group is LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION (LACERA).

Home health agencies are home health care providers which are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in your home, and recognized as home health providers under Medicare and/or accredited by a recognized accrediting agency such as the Joint Commission on the Accreditation of Healthcare Organizations.

Home infusion therapy provider is a provider licensed according to state and local laws as a pharmacy, and must be either certified as a home health care provider by Medicare, or accredited as a home pharmacy by the Joint Commission on Accreditation of Health Care Organizations.

Hospice is an agency or organization providing a specialized form of interdisciplinary health care that provides palliative care (pain control and symptom relief) and alleviates the physical, emotional, social, and spiritual discomforts of a terminally ill person, as well as providing supportive care to the primary caregiver and the patient's family. A hospice must be: currently licensed as a hospice pursuant to Health and Safety Code section 1747 or a licensed *home health agency* with federal Medicare certification pursuant to Health and Safety Code sections 1726 and 1747.1. A list of hospices meeting these criteria is available upon request.

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

For the limited purpose of inpatient care, the definition of hospital also includes: (1) *psychiatric health facilities* (only for the acute phase of a *mental or nervous disorder* or substance abuse), and (2) *residential treatment centers*.

Infertility is: (1) the presence of a condition recognized by a *physician* as a cause of infertility; or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

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

Maximum allowed amount is the maximum amount of reimbursement we will allow for covered medical services and supplies under this *plan*. See YOUR MEDICAL BENEFITS: MAXIMUM ALLOWED AMOUNT.

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Medically necessary procedures, supplies equipment or services are those we determine to be:

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Provided for the diagnosis or direct care and treatment of the medical condition;
3. Within standards of good medical practice within the organized medical community;
4. Not primarily for your convenience, or for the convenience of your *physician* or another provider; and
5. The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:
 - a. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and
 - b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
 - c. For *hospital stays*, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received by you as an outpatient or in a less intensified medical setting.

Member is the *subscriber* or *family member*.

Mental or nervous disorders, for the purposes of this *plan*, are conditions that affect thinking and the ability to figure things out, perception, mood and behavior. A mental or nervous disorder is recognized primarily by symptoms or signs that appear as distortions of normal thinking, distortions of the way things are perceived (*e.g.*, seeing or hearing things that are not there), moodiness, sudden and/or extreme changes in mood, depression, and/or unusual behavior such as depressed behavior or highly agitated or manic behavior. Mental or nervous disorders include *severe mental disorders* as defined in this plan (see definition of “severe mental disorders”).

Any condition meeting this definition is a mental or nervous disorder no matter what the cause of the condition may be; but medical conditions that are caused by your behavior that may be.

Network pharmacy is a *pharmacy* or drug store which has entered into a service agreement with CVS Caremark to provide benefits under the *plan* at specified rates for *members* covered under the *plan*.

Note. You are outside of the network pharmacy area if there is no network pharmacy within 10 miles of your address of record with LACERA.

Non-Network pharmacy is a *pharmacy* or drug store which has NOT entered into a service agreement with CVS Caremark to provide benefits under the *plan* at specified rates for *members* covered under the *plan*.

Non-participating provider is one of the following providers which does NOT have a Prudent Buyer Plan Participating Provider Agreement in effect with us at the time services are rendered:

- A *hospital*;
- A *physician*;
- An *ambulatory surgical center*;
- A *home health agency*;
- A facility which provides diagnostic imaging services;
- A durable medical equipment outlet;
- A *skilled nursing facility*;
- A clinical laboratory;
- A *home infusion therapy provider*; or
- A licensed qualified autism service provider

They are not *participating providers*. Remember that the *maximum allowed amount* may only represent a portion of the amount which a *non-participating provider* charges for services. See YOUR MEDICAL BENEFITS: MAXIMUM ALLOWED AMOUNT.

Other health care provider is one of the following providers:

- A certified registered nurse anesthetist;
- A blood bank;
- A licensed ambulance company; or
- A *hospice*.

The provider must be licensed according to state and local laws to provide covered medical services.

Participating provider is one of the following providers or other licensed health care professionals who have a Prudent Buyer Plan Participating Provider Agreement in effect with us at the time services are rendered:

- A *hospital*
- A *physician*
- An *ambulatory surgical center*
- A *home health agency*
- A facility which provides diagnostic imaging services
- A durable medical equipment outlet
- A *skilled nursing facility*
- A clinical laboratory
- A *home infusion therapy provider*
- A licensed qualified autism service provider

Participating providers agree to accept the *maximum allowed amount* as payment for covered services. A directory of *participating providers* is available upon request.

Pharmacy means a licensed retail pharmacy.

Physician means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or
2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license and such license is required to render that service, and is providing a service for which benefits are specified in this booklet:
 - A dentist (D.D.S. or D.M.D.)
 - An optometrist (O.D.)
 - A dispensing optician
 - A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
 - A licensed clinical psychologist
 - A licensed educational psychologist for the provision of behavioral health treatment services for the treatment of pervasive developmental disorder or autism only
 - A chiropractor (D.C.)
 - An acupuncturist (A.C.)

- A licensed clinical social worker (L.C.S.W.)
- A marriage and family therapist (M.F.T.)
- A licensed professional clinical counselor (L.P.C.C.)*
- A physical therapist (P.T. or R.P.T.)*
- A speech pathologist*
- An audiologist*
- An occupational therapist (O.T.R.)*
- A respiratory care practitioner (R.C.P.)*
- A nurse practitioner
- A *psychiatric mental health nurse* (R.N.)*
- A nurse midwife**
- A registered dietitian (R.D.)* for the provision of diabetic medical nutrition therapy only

***Note:** The providers indicated by asterisks (*) are covered only by referral of a physician as defined in 1 above.

**If there is no nurse midwife who is a *participating provider* in your area, you may call the Customer Service telephone number on your ID card for a referral to an OB/GYN.

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

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

Prescription drug specified rate is the rate that CVS Caremark has negotiated with *network pharmacies* under a Network Pharmacy Agreement for prescription drug covered expense. *Network pharmacies* have agreed to charge *members* no more than the prescription drug specified rate. It is also the rate which CVS Caremark Prescription Drug Program - Mail Service accepts as payment in full for mail service *prescription drugs*.

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

Prosthetic devices are appliances which replace all or part of a function of a permanently inoperative, absent or malfunctioning body part. The term "prosthetic devices" includes orthotic devices, rigid or semi-supportive devices which restrict or eliminate motion of a weak or diseased part of the body.

Psychiatric emergency medical condition is a *mental or nervous disorder* that manifests itself by acute symptoms of sufficient severity that the patient is either (1) an immediate danger to himself or herself or to others, or (2) immediately unable to provide for or utilize food, shelter, or clothing due to the *mental or nervous disorder*.

Psychiatric health facility is an acute 24-hour facility as defined in California Health and Safety Code 1250.2. It must be:

1. Licensed by the California Department of Health Services;
2. Qualified to provide short-term inpatient treatment according to state law;
3. Accredited by the Joint Commission on Accreditation of Health Care Organizations; and
4. Staffed by an organized medical or professional staff which includes a *physician* as medical director.

Benefits provided for treatment in a psychiatric health facility which does not have a Standard Hospital Contract in effect with us will be subject to the *non-contracting hospital* penalty in effect at the time of service.

Psychiatric mental health nurse is a registered nurse (R.N.) who has a master's degree in psychiatric mental health nursing, and is registered as a psychiatric mental health nurse with the state board of registered nurses.

Reasonable and customary value is (1) for professional *non-participating providers*, the reasonable and customary value is determined by using a percentile of billed charges from a database of a third-party that takes into consideration various factors, such as the amounts billed for same or similar services, and the geographic locations in which the services were rendered; and (2) for facility *non-participating providers* and *non-contracting hospitals*, the reasonable and customary value is determined by using a percentile of billed charges from a database of Anthem's actual claims experience, subject to certain thresholds based on each provider's cost-to-charge ratio as reported by the provider to a California governmental agency and the actual claim submitted to us.

Residential treatment center is an inpatient treatment facility where the patient resides in a modified community environment and follows a RT20477-2 2012

comprehensive medical treatment regimen for treatment and rehabilitation as the result of a *mental or nervous disorder* or substance abuse. The facility must be licensed to provide psychiatric treatment of *mental or nervous disorders* or rehabilitative treatment of substance abuse according to state and local laws.

Retiree is a former full-time employee who meets the eligibility requirements described in the "Eligible Status" provision in HOW COVERAGE BEGINS AND ENDS.

Severe mental disorders include the following psychiatric diagnoses specified in California Health and Safety Code section 1374.72: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, and bulimia.

"Severe mental disorders" also includes serious emotional disturbances of a child as indicated by the presence of one or more mental disorders as identified in the Diagnostic and Statistical Manual (DSM) of Mental Disorders, other than primary substance abuse or developmental disorder, resulting in behavior inappropriate to the *child's* age according to expected developmental norms. The child must also meet one or more of the following criteria:

1. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community and is at risk of being removed from the home or has already been removed from the home or the mental disorder has been present for more than six months or is likely to continue for more than one year without treatment.
2. The child is psychotic, suicidal, or potentially violent.
3. The child meets special education eligibility requirements under California law (Government Code Section 7570).

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

Skilled nursing facility is an institution that provides continuous skilled nursing services. It must be licensed according to state and local laws and be recognized as a skilled nursing facility under Medicare.

Special care units are special areas of a *hospital* which have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

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

Stay is inpatient confinement which begins when you are admitted to a facility and ends when you are discharged from that facility.

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

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

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

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

We (us, our) refers to Anthem Blue Cross.

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

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

FOR YOUR INFORMATION

Your Rights and Responsibilities as an Anthem Blue Cross Member

As an Anthem Blue Cross *member* you have certain rights and responsibilities to help make sure that you get the most from your plan and access to the best care possible. That includes certain things about your care, how your personal information is shared and how you work with us and your doctors. It's kind of like a "Bill of Rights". It helps you know what you can expect from your overall health care experience and become a smarter health care consumer.

You have the right to:

- Speak freely and privately with your doctors and other health professionals about all health care options and treatment needed for your condition, no matter what the cost or whether it's covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect, dignity, and the right to privacy.
- Privacy, when it comes to your personal health information, as long as it follows state and Federal laws, and our privacy rules.
- Get information about our company and services, and our network of doctors and other health care providers.
- Get more information about your rights and responsibilities and give us your thoughts and ideas about them.
- Give us your thoughts and ideas about any of the rules of your health care plan and in the way your plan works.
- Make a complaint or file an appeal about:
 - Your health care plan
 - Any care you get
 - Any covered service or benefit ruling that your health care plan makes
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future; and the right to have your doctor tell you how that may affect your health now and in the future
- Participate in matters that deal with the company policies and operations.
- Get all of the most up-to-date information about the cause of your illness, your treatment and what may result from that illness or treatment from a doctor or other health care professional. When it seems that you will not be able to understand certain information, that information will be given to someone else that you choose.

- Get help at any time, by contacting your local insurance department.

You have the responsibility to:

- Choose any primary care physician (doctor), also called a PCP, who is in our network if your health care plan says that you have to have a PCP.
- Treat all doctors, health care professionals and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers and call their office if you have a delay or need to cancel.
- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- To the extent possible, understand your health problems and work with your doctors or other health care professionals to make a treatment plan that you all agree on.
- Follow the care plan that you have agreed on with your doctors or health care professionals.
- Tell your doctors or other health care professionals if you don't understand any care you're getting or what they want you to do as part of your care plan.
- Follow all health care plan rules and policies.
- Let our Customer Service department know if you have any changes to your name, address or family members covered under your plan.
- Give us, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health care plans and insurance benefits you have in addition to your coverage with us.

For details about your coverage and benefits, please read your Evidence of Coverage.

ORGAN DONATION

Each year, organ transplantation saves thousands of lives. The success rate for transplantation is rising but there are far more potential recipients than donors. More donations are urgently needed.

Organ donation is a singular opportunity to give the gift of life. Anyone age 18 or older and of sound mind can become a donor when he or she dies. Minors can become donors with parental or guardian consent.

Organ and tissue donations may be used for transplants and medical research. Today it is possible to transplant more than 25 different organs and tissues; this can save the lives of as many as eight people and improve the lives of another 50 people. Your decision to become a donor could someday save or prolong the life of someone you know, perhaps even a close friend or family member.

If you decide to become a donor, please discuss it with your family. Let your physician know your intentions as well. You may register as a donor by obtaining a donor card from the Department of Motor Vehicles. Be sure to sign the donor card and keep it with your driver's license or identification card. In California, you may also register online at:

www.donatelifecalifornia.org/

While organ donation is a deeply personal decision, please consider making this profoundly meaningful and important gift.

ANTHEM BLUE CROSS WEB SITE

Information specific to your benefits and claims history are available by calling the 800 number on your identification card or on the Anthem Blue Cross web site at www.anthem.com/ca. To access benefit information, claims payment status, benefit maximum status, participating providers or to order an ID card, simply log on to the web site, select "Member", and click the "Register" button on your first visit to establish a User ID and Password to access the personalized and secure MemberAccess Web site. Once registered, simply click the "Login" button and enter your User ID and Password to access the MemberAccess Web site. Our privacy statement can also be viewed on our website. You may also submit a grievance online or print the Plan Grievance form through the website.

LANGUAGE ASSISTANCE PROGRAM

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

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

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

- Spanish

- Chinese
- Vietnamese
- Korean
- Tagalog

Oral interpretation services are available in additional languages.

To request a written or oral translation, please contact customer service by calling the phone number on your ID card to update your language preference to receive future translated documents or to request interpretation assistance.

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

STATEMENT OF RIGHTS UNDER THE NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However the plan or issuer may pay for a shorter stay if the attending *physician* (e.g., your *physician*, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a *physician* or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, please call us at the customer service telephone number listed on your ID card.

**STATEMENT OF RIGHTS UNDER THE WOMEN'S HEALTH AND
CANCER RIGHTS ACT OF 1998**

This *plan*, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). If you have any questions about this coverage, please call us at the customer service telephone number listed on your ID card.