LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION (LACERA)

July 1, 2020

PLAN II
(Out-of-State)

PPO

(non-California resident)

NOTE: If you are 65 years or older at the time your certificate is issued, you may examine your certificate and, within 30 days, decide to cancel and request a refund of premiums paid.

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CERTIFICATE OF INSURANCE

Anthem Blue Cross Life and Health Insurance Company
21215 Burbank Blvd.
Woodland Hills, California 91367

This Certificate of Insurance, including any amendments and endorsements to it, is a summary of the important terms of your health plan. It replaces any older certificates issued to you for the coverages described in the Summary of Benefits. The Group Policy, of which this certificate is a part, 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 Certificate of Insurance that apply to those needs. LACERA will provide you with a copy of the Group Policy upon request.

Your health care coverage is insured by Anthem Blue Cross Life and Health Insurance Company (Anthem Blue Cross Life and Health). The following pages describe your health care benefits and includes the limitations and all other *policy* provisions which apply to you. The *insured person* is referred to as "you" or "your," and Anthem Blue Cross Life and Health as "we," "us" or "our." All italicized words have specific *policy* definitions. These definitions can be found in the DEFINITIONS section of this certificate.

COMPLAINT NOTICE

Should you have any complaints or questions regarding your coverage or about your health care provider, including your ability to access needed health care in a timely manner, and this certificate was delivered by a broker, you may first contact the broker. You may also contact us at:

Anthem Blue Cross Life and Health Insurance Company
Member Services
21215 Burbank Blvd.
Woodland Hills, CA 91367

If the problem is not resolved, you may also contact the California Department of Insurance at:

California Department of Insurance
Consumer Services Division, 11th Floor
300 South Spring Street
Los Angeles, California 90013

1-800-927-HELP (4357) – In California

1-213-897-8921 – Out of California

1-800-482-4833 – Telecommunication Device for the Deaf

E-mail Inquiry: "Consumer Services" link at www.insurance.ca.gov

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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. There are two kinds of *participating providers* in this *plan:*

- **PPO Providers** are providers who participate in a Blue Cross and/or Blue Shield Plan. PPO Providers have agreed to a rate they will accept as reimbursement for covered services that is generally lower than the rate charged by Traditional Providers. *Participating providers* have agreed to a rate they will accept as reimbursement for covered services.
- **Traditional Providers** are providers who might not participate in a Blue Cross and/or Blue Shield Plan, but have agreed to a rate they will accept as reimbursement for covered services for PPO members.

The level of benefits we will pay under this *plan* is determined as follows:

- If your *plan* identification card (ID card) shows a PPO suitcase logo and:
  - You go to a PPO Provider, you will get the higher level of benefits of this *plan*.
  - You go to a Traditional Provider because there are no PPO Providers in your area, you will get the higher level of benefits of this *plan*.
- If your ID card does NOT have a PPO suitcase logo, you must go to a Traditional Provider to get the higher level of benefits of this *plan*.

How to Access Primary and Specialty Care Services

- Your health plan covers care provided by primary care *physicians* and specialty care providers. To see a primary care *physician*, simply visit any *participating provider physician* who is a general or family practitioner, internist or pediatrician. Your health plan also covers care provided by any *participating provider* specialty care provider you choose (certain providers' services are covered only upon referral of an M.D. (medical doctor) or D.O. (doctor of osteopathy), see "Physician," below). Referrals are never needed to visit any *participating provider* specialty care provider including a behavioral health care provider.

- To make an appointment call your *physician's* office:
- Tell them you are a Prudent Buyer Plan *member*.
- Have your Member ID card handy. They may ask you for your group number, member I.D. number, or office visit copay.
- Tell them the reason for your visit.
- When you go for your appointment, bring your Member ID card.
- After hours care is provided by your *physician* who may have a variety of ways of addressing your needs. Call your *physician* for instructions on how to receive medical care after their normal business hours, on weekends and holidays. This includes information about how to receive non-e*mergency* Care and non-*urgent care* within the service area for a condition that is not life threatening, but that requires prompt medical attention. If you have an *emergency*, call 911 or go to the nearest emergency room.

Please call the toll-free BlueCard® Provider Access number on your ID card to find a *participating provider* in your area. A directory of PPO Providers is available. You may request a directory of Participating Providers by contacting the LACERA dedicated Member Services number, 1-800-284-1110.

Certain categories of providers defined in this certificate as *participating providers* may not be available in the Blue Cross and/or Blue Shield Plan in the service area where you receive services. See "Co-Payments" in the SUMMARY OF BENEFITS section and "Maximum Allowed Amount" in the YOUR MEDICAL BENEFITS section for additional information on how health care services you obtain from such providers are covered.

Non-Participating Providers. *Non-participating providers* are providers which have not agreed to participate in a Blue Cross and/or Blue Shield Plan. They have not agreed to the reimbursement rates and other provisions.

Anthem Blue Cross Life and Health has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. *Insured persons* seeking services from *non-participating providers* could be balance billed by the *non-participating provider* for those services that are determined to be not payable as a result of these review processes and meets the criteria set forth in any applicable state regulations adopted pursuant to state law. A claim may also be determined to be not payable due to a provider's failure to submit medical records with the claims that are under review in these processes.

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. 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 *participating providers*.

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 Member Services 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— Blue Cross Blue Shield Global Core®

Prior to travel outside the United States, call the Member Services telephone number listed on your ID card to find out if your plan has Blue Cross Blue Shield Global Core® benefits. Your coverage outside the United States is limited and we recommend:

- Before you leave home, call the Member Services 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 Blue Cross Blue Shield Global Core® 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 Blue Cross Blue Shield Global Core® hospitals.** In most cases, you should not have to pay upfront for inpatient care at participating Blue Cross Blue Shield Global Core® *hospitals* except for the out-of-pocket costs you normally pay (non-covered 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 Blue Cross Blue Shield Global Core® *hospital*. Then you can complete a Blue Cross Blue Shield Global Core® claim form and send it with the original bill(s) to the Blue Cross Blue Shield Global Core® Service Center (the address is on the form).

Claim Filing

- **Participating Blue Cross Blue Shield Global Core® 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 Blue Cross Blue Shield Global Core®. You will need to pay the health care provider and subsequently send an international claim form with the original bills to us.

Additional Information About Blue Cross Blue Shield Global Core® Claims.

- You are responsible, at your expense, for obtaining an English-language translation of foreign country provider claims and medical records.
- Exchange rates are determined as follows:
  - For inpatient *hospital* care, the rate is based on the date of admission.
  - For outpatient and professional services, the rate is based on the date the service is provided.

Claim Forms

- International claim forms are available from us, from the Blue Cross Blue Shield Global Core® Service Center, or online at:

  www.bcbsglobalcore.com.

  The address for submitting claims is on the form.

Timely Access to Care

Anthem has contracted with health care service providers to provide covered services in a manner appropriate for your condition, consistent with good professional practice. Anthem ensures that its contracted provider networks have the capacity and availability to offer appointments within the following timeframes:

- **Urgent Care appointments for services that do not require prior authorization:** within forty-eight (48) hours of the request for an appointment;
- **Urgent Care appointments for services that require prior authorization:** within ninety-six (96) hours of the request for an appointment;
- **Non-Urgent appointments for primary care:** within ten (10) business days of the request for an appointment;
- **Non-Urgent appointments with specialists:** within fifteen (15) business days of the request for an appointment;
- **Appointments for ancillary services (diagnosis or treatment of an injury, illness or other health condition) that are not urgent care:** within fifteen (15) business days of the request for an appointment.

For Mental Health Conditions and Substance Abuse care:

- **Urgent Care appointments for services that do not require prior authorization:** within forty-eight (48) hours of the request for an appointment;
- **Urgent Care appointments for services that require prior authorization:** within ninety-six (96) hours of the request for an appointment;
- **Non-Urgent appointments with mental health and substance abuse providers who are not psychiatrists:** within ten (10) business days of the request for an appointment;

- **Non-Urgent appointments with mental health and substance abuse providers who are psychiatrists:** within fifteen (15) business days of the request for an appointment. Due to accreditation standards, the date will be ten (10) business days for the initial appointment only.

If a provider determines that the waiting time for an appointment can be extended without a detrimental impact on your health, the provider may schedule an appointment for a later time than noted above.

Anthem arranges for telephone triage or screening services for you twenty-four (24) hours per day, seven (7) days per week with a waiting time of no more than thirty (30) minutes. If Anthem contracts with a provider for telephone triage or screening services, the provider will utilize a telephone answering machine and/or an answering service and/or office staff, during and after business hours, to inform you of the wait time for a return call from the provider or how the *member* may obtain *urgent care* or *emergency services* or how to contact another provider who is on-call for telephone triage or screening services.

If you need the services of an interpreter, the services will be coordinated with scheduled appointments and will not result in a delay of an appointment with a *participating provider*.

SUMMARY OF BENEFITS

YOUR EMPLOYER HAS AGREED TO BE SUBJECT TO THE TERMS AND CONDITIONS OF ANTHEM'S PROVIDER AGREEMENTS WHICH MAY INCLUDE PRECERTIFICATION AND UTILIZATION MANAGEMENT REQUIREMENTS, TIMELY FILING LIMITS, AND OTHER REQUIREMENTS TO ADMINISTER THE BENEFITS UNDER THIS PLAN.

THE BENEFITS OF THIS CERTIFICATE ARE PROVIDED ONLY FOR SERVICES WHICH ARE CONSIDERED TO BE MEDICALLY NECESSARY. THE FACT THAT A PHYSICIAN PRESCRIBES OR ORDERS THE SERVICE DOES NOT, IN ITSELF, MAKE IT MEDICALLY NECESSARY OR A COVERED EXPENSE.

This summary provides a brief outline of your benefits. You need to refer to the entire certificate for complete information about the benefits, conditions, limitations and exclusions of your *plan*.

The benefits provided in this certificate are subject to applicable federal and California laws. There are some states that require more generous

benefits be provided to their residents even if the master policy was not issued in their state. If your state has such requirements, we will adjust your benefits to meet the minimum requirements.

Mental Health Parity and Addiction Equity Act. The Mental Health Parity and Addiction Equity Act requires that the financial requirements and treatment limitations imposed on mental health and substance use disorder (MH/SUD) benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical and surgical benefits in the same classification or sub-classification.

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on mental health and substance abuse benefits offered under the Plan.

The Mental Health Parity and Addiction Equity Act also provides for parity in the application of nonquantitative treatment limitations (NQTL). An example of a nonquantitative treatment limitation is a precertification requirement.

Medical Necessity criteria and other plan documents showing comparative criteria, as well as the processes, strategies, evidentiary standards, and other factors used to apply an NQTL are available upon request.

See the “Summary of Benefits” and “Benefits for Mental Health Conditions and Substance Abuse” sections for cost share and benefit information.

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.

After Hours Care. After hours care is provided by your *physician* who may have a variety of ways of addressing your needs. You should call your *physician* for instructions on how to receive medical care after their normal business hours, on weekends and holidays, or to receive non-*emergency* care and non-*urgent care* within the service area for a condition that is not life threatening but that requires prompt medical attention. If you have an *emergency*, call 911 or go to the nearest emergency room.

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, care management and self-management of a patient's physical and mental 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 *plan* may be subject to the REIMBURSEMENT FOR ACTS OF THIRD PARTIES section.

MEDICAL BENEFITS

DEDUCTIBLES

The amounts listed also apply to services provided for the treatment of *mental health conditions* and substance abuse disorders.

Calendar Year Deductibles

- Insured Person Deductible **$500**
- Family Deductible **$1,500**

Additional Deductible

- 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 Preventive Care benefit for dependent children under age 17; and (b) Hepatitis B and Varicella Zoster immunizations for dependent children ages 7 through 18.

- 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 Calendar Year Deductible will not apply to transgender travel expense in connection with an approved transgender surgery.

- The Non-Certification Deductible will not apply to *emergency* admissions or services, services provided by a *participating provider* or to *medically necessary* inpatient facility services available to you through the BlueCard Program. See UTILIZATION REVIEW PROGRAM.

CO-PAYMENTS

Medical Co-Payments and Co-insurance*. After you have met your Calendar Year Deductible, you will be responsible for paying either a co-payment or co-insurance for services you receive. A co-payment is a fixed dollar amount you must pay as part of your responsibility for the cost of the services you received. A co-insurance is a specified percentage of the *maximum allowed amount* for services you receive. Your *plan's* co-payments and co-insurance, as well as any exceptions, are specified below.

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 for Medical Co-Payments and Co-insurance:**

– 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 *non-participating providers* will be the same as for *participating providers* for the following services. You will

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 a Blue Cross and/or Blue Shield Plan (for example, an audiologist);

d. Cancer Clinical Trials; or

e. Non-*emergency services* received at a *participating hospital* or facility at which, or as a result of which, you receive services from a *non-participating provider,* in specified circumstances. Please see "Cost Share" in the YOUR MEDICAL BENEFITS section for more information.

– 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. Preventive Care services when provided by *participating providers* for dependent children under age 17, after a **$25** Co-Payment is made for routine examinations.

f. 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.

- If you receive services from a category of provider defined in this certificate as a *participating provider* that is **not** available in the Blue Cross and/or Blue Shield Plan in that service area, your Co-Payment will be the same as for *participating providers*.

- Co-Payments do not apply to transgender travel expenses authorized by us. Transgender travel expense coverage is available when the facility at which the surgery or series of surgeries will be performed is 75 miles or more from the *insured person's* residence.

Mental Health and Substance Abuse Co-Payments and Co-Insurance.* After you have met your Calendar Year Deductible, you will be responsible for paying either a co-payment or co-insurance for services you receive. A co-payment is a fixed dollar amount you must pay as part of your responsibility for the cost of the services you received. A co-insurance is a specified percentage of the *maximum allowed amount* for services you receive. Your *plan's* co-payments and co-insurance, as well as any exceptions, are specified below. See also the section titled "Benefits for Mental Health Conditions and Substance Abuse" for details on these benefits.

Inpatient Services

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

Outpatient Office Visit Services

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

Other Outpatient Items and Services

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

***Exceptions for Mental Health and Substance Abuse Co-Payments and Co-insurance:**

- 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%**.

- 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 or the Blue Cross and/or Blue Shield Plan;

d. Cancer Clinical Trials; or

e. Non-*emergency services* received at a *participating hospital* or facility at which, or as a result of which, you receive services from a *non-participating provider,* in specified circumstances. Please see "Cost Share" in the YOUR MEDICAL BENEFITS section for more information.

– If you receive services from a category of provider defined in this certificate as a *participating provider* that is **not** available in the Blue Cross and/or Blue Shield Plan in that service area, your Co-Payment will be the same as for *participating providers*.

– Co-Payments do not apply to transgender travel expenses authorized by us. Transgender travel expense coverage is available when the facility at which the surgery or series of surgeries will be performed is 75 miles or more from the *insured person's* residence.

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 no longer be required to pay a Co-Payment for the remainder of that *year,* but you remain responsible for costs in excess of the *maximum allowed amount*. The amount listed also apply to services provided for the treatment of *mental health conditions* and substance abuse disorders.

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*

Preventive Care (Dependent Children Under Age 17)

- 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**

Acupuncture

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

Transgender Travel Expense

- For all travel expenses authorized by us in connection with authorized transgender surgery or surgeries.....up to **$10,000**
  per surgery or
  series of surgeries

Lifetime Maximum

- Transplant Travel Expense.....**$10,000**
  during your lifetime
- For all other 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 Certificate of Insurance, 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 an *insured person* Co-Payment of 30% for *participating provider* services after the Deductible has been met.

- The *insured person* 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 *insured person's* Co-Payment responsibility when a *participating* surgeon is used is 30% of $1,000, or $300. This is what the *insured person* 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 an *insured person* Co-Payment of 50% for *non-participating provider* services after the Deductible has been met.

- The *insured person* 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 *insured person'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 *insured person* the difference between $2,000 and $1,000. So the *insured person'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 Member Services 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.

Note: If an *other health care provider* is participating in a Blue Cross and/or Blue Shield Plan at the time you receive services, such provider will be considered a *participating provider* for the purposes of determining the *maximum allowed amount*.

If a provider defined in this certificate as a *participating provider* is of a type not represented in the local Blue Cross and/or Blue Shield Plan at the time you receive services, such provider will be considered a *non-participating provider* for the purposes of determining the *maximum allowed amount*.

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 Life and Health *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 Life and Health will update such information, which is unadjusted for geographic locality, no less than annually.

Providers who are not contracted for this product, but are contracted for other products, are also considered *non-participating providers*. For this *plan*, the *maximum allowed amount* for services from these providers will be one of the methods shown above unless the provider's contract specifies a different amount.

For covered services rendered outside the Anthem Blue Cross Life and Health service area by *non-participating providers*, claims may be priced using the local Blue Cross Blue Shield plan's *non-participating provider* fee schedule / rate or the pricing arrangements required by applicable state or federal law. In certain situations, the *maximum allowed amount* for out of area claims may be based on billed charges, the pricing we would use if the healthcare services had been obtained within the Anthem Blue Cross Life and Health service area, or a special negotiated price.

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 Member Services number on your ID card for help in finding a *participating provider* or visit our website at www.anthem.com/ca. Member Services 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 "Inter-Plan Arrangements" 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,* reimbursement is based on the greater of the following:

    1. the median of our *participating provider* rates for the *emergency service*, excluding any *participating provider* copayment or coinsurance;

    2. the amount for the *emergency service* calculated using the same method we generally use to determine payments for non-*participating provider* services, excluding any *participating provider* copayment or coinsurance;

    3. the amount that would be paid under Medicare for the *emergency service*, excluding any *participating provider* copayment or coinsurance.

- **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.

– **Services received in *participating* hospitals or facilities from *non-participating providers*.** If you receive covered non-*emergency services* at a *participating hospital* or facility at which, or as a result of which, you receive services from a *non-participating provider*, the *maximum allowed amount* will be based on the greater of the average contracted rate or 125 percent of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered.

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

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 Member Services 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 Life and Health 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 receive covered non-*emergency services* at a *participating* hospital or facility at which, or as a result of which, you receive covered services provided by a *non-participating provider* such as a radiologist, anesthesiologist or pathologist, you will pay the *participating provider* cost share percentage of the *maximum allowed amount* for those covered services, and you will not be liable for the difference between the *maximum allowed amount* and the *non-participating provider's* charge. Such *participating provider* cost share percentage will apply to the *participating provider* deductible (if any) and the *participating provider* out-of-pocket amount. This paragraph does not apply, however, if the *non-participating provider* has your written consent, satisfying the following criteria:

(1) At least 24 hours in advance of care, you consent in writing to receive services from the identified *non-participating provider*.

(2) The consent shall be obtained by the *non-participating provider* in a document that is separate from the document used to obtain the consent for any other part of the care or procedure. The consent shall not be obtained by the facility or any representative of the facility. The consent shall not be obtained at the time of admission or at any time when the member is being prepared for surgery or any other procedure.

(3) At the time consent is provided the *non-participating provider* shall give you a written estimate of your total out-of-pocket cost of care. The written estimate shall be based on the professional's billed charges for the service to be provided. The *non-participating provider* shall not attempt to collect more than the estimated amount without receiving separate written consent from you or your authorized representative, unless circumstances arise during delivery of services that were unforeseeable at the time the estimate was given that would require the provider to change the estimate.

(4) The consent shall advise you that you may elect to seek care from a *participating provider* or may contact Anthem in order to arrange to receive the health service from a *participating provider* for lower out-of-pocket costs.

(5) The consent and estimate shall be provided to you in the language spoken by you, if the language is a Medi-Cal threshold language, as defined in state law (subdivision (d) of Section 128552 of the Health and Safety Code).

(6) The consent shall also advise you that any costs incurred as a result of your use of the *non-participating provider* benefit shall be in addition to *participating provider* cost-sharing amounts and may not count toward the annual out-of-pocket maximum for *participating provider* benefits or a deductible, if any, for *participating provider* benefits.

We and/or our designated *pharmacy benefits manager* may receive discounts, rebates, or other funds from *drug* manufacturers, wholesalers, distributors and/or similar vendors which may be related to certain *prescription drug* purchases under this *plan* and which positively impact the cost effectiveness of covered services and are included when our costs are calculated. However, these amounts are retained by us and will not be applied to your deductible, if any, or taken into account in determining your co-payment or co-insurance for a particular *prescription drug*.

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. In certain situations, however, if you receive non-*emergency* covered services at a *participating hospital* or facility at which, or as a result of which, you receive services from a *non-participating provider,* you will pay no more than the cost sharing that you would pay for the same covered services received from a *participating provider*. Please see "Cost Share" in the YOUR MEDICAL BENEFITS section for more information. If you receive prior authorization for a *non-participating provider* due to network adequacy issues, you will not be responsible for the difference between the *non-participating provider's* charge and the *maximum allowed amount*. Please call the Member Services 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*, 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* 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 *insured person'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* without properly obtaining certification, you are responsible for paying the Non-Certification Deductible. This deductible will not apply to an *emergency* admission or procedure. 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.

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 *insured person* 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 Blue Cross Life and Health, 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 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. Benefits are available for covered services performed by a *home health agency* or other provider in your home. 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. Other organizations may give services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the *home health agency* or other provider as approved by us.

5. *Medically necessary* supplies provided by the *home health agency*.

When available in your area, benefits are also available for *intensive in-home behavioral health services*. These do not require confinement to the home.

One home health visit by a home health aide is defined as a period of covered service of up to four hours during any one day.

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

Hospice Care. You are eligible for *hospice* care if your *physician* and the *hospice* medical director certify that you are terminally ill and likely have less than twelve (12) months to live. You may access *hospice* care while participating in a clinical trial or continuing disease modifying therapy, as ordered by your treating *physician*. Disease modifying therapy treats the underlying terminal illness.

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. Palliative care is care that controls pain and relieves symptoms but is not intended to cure the illness. Covered services include:

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 (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the *insured person's* death. Bereavement services are available to the patient and those individuals who are closely linked to the patient, including the immediate family, the primary or designated care giver and individuals with significant personal ties, for one year after the *insured person's* death..

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.

Benefits for services beyond those listed above that are given for disease modification or palliation, such as but not limited to chemotherapy and radiation therapy, are available to a *member* in *hospice*. These services are covered under other parts of this *plan*.

Infusion Therapy. The following services and supplies when provided by a *home infusion therapy provider* in your home or in any other outpatient setting by a qualified health care provider, for the intravenous administration of your total daily nutritional intake or fluid requirements, including but not limited to Parenteral Therapy and Total Parenteral Nutrition (TPN), 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 (if outpatient prescription drug benefits are provided under this *plan*, *compound medications* must be obtained from a *participating pharmacy*);

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; maintenance and repair charges for such equipment;

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

6. Total Parenteral Nutrition (TPN), Enteral Nutrition Therapy, antibiotic therapy, pain management, chemotherapy, and may also include injections (intra-muscular, subcutaneous, or continuous subcutaneous).

Infusion therapy provider services are subject to pre-service review to determine medical necessity. See UTILIZATION REVIEW PROGRAM.

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.).

Reconstructive Surgery. Reconstructive surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (a) improve function; or (b) create a normal appearance, to the extent possible. This includes surgery performed to restore and achieve symmetry following a *medically necessary* mastectomy. This also 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.

This does not apply to orthognathic surgery. Please see the "Dental Care" provision below for a description of this service.

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

Ambulance. Ambulance services are covered when you are transported by a state licensed vehicle that is designed, equipped, and used to transport the sick and injured and is staffed by Emergency Medical Technicians (EMTs), paramedics, or other licensed or certified medical professionals. Ambulance services are covered when one or more of the following criteria are met:

- For ground ambulance, you are transported:
  - From your home, or from the scene of an accident or medical *emergency*, to a *hospital*,

- Between *hospitals*, including when you are required to move from a *hospital* that does not contract with us to one that does, or
- Between a *hospital* and a *skilled nursing facility* or other approved facility.

- For air or water ambulance, you are transported:
  - From the scene of an accident or medical *emergency* to a *hospital*,
  - Between hospitals, including when you are required to move from a hospital that does not contract with us to one that does, or
  - Between a hospital and another approved facility.

Non-emergency ambulance services are subject to medical necessity reviews. *Emergency* ground ambulance services do not require pre-service review. Pre-service review is required for air ambulance in a non-medical *emergency*. When using an air ambulance in a non-emergency situation, we reserve the right to select the air ambulance provider. If you do not use the air ambulance we select in a non-emergency situation, no coverage will be provided.

You must be taken to the nearest facility that can provide care for your condition. In certain cases, coverage may be approved for transportation to a facility that is not the nearest facility.

Coverage includes *medically necessary* treatment of an illness or injury by medical professionals from an ambulance service, even if you are not transported to a *hospital*. If provided through the 911 emergency response system*, ambulance services are covered if you reasonably believed that a medical *emergency* existed even if you are not transported to a *hospital*. Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your *family members* or *physician* are not a covered service.

Other non-covered ambulance services include, but are not limited to, trips to:

- A *physician's* office or clinic;
- A morgue or funeral home.

Important information about air ambulance coverage. Coverage is only provided for air ambulance services when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a *hospital* than the ground ambulance can provide, this

plan will cover the air ambulance. Air ambulance will also be covered if you are in a location that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a *hospital* that is not an acute care *hospital* (such a skilled nursing facility or a rehabilitation facility), or if you are taken to a *physician's* office or to your home.

Hospital to hospital transport: If you are being transported from one *hospital* to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the *hospital* that first treats you cannot give you the medical services you need. Certain specialized services are not available at all *hospitals*. For example, burn care, cardiac care, trauma care, and critical care are only available at certain *hospitals*. For services to be covered, you must be taken to the closest *hospital* that can treat you. Coverage is not provided for air ambulance transfers because you, your family, or your *physician* prefers a specific *hospital* or *physician*.

* 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, laboratory services and genetic tests. Genetic tests 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.

Radiation Therapy. This includes treatment of disease using x-ray, radium or radioactive isotopes, other treatment methods (such as teletherapy, brachytherapy, intra operative radiation, photon or high energy particle sources), material and supplies used in the therapy process and treatment planning. These services can be provided in a facility or professional setting.

Chemotherapy. This includes the treatment of disease using chemical or antineoplastic agents and the cost of such agents in a professional or facility setting.

Hemodialysis Treatment. This includes services related to renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis home continuous cycling peritoneal dialysis and home continuous ambulatory peritoneal dialysis.

The following renal dialysis services are covered:

- Outpatient maintenance dialysis treatments in an outpatient dialysis facility;
- Home dialysis; and
- Training for self-dialysis at home including the instructions for a person who will assist with self-dialysis done at a home setting.

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, including but not limited to cochlear 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, benefits are available for certain types of orthotics (braces, boots, splints). Covered services include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

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;
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 a*mbulatory surgical center*. This applies only if (a) the *insured person* is less than seven years old, (b) the *insured person* is developmentally disabled, or (c) the *insured person's* health is compromised and general anesthesia is *medically necessary*. Charges for the dental procedure itself, including professional fees of a dentist, may not be 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 the *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* unless the chewing or biting results from a medical or mental condition.

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.

5. **Orthognathic surgery.** Orthognathic surgery for a physical abnormality that prevents normal function of the upper or lower jaw and is *medically necessary* to attain functional capacity of the affected part.

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 Member Services telephone number listed on your ID card. To fully understand your coverage under this *plan*, please carefully review this Certificate of Insurance document.

Pregnancy and Maternity Care

1. All medical benefits for an enrolled *insured person* when provided for pregnancy or maternity care, including the following services:

    - Prenatal, postnatal and postpartum care;
    - Prenatal testing administered by the California Prenatal Screening Program, which is a statewide prenatal testing program administered by the State Department of Public Health. The *calendar year* deductible will not apply and no copayment will be required for services you receive as part of this program;
    - Ambulatory care services (including ultrasounds, fetal non-stress tests, *physician* office visits, and other *medically necessary* maternity services performed outside of a *hospital*);
    - Involuntary complications of pregnancy;
    - Diagnosis of genetic disorders in cases of high-risk pregnancy; and,
    - 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* (for additional information, please see the "Important Note for Newborn and Newly-Adopted Children" under HOW COVERAGE BEGINS AND ENDS). 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 *insured person* 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 pre-service review from us, or which are provided at a facility other than an approved transplant center. See UTILIZATION REVIEW PROGRAM.

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**.

Transgender Services. Services and supplies provided in connection with gender transition when you have been diagnosed with gender identity disorder or gender dysphoria by a *physician*. This coverage is provided according to the terms and conditions of the *plan* that apply to all other covered medical conditions, including medical necessity requirements, utilization management, and exclusions for cosmetic services. Coverage includes, but is not limited to, *medically necessary* services related to

gender transition such as transgender surgery, hormone therapy, psychotherapy, and vocal training.

Coverage is provided for specific services according to *plan* benefits that apply to that type of service generally, if the *plan* includes coverage for the service in question. If a specific coverage is not included, the service will not be covered. For example, transgender surgery would be covered on the same basis as any other covered, *medically necessary* surgery; hormone therapy would be covered under the *plan's prescription drug* benefits (if such benefits are included).

Inpatient admissions related to transgender surgery services are subject to prior authorization in order for coverage to be provided. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews. Prior authorization is not required for all other transgender services.

Transgender Travel Expense. Certain travel expenses incurred in connection with an approved transgender surgery, when the *hospital* at which the surgery is performed is 75 miles or more from your place of residence, provided the expenses are authorized in advance by us. Our maximum payment will not exceed $10,000 per transgender surgery, or series of surgeries (if multiple surgical procedures are performed), for the following travel expenses incurred by you and one companion:

- Ground transportation to and from the *hospital* when it is 75 miles or more from your place of residence.
- Coach airfare to and from the *hospital* when it is 300 miles or more from your residence.
- Lodging, limited to one room, double occupancy.
- Other reasonable expenses. Tobacco, alcohol, drug, and meal expenses are excluded.

The Calendar Year Deductible will not apply and no co-payments will be required for transgender travel expenses authorized in advance by us. We will provide benefits for lodging, transportation, and other reasonable expenses up to the current limits set forth in the Internal Revenue Code, not to exceed the maximum amount specified above. This travel expense benefit is not available for non-surgical transgender services.

Details regarding reimbursement can be obtained by calling the Member Services number on your identification card. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

Preventive 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.

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. All FDA-approved contraceptive drugs, devices, and other products for women, including over-the-counter items, if prescribed by a physician. This includes contraceptive drugs, injectable contraceptives, patches and devices such as diaphragms, intra uterine devices (IUDs) and implants, as well as voluntary sterilization procedures, contraceptive education and counseling. It also includes follow-up services related to the drugs, devices, products and procedures, including but not limited to management of side effects, counseling for continued adherence, and device insertion and removal.

        At least one form of contraception in each of the methods identified in the FDA's Birth Control Guide will be covered as preventive care under this section. If there is only one form of contraception in a given method, or if a form of contraception is deemed not medically advisable by a physician, the prescribed FDA-approved form of contraception will be covered as preventive care under this section.

    b. In order to be covered as preventive care, contraceptive prescription drugs must be *generic* oral contraceptives. *Brand name drugs* will be covered as *preventive care services* when *medically necessary* according to your attending *physician*, otherwise they will be covered under your plan's prescription drug benefits (see your prescription drug benefits).

    c. Breast feeding support, supplies, and counseling. One breast pump will be covered per calendar year under this benefit.

    d. Gestational diabetes screening.

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.

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, human papillomavirus (HPV) screening, and any cervical cancer screening test approved by the federal Food and Drug Administration upon referral by your *physician*.

Osteoporosis. Coverage for services related to diagnosis, treatment, and appropriate management of osteoporosis including, but not limited to, all Food and Drug Administration approved technologies, including bone mass measurement technologies as deemed *medically necessary*.

Breast Cancer. Services and supplies provided in connection with the screening for, diagnosis of, and treatment for breast cancer whether due to illness or injury, including:

1. Diagnostic mammogram examinations in connection with the treatment of a diagnosed illness or injury. Routine mammograms will be covered initially under the Preventive Care Services benefit.

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 of 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 *insured person*.

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 *insured persons* 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 OF GRIEVANCES INVOLVING A DISPUTED HEALTH CARE SERVICE.

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. It does not include massage therapy services at spas or health clubs.)

2. Occupational therapy provided on an outpatient basis when the ability to perform daily life tasks has been lost or reduced by 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.

If you receive *chiropractic services* from a *non-participating provider* and you need to submit a claim to us, please send it to the address listed below. If you have any questions or are in need of assistance, please call us at the Member Services telephone number listed on your ID card.

American Specialty Health
P.O. Box 509001

Injectable Drugs and Implants for Birth Control. Injectable drugs and implants for birth control administered in a *physician's* office if *medically necessary*.

Contraceptive supplies prescribed by a *physician* for reasons other than contraceptive purposes for *medically necessary* treatment such as decreasing the risk of ovarian cancer, eliminating symptoms of menopause or for contraception that is necessary to preserve life or health may also be covered.

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

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; (by 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.

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.

Speech Therapy and speech-language pathology (SLP) services. Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy that will develop or treat communication or swallowing skills to correct a speech impairment.

After your initial visit to a *physician* for speech therapy, pre-service review must be obtained prior to receiving additional services. There is no limit on the number of covered visits for *medically necessary* services. However, visits must be authorized in advance. The precertification requirement under this provision does not apply to outpatient services for *mental health conditions* and substance abuse. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

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, electro-acupuncture, 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.

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 an *insured person* 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 *insured person* 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 directly affecting the upper or lower jawbone or the joints linking the jawbones and the skull (the temporomandibular joints), including the complex of muscles, nerves and other tissues related to those joints.

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.

Phenylketonuria (PKU). Benefits for the testing and treatment of phenylketonuria (PKU) are paid on the same basis as any other medical condition. Coverage for treatment of PKU shall include those formulas and special food products that are part of a diet prescribed by a licensed *physician* and managed by a health care professional in consultation with a *physician* who specializes in the treatment of metabolic disease and who participates in or is authorized by us. The diet must be deemed *medically necessary* to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

The cost of the necessary formulas and special food products is covered only as it exceeds the cost of a normal diet. “Formula” means an enteral product or products for use at home. The formula must be prescribed by a *physician* or nurse practitioner, or ordered by a registered dietician upon referral by a health care provider authorized to prescribe dietary treatments, and is *medically necessary* for the treatment of PKU. Formulas and special food products used in the treatment of PKU that are obtained from a *pharmacy* are covered as prescription drugs (see “Prescription Drugs and Medications”). Formulas and special food products that are not obtained from a *pharmacy* are covered under this benefit.

“Special food product” means a food product that is all of the following:

- Prescribed by a *physician* or nurse practitioner for the treatment of PKU, and
- Consistent with the recommendations and best practices of qualified *physicians* with expertise in the treatment and care of PKU, and
- Used in place of normal food products, such as grocery store foods, used by the general population.

Note: It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving.

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

Designated Pharmacy Provider. We may establish one or more *designated pharmacy provider* programs which provide specific pharmacy services (including shipment of *prescription drugs*) to *members*. A *participating provider* is not necessarily a *designated pharmacy provider*. To be a *designated pharmacy provider*, the *participating provider* must have signed a *designated pharmacy provider* agreement with us. You or your *physician* can contact Member Services to learn which *pharmacy* or *pharmacies* are part of a *designated pharmacy provider* program.

For *prescription drugs* that are shipped to you or your *physician* and administered in your *physician's* office, you and your *physician* are required to order from a *designated pharmacy provider*. A patient care coordinator will work with you and your *physician* to obtain precertification and to assist shipment to your *physician's* office.

We may also require you to use a *designated pharmacy provider* to obtain *prescription drugs* for treatment of certain clinical conditions. We reserve our right to modify the list of *prescription drugs* as well as the setting and/or level of care in which the care is provided to you. We may, from time to time, change with or without advance notice, the *designated pharmacy provider* for a *drug*, such change can help provide cost effective, value based and/or quality services.

If you are required to use a *designated pharmacy provider* and you choose not to obtain your *prescription drug* from a *designated pharmacy provider*, coverage will be the same as for a *non-participating provider*.

You can get the list of the *prescription drugs* covered under this section by calling Member Services at the phone number on the back of your Identification Card or check our website at www.anthem.com.

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 REVIEW OF DENIALS OF EXPERIMENTAL OR INVESTIGATIVE TREATMENT.

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.

Uninsured. 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.

Services Received from Providers on a Federal or State Exclusion List. Any service, *drug*, *drug* regimen, treatment, or supply furnished, ordered or prescribed by a provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies. This exclusion does not apply to an *emergency medical condition*.

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

Waived Cost-Shares Non-Participating Provider. For any service for which you are responsible under the terms of this *plan* to pay a co-payment or deductible, and the co-payment or deductible is waived by a *non-participating provider*.

Work-Related. Any injury, condition or disease arising out of employment for which benefits or payments are covered by any worker's compensation law or similar law. If we provide benefits for such injuries, conditions or diseases we shall be entitled to establish a lien or other recovery under section 4903 of the California Labor Code or any other applicable law, and as described in REIMBURSEMENT FOR ACTS OF THIRD PARTIES.

Government Treatment. Any services actually given to you 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*.

Medicare. For which benefits are payable under Medicare Parts A and/or B, or would have been payable if you had applied for Parts A and/or B, except as listed in this booklet or as required by federal law, as described in the section titled "BENEFITS FOR MEDICARE ELIGIBLE MEMBERS: Coordinating Benefits With Medicare". If you do not enroll in Medicare Part B when you are eligible, you may have large out-of-pocket costs. Please refer to Medicare.gov for more details on when you should enroll and when you are allowed to delay enrollment without penalties.

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

Voluntary Payment. Services for which you are not legally obligated to pay. Services for which you are not charged. Services for which no charge is made in the absence of insurance 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.

Private Contracts. Services or supplies provided pursuant to a private contract between the *insured person* 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.

Residential accommodations. Residential accommodations to treat medical or behavioral health conditions, except when provided in a *hospital*, *hospice*, *skilled nursing facility* or *residential treatment center*. This exclusion includes procedures, equipment, services, supplies or charges for the following:

- Domiciliary care provided in a residential institution, treatment center, halfway house, or school because an *insured person's* own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, *custodial care* center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.

Gene Therapy. Gene therapy as well as any *drugs*, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

Wilderness. Wilderness or other outdoor camps and/or programs. This exclusion does not apply to *medically necessary* services to treat *severe mental disorders* or serious emotional disturbances of a child as required by state law.

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. For dental treatment, regardless of origin or cause, except as specified below. "Dental treatment" includes but is not limited to preventative care and fluoride treatments; dental x rays, supplies, appliances, dental implants and all associated expenses; diagnosis and treatment related to the teeth, jawbones or gums, including but not limited to:

- Extraction, restoration, and replacement of teeth;
- Services to improve dental clinical outcomes.

This exclusion does not apply to the following:

- Services which we are required by law to cover;
- Services specified as covered in this booklet;
- Dental services to prepare the mouth for radiation therapy to treat head and/or neck cancer.

Hearing Aids or Tests. Hearing aids. Routine hearing tests, except as provided under the "Accidental Injury" provision or as part of routine physical examinations under the "Preventive Care" benefits of MEDICAL CARE THAT IS COVERED.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, except routine eye screenings provided as part of routine physical examinations under "Preventive Care" benefits of MEDICAL CARE THAT IS COVERED. Eyeglasses or contact lenses, except as specifically stated in the "Prosthetic Devices" provision of MEDICAL CARE THAT IS COVERED.

Outpatient Occupational Therapy. Outpatient occupational therapy, except as specifically stated in the "Infusion Therapy" provision of MEDICAL CARE THAT IS COVERED, or when provided by a *home health agency* or *hospice,* as specifically stated in the "Home Health Care", "Hospice Care" or "Physical Therapy, Physical Medicine and Occupational Therapy" provisions of that section. 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.

Speech Therapy. Speech therapy except as stated in the "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 to alter or reshape normal (including aged) structures or tissues of the body to improve appearance.

Medical Equipment, Devices and Supplies. This *plan* does not cover the following:

- Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
- Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
- Enhancements to standard equipment and devices that is not *medically necessary*.
- Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is *medically necessary* in your situation.

This exclusion does not apply to *medically necessary* treatment as specifically stated in "Durable Medical Equipment" provision of MEDICAL CARE THAT IS COVERED.

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.

Sterilization Reversal. Reversal of an elective 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.

In-vitro Fertilization. Services or supplies for in-vitro fertilization (IVF) for purposes of pre-implant genetic diagnosis (PGD) of embryos, regardless of whether they are provided in connection with infertility treatment.

Foot Orthotics. Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes.

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.

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. Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.

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. Additionally, this exclusion does not apply to the *medically necessary* services to treat *severe mental disorders* or serious emotional disturbances of a child as required by state law.

Food or Dietary Supplements. Nutritional and/or dietary supplements, 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, Facsimile Machine, and Electronic Mail Consultations. Consultations provided using telephone, facsimile machine, or electronic mail.

Routine Physicals and Immunizations. Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the "Preventive Care", "Cervical Cancer Screening", " Breast Cancer ", “Prostate Cancer Screening”, or “Screening For Blood Lead Levels” 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 section of this booklet. Non-prescription, over-the-counter patent or proprietary drugs or medicines. Cosmetics, health or beauty aids. However, health aids that are *medically necessary* and meet the requirements for durable medical equipment as specified under the “Durable Medical Equipment” provision of MEDICAL CARE THAT IS COVERED, are covered, subject to all terms of this *plan* that apply to that benefit.

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specifically stated in “Injectable Drugs and Implants for Birth Control” provision in MEDICAL CARE THAT IS COVERED.

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. Any investigational *drugs* or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a covered service under this *plan* for non-Investigative treatments, except as specifically stated in the “Cancer Clinical Trials” provision under the section MEDICAL CARE THAT IS COVERED.

BENEFITS FOR MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE

This *plan* provides coverage for the *medically necessary* treatment of *mental health conditions* and substance abuse. 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.

Pre-service review is required for all *mental health conditions* and substance abuse inpatient facility and residential treatment services, except in a medical *emergency* (see UTILIZATION REVIEW PROGRAM for details).

Services for the treatment of *mental health conditions* and substance abuse covered under this *plan* are subject to financial requirements (deductibles, coinsurance, and copayments) and treatment limitations that are no more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical and surgical benefits in the same classification or sub-classification.

SERVICES FOR MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE THAT ARE COVERED

Covered services are shown below for the *medically necessary* treatment of *mental health conditions* and substance abuse, or to prevent the deterioration of chronic conditions.

- **Inpatient Services**: Inpatient *hospital* services and services from a *residential treatment center* (including crisis residential treatment) for inpatient services and supplies, and *physician* visits during a covered inpatient *stay*.
- **Outpatient Office Visits** for the following:
    - individual and group mental health evaluation and treatment,
    - nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa,
    - drug therapy monitoring,
    - individual and group chemical dependency counseling,
    - medical treatment for withdrawal symptoms,
    - methadone maintenance treatment, and
    - Behavioral health treatment for pervasive Developmental Disorder or autism delivered in an office setting.

- **Other Outpatient Items and Services**:
  - *Partial hospitalization programs*, including i*ntensive outpatient programs* and visits to a *day treatment center*.
  - Psychological testing,
  - Multidisciplinary treatment in an intensive outpatient psychiatric treatment program,
  - Behavioral health treatment for Pervasive Developmental Disorder or autism delivered at home.
- **Behavioral health treatment for pervasive developmental disorder or autism**. Inpatient services, office visits, and other outpatient items and services are covered under this section. 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 inpatient facility and residential treatment related to behavioral health treatment services for 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.
- Diagnosis and all *medically necessary* treatment of *severe menta*l *disorder* of a person of any age and serious emotional disturbances of a child.
- Treatment for substance abuse does not include smoking cessation programs, nor treatment for nicotine dependency or tobacco use. Certain services are covered under the "Preventive Care Services" benefit or as specified in the "Preventive Prescription Drugs and Other Items" covered under YOUR PRESCRIPTION DRUG BENEFITS. Please see those provisions for further details.

Coverage is also provided for *emergency services* for treatment of a *psychiatric emergency medical condition*, which is a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following: a) an immediate danger to himself or herself or to others, or b) immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder. Cost sharing for *emergency services* received from *non-participating providers* will be the same as *participating providers*.

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.

Behavioral health treatment services covered under this *plan* are subject to financial requirements (deductibles, co-insurance, and co-payments) and treatment limitations that are no more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical and surgical benefits in the same classification or sub-classification.

You must obtain pre-service review for all inpatient facility and residential treatment related to 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).

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 or autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

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, 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 who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification 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 who 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.

The network of *participating providers* is limited to licensed Qualified Autism Service Providers who contract with us or a Blue Cross and/or Blue Shield Plan 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, which may include clinical case management and case supervision under the direction and supervision of a Qualified Autism Service Provider.
- Is 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 who meets the education and experience qualifications defined in the state regulations for an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program, or who meets equivalent criteria in the state in which he or she practices if not providing services in California,
- Has training and experience in providing services for Pervasive Developmental Disorder or autism pursuant to applicable state law, and
- Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

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

- Is supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional at a level of clinical supervision that meets professionally recognized standards of practice,

- Provides treatment and implements services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider,

- Meets the education and training qualifications set forth in any applicable state regulations adopted pursuant to state law concerning the use of paraprofessionals in group practice provider behavioral intervention services,

- Has adequate education, training, and experience, as certified by a Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers, and

- Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

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 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 by the Qualified Autism Service Provider, or (c) Qualified Autism Service Paraprofessional supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional, 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. The treatment plan must be made available to us upon request.

REIMBURSEMENT FOR ACTS OF THIRD PARTIES

Under some circumstances, an *insured person* 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.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. You will pay 100% of the cost of the drug at a retail pharmacy and will be reimbursed later at the participating or non-participating provider rate by Anthem Blue Cross.

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.

Prescription drugs dispensed at a retail pharmacy are limited to a thirty-four (34) day supply per prescription or refill and are subject to the retail prescription benefit as described above. Maintenance drugs, as classified by the Plan, can be filled for a ninety (90) day supply at mail order or a CVS/pharmacy and are subject to the mail order co-pay.

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 you to get started with mail service and stay on track with your therapies. You can fill out and print the form online at www.caremark.com by clicking on New Prescriptions. You can then mail in your form along with prescription and payment. You can also contact FastStart from 7am to 7pm CT Monday – Friday to get started on your mail order. Your 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	$50 copay for a 1-30 day supply $100 copay for a 31-60 day supply $150 copay for a 61-90 day supply

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

Your 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.

Your 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 you appeal CVS Caremark's decision, you 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 Protropin (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 medical plan, your benefits under This Plan will be coordinated with the benefits of those Other Plans, as shown below. 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 any 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. An expense that is not covered by any plan covering the person for whom claim is made is not an Allowable Expense.

The following are not Allowable Expense:

1. Use of a private hospital room is not an Allowable Expense unless the patient's stay in a private *hospital* room is *medically necessary* in terms of generally accepted medical practice, or one of the plans routinely provides coverage for *hospital* private rooms.

2. If you are covered by two plans that calculate benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method, any amount in excess of the higher of the reasonable and customary amounts.

3. If a person is covered by two plans that provide benefits or services on the basis of negotiated rates or fees, an amount in excess of the lower of the negotiated rates.

4. If a person is covered by one plan that calculates its benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method and another plan provides its benefits or services on the basis of negotiated rates or fees, any amount in excess of the negotiated rate.

5. The amount of any benefit reduction by the Principal Plan because you did not comply with the plan's provisions is not an Allowable Expense. Examples of these types of provisions include second surgical opinions, utilization review requirements, and network provider arrangements.

6. If you advise us that all plans covering you are high deductible health plans as defined by Section 223 of the Internal Revenue Code, and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code, any amount that is subject to the primary high deductible health plan's deductible.

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 trusteed 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 first of the following rules which applies will 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 an *insured employee* 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 retiree.

For example: You are covered as a retiree 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, Medicare will pay second and the plan which covers you as a retiree 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 INSURED PERSONS

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. In general, when Medicare is the primary payor according to federal law, Medicare must provide benefits

first to any services that are covered both by Medicare and under this *plan*. For any given claim, the combination of benefits provided by Medicare and under this *plan* will not exceed the *maximum allowed amount* for the covered services.

Except when federal law requires us to be the primary payer, the benefits under this *plan* for *members* age 65 and older, or for *members* who are otherwise eligible for Medicare (such as due to a disability or receiving treatment for end-stage renal disease), will not duplicate any benefit for which *members* are entitled under Medicare, including Medicare Part B. Where Medicare is the responsible primary payer, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to us, to the extent we have made primary payment for such services. If you do not enroll in Medicare Part B when you are eligible, you may have large out-of-pocket costs. Please refer to Medicare.gov for more details on when you should enroll, and when you are allowed to delay enrollment without penalties.

UTILIZATION REVIEW PROGRAM

Your *plan* includes the process of utilization review to decide when services are *medically necessary* or *experimental* / *investigative* as those terms are defined in this booklet. Utilization review aids the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed.

REVIEWING WHERE SERVICES ARE PROVIDED

A service must be *medically necessary* to be a covered service. When level of care, setting or place of service is reviewed, services that can be safely given to you in a lower level of care or lower cost setting / place of care, will not be *medically necessary* if they are given in a higher level of care, or higher cost setting / place of care. This means that a request for a service may be denied because it is not *medically necessary* for the service to be provided where it is being requested. When this happens the service can be requested again in another place and will be reviewed again for medical necessity. At times a different provider or facility may need to be used in order for the service to be considered *medically necessary*. Examples include, but are not limited to:

- A service may be denied on an inpatient basis at a *hospital* but may be approvable if provided on an outpatient basis at a *hospital*.
- A service may be denied on an outpatient basis at a *hospital* but may be approvable at a free standing imaging center, infusion center, ambulatory surgery center, or in a *physician's* office.
- A service may be denied at a *skilled nursing facility* but may be approvable in a home setting.

Utilization review criteria will be based on many sources including medical policy and clinical guidelines. We may decide that a treatment that was asked for is not *medically necessary* if a clinically equivalent treatment that is more cost-effective is available and appropriate. "Clinically equivalent" means treatments that for most *members*, will give you similar results for a disease or condition.

If you have any questions about the utilization review process, the medical policies or clinical guidelines, you may call the Member Services phone number on the back of your Identification Card.

Coverage for or payment of the service or treatment reviewed is not guaranteed. For benefits to be covered, on the date you get service:

1. You must be eligible for benefits;

2. The service or supply must be a covered service under your *plan*;

3. The service cannot be subject to an exclusion under your *plan* (please see MEDICAL CARE THAT IS NOT COVERED for more information); and

4. You must not have exceeded any applicable limits under your *plan*.

TYPES OF REVIEWS

- **Pre-service Review –** A review of a service, treatment or admission for a benefit coverage determination which is done before the service or treatment begins or admission date.

  - **Precertification** – A required pre-service review for a benefit coverage determination for a service or treatment. Certain services require precertification. The benefit coverage review will include a review to decide whether the service meets the definition of medical necessity or is *experimental* / *investigative* as those terms are defined in this booklet.

    For admissions following an *emergency*, you, your authorized representative or *physician* must tell us within 24 hours of the admission or as soon as possible within a reasonable period of time.

    For childbirth admissions, precertification is not needed for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require precertification.

    For inpatient *hospital* stays for mastectomy surgery, including the length of *hospital* stays associated with mastectomy, precertification is not needed.

- **Continued Stay / Concurrent Review –** A utilization review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment.

  - Both pre-service and continued stay / concurrent reviews may be considered urgent when, in the view of the treating provider or any *physician* with knowledge of your medical condition, without such care or treatment, your life or health or your ability to regain maximum function could be seriously threatened or you could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.

- **Post-service Review –** A review of a service, treatment or admission for a benefit coverage that is conducted after the service has been provided. Post-service reviews are performed when a service,

treatment or admission did not need a precertification, or when a needed precertification was not obtained. Post-service reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

Services for which precertification is required (i.e., services that need to be reviewed by us to determine whether they are *medically necessary*) are the following:

Note: The appropriate utilization reviews must be performed in accordance with this *plan*. When pre-service review is not performed as required for the services listed below, the benefits to which you would have been otherwise entitled will be subject to the Non-Certification Deductible shown in the SUMMARY OF BENEFITS.

- Scheduled, non-emergency inpatient *hospital stays* and *residential treatment center* admissions, including detoxification and rehabilitation.

  Exceptions: Pre-service 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.

- Diagnostic treatment, wherever performed, except when needed for *mental health conditions* and substance abuse.
- Surgical procedures, wherever performed.
- Transplant services, if the *physicians* on the surgical team and the facility in which the transplant is to take place are approved for the transplant requested.
- Speech therapy services. A specified number of additional visits may be authorized after your initial visit. While there is no limit on the number of covered visits for medically necessary speech therapy, visits must be authorized in advance. The precertification requirement under this provision does not apply to outpatient services for *mental health conditions* and substance abuse.
- Infusion therapy or home infusion therapy, if the attending physician has submitted both a prescription and a plan of treatment before services are rendered.
- All interventional spine pain, elective hip, knee, and shoulder arthroscopic/open sports medicine, and outpatient spine surgery procedures must be authorized in advance.

- Inpatient admission related to transgender surgery services, including transgender travel expense. Precertification is not required for all other transgender services.

For a list of current procedures requiring precertification, please call the toll-free number for Member Services printed on your Identification Card.

WHO IS RESPONSIBLE FOR PRECERTIFICATION?

Typically, *participating providers* know which services need precertification and will get any precertification when needed. Your *physician* and other *participating providers* have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering provider, *hospital* or attending *physician* ("requesting provider") will get in touch with us to ask for a precertification. However, you may request a precertification or you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for precertification and under what circumstances.

Provider Network Status	**Responsibility to Get Precertification**	**Comments**
Participating Providers	Provider	• The provider must get precertification when required.
Non-Participating Providers	*Insured Person*	• *Insured person* must get precertification when required. (Call Member Services.) • *Insured person* may be financially responsible for charges or costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be *medically necessary*.

Provider Network Status	Responsibility to Get Precertification	Comments
Blue Card Provider	*Insured Person* **(Except for Inpatient Admissions)**	• *Insured person* must get precertification when required. (Call Member Services.) • *Insured person* may be financially responsible for charges or costs related to the service and/or setting in whole or in part if the service and or setting is found to not be *medically necessary*. • **Blue Card Providers must obtain precertification for all Inpatient Admissions.**
NOTE: For an *emergency* admission, precertification is not required. However, you, your authorized representative or *physician* must tell us within 24 hours of the admission or as soon as possible within a reasonable period of time.		

HOW DECISIONS ARE MADE

We use our clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make our medical necessity decisions. This includes decisions about *prescription drugs* as detailed in the section "Prescription Drugs Obtained From Or Administered By a Medical Provider." Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the precertification phone number on the back of your identification card.

If you are not satisfied with our decision under this section of your benefits, please refer to the "Grievance Procedures" section to see what rights may be available to you.

DECISION AND NOTICE REQUIREMENTS

We will review requests for medical necessity according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, we will follow state laws. If you live in and/or get services in a state other than the state where your *policy* was issued other state-specific requirements may apply. You may call the phone number on the back of your identification card for more details.

Request Category	**Timeframe Requirement for Decision**
Urgent Pre-Service Review	72 hours from the receipt of the request
Non-Urgent Pre-Service Review	5 business days from the receipt of the request
Continued Stay / Concurrent Review when hospitalized at the time of the request and no previous authorization exists	72 hours from the receipt of the request
Urgent Continued Stay / Concurrent Review when request is received at least 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Urgent Continued Stay / Concurrent Review when request is received less than 24 hours before the end of the previous authorization	72 hours from the receipt of the request
Non-Urgent Continued Stay / Concurrent Review	5 business days from the receipt of the request
Post-Service Review	30 calendar days from the receipt of the request

If more information is needed to make our decision, we will tell the requesting *physician* of the specific information needed to finish the review. If we do not get the specific information we need by the required timeframe identified in the written notice, we will make a decision based upon the information we have.

We will notify you and your *physician* of our decision as required by state and federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

For a copy of the medical necessity review process, please contact Member Services at the telephone number on the back of your Identification Card.

Revoking or modifying a Precertification Review decision. We will determine **in advance** whether certain services (including procedures and admissions) are *medically necessary* and are the appropriate length of stay, if applicable. These review decisions may be revoked or modified prior to the service being rendered for reasons including but not limited to the following:

- Your coverage under this *plan* ends;
- The *policy* with the *group* terminates;
- You reach a benefit maximum that applies to the service in question;
- Your benefits under the *plan* change so that the service is no longer covered or is covered in a different way.

HEALTH PLAN INDIVIDUAL CASE MANAGEMENT

The health plan individual case management program enables us to assist 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 discuss possible options for an alternative plan of treatment which may include services not covered under this *plan*. It is not your right to receive individual case management, nor do we have an obligation to provide it; we provide these services at our sole and absolute discretion.

HOW HEALTH PLAN INDIVIDUAL CASE MANAGEMENT WORKS

Our health plan individual case management program (Case Management) helps coordinate services for *insured persons* with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate *insured persons* who agree to take part in the Case Management program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary, and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any covered services you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and /or your chosen authorized representative, treating *physicians*, and other providers.

In addition, we may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

Alternative Treatment Plan. In certain cases of severe or chronic illness or injury, we may provide benefits for alternate care that is not listed as a covered service. We may also extend services beyond the benefit maximums of this *plan*. We will make our decision case-by-case, if in our discretion the alternate or extended benefit is in the best interest of you and us and you or your authorized representative agree to the alternate or extended benefit in writing. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to you or to any other member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, we will notify you or your authorized representative in writing.

HOW COVERAGE BEGINS AND ENDS

HOW COVERAGE BEGINS

ELIGIBLE STATUS

1. **Insured Retiree.** 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 *retiree's* eligible *spouse* or eligible *domestic partner;* and (b) An eligible unmarried *child*.

Definition of Family Member

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

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

3. **Child** is the *retiree's*, *spouse's* or *domestic partner's* natural child, stepchild, legally adopted child, or a child for whom the *subscriber*, *spouse* or *domestic partner* is legally required to provide group health coverage for the child pursuant to an administrative or court order, subject to the following:

    a. The child is under 26 years of age.

    b. The unmarried child is 26 years of age, or more and: (i) was covered under the *prior plan*, was covered as a *family member* of the *subscriber* under another plan or health insurer, or has six or more months of *creditable coverage*, (ii) is chiefly dependent on the *retiree, 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 *retiree* 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 *retiree, spouse* or *domestic partner* for support and maintenance due to a continuing physical or mental condition. A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

    c. A child who is in the process of being adopted is considered a legally adopted child if we receive legal evidence of both: (i) the intent to adopt; and (ii) that the *retiree*, *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 *retiree's*, the *spouse's* or the *domestic partner's* right to control the health care of the child.

d. The term "child" does not include: (i) any child for whom the *retiree, 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.

e. If both parents are covered as *retirees*, 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 *retirees,* you become eligible for coverage on the first day of the month coinciding with or following the date premiums are paid on your behalf.

2. For *family members,* you become eligible for coverage on the later of: (a) the date the *employee* becomes eligible for coverage; or, (b) the date you meet the *family member* definition.

ENROLLMENT

To enroll as a *retiree,* or to enroll *family members,* the *retiree* 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 *retiree* 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 premium 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 *retirees,* on your eligibility date;

and (b) for *family members,* on the later of (i) the date the *retiree's* coverage begins, or (ii) the first day of the month after the *family member* becomes eligible. If you become eligible before the *policy* takes effect, coverage begins on the effective date of the *policy,* 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 retirees or add new dependents after 30 days from the date they become eligible, coverage will begin six months following the date you filed the enrollment application.

3. **Disenrollment:** If you voluntarily choose to disenroll from coverage under this *plan*, you must complete a six month waiting period from the date you submit an application to the group. You may enroll earlier than the six months if you meet any of the conditions listed under SPECIAL ENROLLMENT PERIODS.

Important Note for Newborn and Newly-Adopted Children. If the *insured retiree* (or *spouse* or *domestic partner,* if the *spouse* or *domestic partner* is enrolled) is already covered: (1) any *child* born to the *retiree*, *spouse* or *domestic partner* will be enrolled from the moment of birth; and (2) any *child* being adopted by the *retiree* or *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 *retiree*, *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 *retiree's*, *spouse's* or *domestic partner's* right to control the health care of the *child* may be used)*;* or (b) the *retiree*, *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 *retiree* 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 so.

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

i. If the other health plan was another employer group health plan or health insurance coverage, including coverage under a COBRA 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 group health plan and an application is filed within 31 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 31 days after your eligibility date, or if you disenroll, and later file an enrollment application, your coverage may not begin until the first day of the month following the end of the *group's* next open enrollment period.

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

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

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

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

6. You become eligible for assistance, with respect to the cost of coverage under the employer's group *plan*, under a state Medicaid or SCHIP health plan, including any waiver or demonstration project conducted under or in relation to these plans. You must properly file an application with the *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 *policy* terminates, your coverage ends at the same time. This *policy* 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 *policy* 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 *retiree's* coverage ends.

4. Coverage ends at the end of the period for which premium has been paid to us on your behalf when the required premium for the next period is not paid.

5. If you voluntarily cancel coverage at any time, coverage ends on the premium 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 premium due date coinciding with or following the date you cease to meet such requirements.

   Exception 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 *retiree, 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 *insured person* 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 *insured person* must send proof of the *child's* physical or mental condition within 60-days of the date the *insured person* 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 *retiree, 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 *retiree* 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 Blue Cross Life and Health suffers a loss because of the *retiree* failing to notify the *group* of the termination of their marriage or domestic partnership, Anthem Blue Cross Life and Health may seek recovery from the *retiree* 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 *retiree* 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 *retiree'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, and EXTENSION OF BENEFITS.

Unfair Termination of Coverage. If you believe that your coverage has been or will be improperly terminated, you may request a review of the matter by the California Department of Insurance (CDI). You may contact the CDI using the address and telephone numbers listed in the COMPLAINT NOTICE. You must make your request for review with the CDI within 180 days from the date you receive notice that your coverage will end, or the date your coverage is actually cancelled, whichever is later, but you should make your request as soon as possible after you receive notice that your coverage will end. This 180 day timeframe will not apply if, due to substantial health reasons or other incapacity, you are unable to understand the significance of the cancellation notice and act upon it. If you make your request for review within 30 days after you receive notice that your coverage will end, or your coverage is still in effect when you make your request, 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 by the CDI (this does not apply if your coverage is cancelled for non-payment of premium). If your coverage is maintained in force pending outcome of the review, premium 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), you may be entitled to a period of continuation of coverage. Check with your employer 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 be capitalized. 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 *policy* as either an *insured employee* or *insured family member;* and (b) a *child* who is born to or placed for adoption with the *insured employee* 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 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 *policy.* The events will be referred to throughout this section by number.

1. **For Retired Employees and their Insured Family Members.** Cancellation or a substantial reduction of retiree benefits under the *plan* due to the *group's* filing for Chapter 11 bankruptcy, provided:

    a. The *policy* 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 Insured Family Members:**

    a. The death of the *insured retiree;*

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

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

d. The *retiree's* entitlement to Medicare.

ELIGIBILITY FOR COBRA CONTINUATION

An *insured employee* or *insured family member*, **other than a *domestic partner,* and a *child* of a *domestic partner***, may choose to continue coverage under the *policy* if his or her coverage would otherwise end due to a Qualifying Event.

TERMS OF COBRA CONTINUATION

Notice. The *group* or its administrator (we are not the administrator) will notify either the *insured retiree* or *insured 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 *employee* of the right to continue coverage.
2. For Qualifying Events 3(a) or 3(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 3(b) or 3(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 *insured persons* within a family, or only for selected *insured persons*.

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 premium, must be delivered to us by the *group* within 45 days after you elect COBRA continuation coverage.

Additional Insured 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 *policy* 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 "premium", must be remitted to the *group* each month during the COBRA continuation period. We must receive payment of the premium each month from the *group* in order to maintain the coverage in force.

Besides applying to the *insured retiree,* the *retiree's* premium rate will also apply to:

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

2. A *child,* if neither the *retiree* nor the *spouse* has enrolled for this COBRA continuation coverage (if more than one *child* is so enrolled, the premium 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, an *insured person,* 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 *insured retiree's* employment, and was 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 premium 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 *policy*.

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 *insured retiree,* divorce or legal separation, or the end of dependent *child* status;*

3. The end of 36 months from the date the *insured retiree* became entitled to Medicare, if the Qualifying Event was the *employee's* entitlement to Medicare. If entitlement to Medicare does not result in coverage terminating and Qualifying Event 1 occurs within 18 months after Medicare entitlement, coverage for Qualified Beneficiaries other than the *insured retiree* will end 36 months from the date the *insured retiree* became entitled to Medicare;

4. The date the *policy* terminates;

5. The end of the period for which premiums are last paid;

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

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

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 *insured persons* 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 *insured person* 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 *insured person* 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 "premium") shall be subject to the following conditions:

1. If the disabled *insured person* continues coverage during this extension, this rate shall be **150%** of the applicable rate for the length of time the disabled *insured person* remains covered, depending upon the number of covered dependents. If the disabled *insured person* 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 premium 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 premium rate shall then be **150%** of the applicable rate for the 19th through 36th months if the disabled *insured person* remains covered. The charge will be **102%** of the applicable rate for any periods of time the disabled *insured person* 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 *policy* terminates;

4. The end of the period for which premiums are last paid;

5. The date, following the election of COBRA, the *insured person* first becomes covered under the other group health plan, unless the other group health plan contains an exclusion or limitation to a pre-existing condition of the *insured person*, 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 *insured person* 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 *policy* 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 “premium”). 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 premium 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 premium and premium due. Failure to submit the correct amount within this 45-day period will disqualify you from receiving continuation coverage under CalCOBRA. Succeeding premium payments are due on the first day of each following month.

If premium payments 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 premium payments that you owe to us, including premium payments that apply during any grace period.

Premium Rate Change. The premium rates may be changed by us as of any premium due date. We will provide you with written notice at least 60 days prior to the date any premium rate 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 premium 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 premium, 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 *policy*.

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 *policy* terminates;
3. The date the *group* no longer provides coverage to the class of employees to which you belong;
4. The end of the period for which premium is 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*.

COVERAGE FOR SURVIVING FAMILY MEMBERS

If the *retiree* 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 *retiree* must have occurred more than twelve months prior to the *retiree's* date of retirement. Coverage for such *family members* continues until one of the following occurs:

1. Premiums are not paid to Anthem Blue Cross Life and Health on the *insured person's* behalf, or

2. The *group* cancels coverage for the class of *insured retirees* to which the *insured person* belongs, or

3. The agreement between the *group* and Anthem Blue Cross Life and Health 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 *insured person* may be responsible for all or part of the premiums.

EXTENSION OF BENEFITS

If you are a *totally disabled retiree* or a *totally disabled family member* and under the treatment of a *physician* on the date of discontinuance of the *policy,* 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.

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*.

Inter-Plan Arrangements

Out-of-Area Services

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

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

Inter-Plan Arrangements Eligibility – Claim Types

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

A. BlueCard® Program

Under the BlueCard® Program, when you receive covered services within the geographic area served by a Host Blue, we will still fulfill our contractual obligations. But, the Host Blue is responsible for: (a) contracting with its providers; and (b) handling its interactions with those providers.

When you receive covered services outside the Anthem Blue Cross Service Area and the claim is processed through the BlueCard® Program, the amount you pay is calculated based on the lower of:

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

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the provider. Sometimes, it is an estimated price that takes into account special arrangements with that provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

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

B. Negotiated (non–BlueCard® Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard® Program, Anthem Blue Cross may process your claims for covered services through Negotiated Arrangements for National Accounts.

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

C. Special Cases: Value-Based Programs

BlueCard® Program

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

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

If Anthem Blue Cross has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the *group* on your behalf, Anthem Blue Cross will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard® Program.

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

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

E. Non-participating Providers Outside Our Service Area

1. Allowed Amounts and Member Liability Calculation

When covered services are provided outside of Anthem Blue Cross's Service Area by non-participating providers, we may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services as deductible or copayment will be based on that allowed amount. Also, you may be responsible for the difference between the amount that the non-participating provider bills and the payment we will make for the covered services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network *emergency* services.

2. **Exceptions**

In certain situations, we may use other pricing methods, such as billed charges or the pricing we would use if the healthcare services had been obtained within the Anthem Blue Cross Service Area, or a special negotiated price to determine the amount we will pay for services provided by non-participating providers. In these situations, you may be liable for the difference between the amount that the non-participating provider bills and the payment we make for the covered services as set forth in this paragraph.

F. Blue Cross Blue Shield Global Core® Program

If you plan to travel outside the United States, call Member Services to find out your Blue Cross Blue Shield Global Core® benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care, you can call the Blue Cross Blue Shield Global Core® Service Center any time. They are

available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177.

If you need inpatient hospital care, you or someone on your behalf, should contact us for preauthorization. Keep in mind, if you need *emergency* medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the "Utilization Review Program" section in this booklet for further information. You can learn how to get pre-authorization when you need to be admitted to the hospital for *emergency* or non-emergency care.

How Claims are Paid with Blue Cross Blue Shield Global Core®

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

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

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

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

When you need Blue Cross Blue Shield Global Core® claim forms you can get international claims forms in the following ways:

- Call the Blue Cross Blue Shield Global Core® Service Center at the numbers above; or
- Online at www.bcbsglobalcore.com.

You will find the address for mailing the claim on the form.

Terms of Coverage

1. In order for you to be entitled to benefits under the *policy,* both the *policy* and your coverage under the *policy* 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 *policy* is subject to amendment, modification or termination according to the provisions of the *policy* without your consent or concurrence.

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

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

Free Choice of Provider. This *plan* in no way interferes with your right as an *insured person* 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. But your choice may affect the benefits payable according to this *plan*.

Medical Necessity. The benefits of this *plan* are provided only for services which are determined 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 *insured persons* are entitled to receive benefits under this *plan*. The right to benefits cannot be transferred.

Notice of Claim. You, the provider of service or someone on your behalf, must give us written notice of a claim within 20 days after you incur covered charges under this plan, or as soon as reasonably possible thereafter.

Claim Forms. After we receive a written notice of claim, we will give you any forms you need to file proof of loss. If we do not give you these forms within 15 days after you have filed your notice of claim, you will not have to use these forms, and you may file proof of loss by sending us written proof of the occurrence giving rise to the claim. Such written proof must include the extent and character of the loss.

Note: To obtain a claim form you or someone on your behalf may call the Member Services phone number shown on your ID Card or go to our website at **www.anthem.com/ca** and download and print one.

Member's Cooperation. You will be expected to complete and submit to us all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If you fail to cooperate (including if you fail to enroll under Part B of the Medicare program where Medicare is the responsible payer), you will be responsible for any charge for services.

Proof of Loss. You or the provider of service must send us properly and fully completed claim forms within 90 days of the date you receive the service or supply for which a claim is made. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 24 months will be allowed. Except in the absence of legal capacity, we are not liable for the benefits of the *plan* if you do not file claims within the required time period, unless an extension is required by federal law. We will not be liable for benefits if we do not receive written proof of loss on time.

Services received and charges for the services must be itemized, and clearly and accurately described. Claim forms must be used; canceled checks or receipts are not acceptable.

Timely Payment of Claims. Any benefits due under this plan shall be payable, as soon as practical, but no later than 30 working days after we have received proper, written proof of loss, together with such reasonably necessary additional information we may require to determine our obligation. If a claim is contested or denied, Anthem Blue Cross Life and Health shall notify the *insured person* in writing, within 30 working days after receipt of the claim, that the claim is contested or denied. This will be done through a letter or an explanation of benefits (EOB), identifying the portion of the claim that is contested or denied and describing the reasons for the contention or denial of the claim. A copy of the letter or EOB will also be sent to the health care provider who rendered the services at issue. Any balance remaining unpaid at termination of the period of liability will be paid to the *insured person* or health care provider, as applicable, immediately upon receipt of due written proof.

Payment of Benefits. You authorize us to make payments directly to providers for covered services. In no event, however, shall our right to make payments directly to a provider be deemed to suggest that any provider is a beneficiary with independent claims and appeal rights under the *plan*. We reserve the right to make payments directly to you as opposed to any provider for covered service, at our discretion. In the event that payment is made directly to you, you have the responsibility to apply this payment to the claim from the *non-participating provider*. Payments

and notice regarding the receipt and/or adjudication of claims may also be sent to, an Alternate Recipient (which is defined herein as any child of a *insured person* who is recognized, under a "Qualified Medical Child Support Order", as having a right to enrollment under the *group's policy*), or that person's custodial parent or designated representative. Any payments made by us (whether to any provider for covered service or you) will discharge our obligation to pay for covered services. You cannot assign your right to receive payment to anyone, except as required by a "Qualified Medical Child Support Order" as defined by, and if subject to, ERISA or any applicable state law.

We will pay *non-participating providers* and other providers of service directly when *emergency services* and care are provided to you or one of your *family members*. We will continue such direct payment until the *emergency* care results in stabilization. If the *emergency* care is rendered within California by a *non-participating provider*, other than an ambulance provider, you will not be responsible for any amount in excess of the reasonable and customary amount. However, you are responsible for any charges in excess of the reasonable and customary amount that may be billed by an ambulance provider that is a *non-participating provider*.

If you receive services from a facility that is a *participating provider*, at which or as a result of which, you receive non-*emergency* covered services provided by a *non-participating provider*, you will pay the *non-participating provider* no more than the same cost sharing that you would pay for the same covered services received from a *participating provider*. You will not have to pay the *non-participating provider* more than the *participating provider* cost sharing for such non-*emergency* covered services. Please see "Member Cost Share" above for more information.

Once a provider performs a covered service, we will not honor a request to withhold payment of the claims submitted.

The coverage, rights, and benefits under the *policy* are not assignable by any *insured person* without the written consent of the *plan*, except as provided above. This prohibition against assignment includes rights to receive payment, claim benefits under the *policy* and/or law, sue or otherwise begin legal action. Any assignment made without written consent from the *policy* will be void and unenforceable.

Care Coordination. We pay *participating providers* in various ways to provide covered services to you. For example, sometimes we may pay *participating providers* a separate amount for each covered service they provide. We may also pay them one amount for all covered services related to treatment of a medical condition. Other times, we may pay a periodic, fixed pre-determined amount to cover the costs of covered services. In addition, we may pay *participating providers* financial incentives or other amounts to help improve quality of care and/or promote

the delivery of health care services in a cost-efficient manner, or compensate *participating providers* for coordination of your care. In some instances, *participating providers* may be required to make payment to us because they did not meet certain standards. You do not share in any payments made by *participating providers* to us under these programs.

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

Under certain circumstances, if we pay your healthcare provider amounts that are your responsibility, such as deductibles, co-payments or co-insurance, we may collect such amounts directly from you. You agree that we have the right to recover such amounts from you.

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

We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses, and whether to settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by us or you if the recovery method makes providing such notice administratively burdensome.

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 *policy* does not affect any requirement for coverage by workers' compensation insurance. It also does not replace that insurance.

Entire Contract. This certificate, including any amendments and endorsements to it, is a summary of your benefits. It replaces any older certificates issued to you for the coverages described in the Summary of Benefits. All benefits are subject in every way to the entire *policy* which includes this certificate. The terms of the *policy* may be changed only by a written endorsement signed by one of our authorized officers. No agent or employee has any authority to change any of the terms, or waive the provisions of, the *policy*.

Liability For Statements. No statements made by you, unless they appear on a written form signed by you or are fraudulent, will be used to deny a claim under the *policy*. Statements made by you will not be deemed warranties. With regard to each statement, no statement will be used by us in defense to a claim unless it appears in a written form signed by you and then only if a copy has been furnished to you. After two years following the filing of such claim, if the coverage under which such claim is filed has been in force during that time, no such statement will be used to deny such a claim, unless the statement is fraudulent.

Physical Examination. At our expense, we have the right and opportunity to examine any *insured person* claiming benefits when and as often as reasonably necessary while a claim is pending.

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

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

Financial Arrangements with Providers. Anthem Blue Cross Life and Health 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 *insured persons* and members entitled to health care benefits under individual certificates and group policies or contracts to which Anthem Blue Cross Life and Health or an affiliate is a party, including all persons covered under the *policy*.

Under the above-referenced contracts between Providers and Anthem Blue Cross Life and Health or an affiliate, the negotiated rates paid for certain medical services provided to persons covered under the *policy* may

differ from the rates paid for persons covered by other types of products or programs offered by Anthem Blue Cross Life and Health or an affiliate for the same medical services. In negotiating the terms of the *policy*, the *group* was aware that Anthem Blue Cross Life and Health or its affiliates offer several types of products and programs. The *insured employees*, *family members*, and the *group* are entitled to receive the benefits of only those discounts, payments, settlements, incentives, adjustments and/or allowances specifically set forth in the *policy*.

Under arrangements with some health care providers and suppliers (hereafter referred to together as "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 Blue Cross Life and Health 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 Blue Cross Life and Health 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 Blue Cross Life and Health or an affiliate in determining its fees or subscription charges or premiums.

Confidentiality and Release of Information. Applicable state and federal law requires us to undertake efforts to safeguard your medical information.

For informational purposes only, please be advised that a statement describing our policies and procedures regarding the protection, use and disclosure of your medical information is available on our website and can be furnished to you upon request by contacting our Member Services department.

Obligations that arise under state and federal law and policies and procedures relating to privacy that are referenced but not included in this booklet are not part of the contract between the parties and do not give rise to contractual obligations.

Continuity of Care after Termination of Provider: Subject to the terms and conditions set forth below, we 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 we terminate our contractual relationship with the provider (unless the provider's contract is terminated for reasons of medical disciplinary cause or reason, fraud, or other criminal activity). This does not apply to a provider who voluntarily terminates his or her contract.

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 us prior to termination. The provider must also agree in writing to accept the terms and reimbursement rates under his or her agreement with us 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.

We 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 us 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.

Please contact Member Services 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 your 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 complaint with us as described in the COMPLAINT NOTICE.

Value-Added Programs. We may offer health or fitness related programs, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not covered services under your *plan* but are in addition to *plan* benefits. As such, program features are not guaranteed under your health *plan* contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Program Incentives. We may offer incentives from time to time at our discretion in order to introduce you to new programs and services available under this *plan*. The purpose of these incentives include, but is not limited to, making you aware of cost effective benefit options or services, helping you achieve your best health, and encouraging you to update member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards and health-related merchandise. Acceptance of these incentives is voluntary as long as we offer the incentives program. We may discontinue an incentive for a particular new service or program at any time. If you have any questions about whether receipt of an incentive or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

Policies and Procedures. We are able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the *plan* more orderly and efficient. *Insured persons* must follow and accept any new policies, procedures, rules, and interpretations.

Under the terms of the *policy*, we have the authority to introduce or terminate from time to time, pilot or test programs for disease management, care management or wellness initiatives which may result in the payment of benefits not otherwise specified in this booklet. We reserve the right to discontinue a pilot or test program at any time.

GRIEVANCE PROCEDURES

Except where an *insured person's* life or health would be seriously jeopardized, you must first exhaust our internal grievance process before we will grant your request for an external review (see the COMPLAINT NOTICE at the end of this booklet). In no event shall your rights to an external review be any more restrictive that those set forth in the Uniform External Review Model Act established by the National Association of Insurance Commissioners (NAIC), by the Secretary of the federal Department of Health and Human Services (HHS), or within the California state external review act, as applicable under state and federal law. There is no fee for an external review. If you have a question about our internal grievance process, filing a grievance, or the external review process, please call Member Services at the Member Services number listed on your ID card or you may write to us at Anthem Blue Cross Life and Health Insurance Company, 21215 Burbank Blvd., Woodland Hills, CA 91367.

If, after our denial, we consider, rely on or generate any new or additional evidence in connection with your claim, we will provide you with that new or additional evidence, free of charge. We will not base our appeal decision on a new or additional rationale without first providing you (free of charge) with, and a reasonable opportunity to respond to, any such new or additional rationale. If we fail to follow the appeal procedures outlined under this section the appeals process may be deemed exhausted. However, the appeals process will not be deemed exhausted due to minor violations that do not cause, and are not likely to cause, prejudice or harm so long as the error was for good cause or due to matters beyond our control.

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 California Department of Insurance ("CDI"). Your request for this review may be submitted to the CDI. 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 Life and Health Insurance Company, 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 are not required to go through our grievance process for more than 30 days. If your grievance needs expedited review, you are not required to go through our grievance process for more than three days.

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 CDI for good cause.

Within three business days of receiving notice from the CDI 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.

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 California Department of Insurance ("CDI") 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 CDI will review your application for IMR to confirm that:

1. (a) Your provider has recommended a health care service as *medically necessary*, or

   (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 CDI 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 CDI 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 CDI 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 Member Services telephone number listed on your ID card.

BINDING ARBITRATION

ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT.

It is understood that any dispute including disputes relating to the delivery of services under the plan/Policy or any other issues related to the plan/Policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided

in a court of law before a jury, and instead are accepting the use of arbitration.

THIS MEANS THAT YOU AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AND/OR ANTHEM BLUE CROSS AGREE TO BE BOUND BY THIS ARBITRATION PROVISION AND ACKNOWLEDGE THAT THE RIGHT TO A JURY TRIAL OR TO PARTICIPATE IN A CLASS ACTION IS WAIVED FOR BOTH DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND MEDICAL MALPRACTICE CLAIMS.

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

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

The arbitration is initiated by the Insured making written demand on Anthem Blue Cross Life and Health and/or Anthem Blue Cross. 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 Insured and Anthem Blue Cross Life and Health and/or Anthem Blue Cross, or by order of the court, if the Insured and Anthem Blue Cross Life and Health and/or Anthem Blue Cross cannot agree.

Should damages claimed be $50,000 or less, the arbitration shall be held by a single, neutral arbitrator mutually agreed to by the parties. Such arbitrator shall have no jurisdiction to award more than $50,000. The arbitrator shall be selected in accordance with the applicable rules of the arbitration administration entity. With respect to an arbitration held in California, if the parties are unable to agree on the selection of an arbitrator using the rules of the arbitration administration entity, the method provided in Code of Civil Procedure Section 1281.6 shall be used.

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, we will assume all or a portion of the Insured's costs of the arbitration. Unless you, Anthem Blue Cross Life and Health Insurance Company and/or Anthem Blue Cross agree

otherwise, the arbitrator may not consolidate more than one person's claims, and may not otherwise preside over any form of a representative or class proceeding. Anthem Blue Cross Life and Health and/or Anthem Blue Cross will provide Insureds, upon request, with an application, or information on how to obtain an application from the neutral arbitration entity, for relief of all or a portion of their share of the fees and expenses of the neutral arbitration entity. Approval or denial of an application in the case of extreme financial hardship will be determined by the neutral arbitration entity.

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 Member Services listed on your identification card.

DEFINITIONS

The meanings of key terms used in this certificate 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 your certificate, 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.

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 Life and Health Insurance Company (Anthem Blue Cross Life and Health) is the company which insures the benefits of the *plan*.

Authorized referral occurs when you, because of your medical needs, require the services of a specialist who is a *non-participating provider,* or require special services or facilities not available at a *contracting hospital*, but only when the referral has been authorized by us before services are rendered and when the following conditions are met:

- there is no *participating provider* who practices in the appropriate specialty, or there is no *contracting hospital* which provides the required services or has the necessary facilities;

- that meets the adequacy and accessibility requirements of state or federal law; and
- you are referred to *hospital* or *physician* that does not have an agreement with Anthem for a covered service by a *participating provider*.

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.

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

Cosmetic services are services or surgery performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance.

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 health conditions* or substance abuse under the supervision of *physicians*.

Designated pharmacy provider is a *participating pharmacy* that has executed a Designated Pharmacy Provider Agreement with us or a *participating provider* that is designated to provide *prescription drugs*, including *specialty drugs*, to treat certain conditions.

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 drug approved by the Food and Drug Administration for general use by the public which requires a prescription before it can be obtained. 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 (medical condition) is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition placing the health of the individual in serious jeopardy, with serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

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.

Group refers to the business entity to which we have issued this *policy*. 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 primarily engaged in providing palliative care (pain control and symptom relief) to terminally ill persons and supportive care to those persons and their families to help them cope with terminal illness. This care may be provided in the home or on an inpatient basis. A hospice must be: (1) certified by Medicare as a hospice; (2) recognized by Medicare as a hospice demonstration site; or (3) accredited as a hospice by the Joint Commission on Accreditation of Hospitals. 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 health condition* or substance abuse), and (2) *residential treatment centers*.

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

Insured person is the *insured retiree* or *insured family member*.

Insured retiree is the primary insured; that is, the person who is allowed to enroll under this *plan* for himself or herself and his or her eligible *family members*.

Intensive In-Home Behavioral Health Program is a range of therapy services provided in the home to address symptoms and behaviors that, as the result of a *mental health condition* or substance abuse disorder, put you and others at risk of harm.

Intensive Outpatient Program is a structured, multidisciplinary behavioral health treatment that provides a combination of individual, group and family therapy in a program that operates no less than 3 hours per day, 3 days per week.

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

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

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.

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

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;

2. Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease;

3. Provided for the diagnosis or direct care and treatment of the medical condition;

4. Within standards of good medical practice within the organized medical community;

5. Not primarily for your convenience, or for the convenience of your *physician* or another provider;

6. Not more costly than an equivalent service, including the same service in an alternative setting, or sequence of services that is medically appropriate and is likely to produce equivalent therapeutic or diagnostic results in regard to the diagnosis or treatment of the patient's illness, injury, or condition; and

7. The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:

    a. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and

    b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable.

When setting or place of service is part of the review, services that can be safely provided to you in a lower cost setting will not be *medically necessary* if they are performed in a higher cost setting. For example we will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a *specialty drug* provided in the outpatient department of a hospital if the *drug* could be provided in a *physician's* office or the home setting.

Mental health conditions, including substance abuse, for the purposes of this *plan*, are those that are listed in the most current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders. *Mental health conditions* include *severe mental disorders* as defined in this plan (see definition of "severe mental disorders").

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 to persons 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 to persons covered under the *plan*.

Non-participating provider is one of the following providers which is NOT participating in a Blue Cross and/or Blue Shield Plan 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.

Partial Hospitalization Program is a structured, multidisciplinary behavioral health treatment that offers nursing care and active individual, group and family treatment in a program that operates no less than 6 hours per day, 5 days per week.

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

Participating provider is one of the following providers which is participating in a Blue Cross and/or Blue Shield Plan 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.

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 or other provider permitted by California law to provide behavioral health treatment services for the treatment of pervasive developmental disorder or autism only
    - A chiropractor (D.C.)
    - An acupuncturist (A.C.)
    - A nurse midwife
    - A nurse practitioner
    - A physician assistant
    - 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 *psychiatric mental health nurse* (R.N.)*
- A registered dietitian (R.D.)* or another nutritional professional* with a master's or higher degree in a field covering clinical nutrition sciences, from a college or university accredited by a regional accreditation agency, who is deemed qualified to provide these services by the referring M.D. or D.O. A registered dietitian or other nutritional professional as described here are covered for the provision of diabetic medical nutrition therapy and nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa only.

- A qualified autism service provider, qualified autism service professional, and a qualified autism service paraprofessional, as described under the benefits for pervasive developmental disorder or autism section.

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

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 *policy* 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 *employee* affected by the change. (The word "plan" here does not mean the same as "plan" as used in ERISA.)

Policy is the Group Policy we have issued to the *group*.

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 *insured persons* no more than the prescription drug negotiated rate. It is also the rate which CVS Caremark Prescription 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 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 disorder.

Psychiatric health facility is an acute 24-hour facility operating within the scope of a state license, or in accordance with a license waiver issued by the State. It must be:

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

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.

Reconstructive surgery is surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (a) improve function; or (b) create a normal appearance, to the extent possible.

Residential treatment center is a provider licensed and operated as required by law, which includes:

- Room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24 hour availability;
- A staff with one or more *doctors* available at all times;
- Residential treatment that takes place in a structured facility-based setting;

- The resources and programming to adequately diagnose, care and treat a *mental health conditions* or substance abuse;
- Facilities that are designated for residential, sub-acute, or intermediate care and that may occur in care systems that provide multiple levels of care; and
- Accreditation by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

The term Residential Treatment Center/Facility does not include a provider, or that part of a provider, used mainly for:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- *Custodial Care*
- Educational care

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 severe mental illness specified in California Insurance Code section 10144.5: 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 most recent edition of 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 (Education Code Section 56320).

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.

Specialist is a *physician* who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has added training in a specific area of health care.

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.

Substance abuse conditions are defined under the definition for *mental health conditions*.

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

Totally disabled family members are *family member*s who are 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 Life and Health Insurance Company or Anthem Blue Cross (an affiliate of Anthem Blue Cross Life and Health).

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 *insured employee* and *insured family members* who are enrolled for benefits under this *plan*.

FOR YOUR INFORMATION

Your Rights and Responsibilities as an Anthem Blue Cross Life and Health Insured Person

As an Anthem Blue Cross Life and Health *insured person* you have rights and responsibilities when receiving health care. As your health care partner, we want to make sure your rights are respected while providing your health benefits. That means giving you access to our network health care providers and the information you need to make the best decisions for your health. As *an insured person*, you should also take an active role in your care.

These are your rights and responsibilities:

You have the right to:

- Speak freely and privately with your health care providers about all health care options and treatment needed for your condition, no matter what the cost or whether it is covered under your plan.
- Work with your doctors to make choices about your health care.
- Be treated with respect and dignity.
- Expect us to keep your personal health information private by following our privacy policies, and state and federal laws.
- Get the information you need to help make sure you get the most from your health plan, and share your feedback. This includes information on:
    - Our company and services
    - Our network of health care providers
    - Your rights and responsibilities
    - The rules of your health plan
    - The way your health plan works
- Make a complaint or file an appeal about:
    - Your health plan and any care you receive
    - Any covered service or benefit decision that your health plan makes
- Say no to care, for any condition, sickness or disease, without having an effect on any care you may get in the future. This includes asking your doctor to tell you how that may affect your health now and in the future.

- Get the most up-to-date information from a health care provider about the cause of your illness, your treatment and what may result from it. You can ask for help if you do not understand this information.

You have the responsibility to:

- Read all information about your health benefits and ask for help if you have questions.
- Follow all health plan rules and policies.
- Choose any primary care physician, also called a PCP, who is in our network if your health plan requires it.
- Treat all doctors, health care providers, and staff with respect.
- Keep all scheduled appointments. Call your health care provider's office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your health care providers to make a treatment plan that you all agree on.
- Inform your health care providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the health care plan that you have agreed on with your health care providers.
- Give us, your doctors and other health care providers the information needed to help you get the best possible care and all the benefits you are eligible for under your health plan. This may include information about other health insurance benefits you have along with your coverage with us.
- Let our Member Services department know if you have any changes to your name, address or family members covered under your plan.

For details about your coverage and benefits, please read your Certificate.

If you would like more information, have comments, or would like to contact us, please go to **www.anthem.com/ca** and select "Contact Us", or you may call the Member Services number on your ID card.

We want to provide high quality benefits and Member Services to our *insured persons*. Benefits and coverage for services given under the plan are governed by the Certificate and not by this Member Rights and Responsibilities statement.

WEB SITE

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

LANGUAGE ASSISTANCE PROGRAM

Anthem introduced its Language Assistance Program to provide certain written translation and oral interpretation services to Californi*an insured persons* 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 and in a timely manner.

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 top 15 languages as determined by state law.

Oral interpretation services are also available in these languages.

In addition, appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats are also available, free of charge and in a timely manner, when those aids and services are necessary to ensure an equal opportunity to participate for individuals with disabilities.

Anthem Blue Cross Life and Health does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

For information on how to file a complaint, please see COMPLAINT NOTICE at the front of this certificate. To file a discrimination complaint, please see GET HELP IN YOUR LANGUAGE at the end of this certificate.

Requesting a written or oral translation is easy. Just contact Member Services by calling the phone number on your ID card to update your language preference to receive future translated documents or to request interpretation assistance. Anthem Blue Cross Life and Health also sends/receives TDD/TTY messages at **1-866-333-4823** or by using the National Relay Service through **711**.

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

IDENTITY PROTECTION SERVICES

Identity protection services are available with our Anthem health plans. To learn more about these services, please visit https://anthemcares.allclearid.com/**.**

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 Member Services 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 Member Services telephone number listed on your ID card.

Get help in your language

Notice of Language Assistance

Curious to know what all this says? We would be too. Here's the English version:

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-888-254-2721. For more help call the CA Dept. of Insurance at 1-800-927-4357. (TTY/TDD: 711)

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

Spanish
Servicios lingüísticos sin costo. Puede tener un intérprete. Puede solicitar que le lean los documentos y algunos puede recibirlos en su idioma. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-888-254-2721. Para obtener ayuda adicional, llame al Departamento de Seguros de California al 1-800-927-4357. (TTY/TDD: 711)

Arabic
يتم تقديم خدمات اللغة دون مقابل. يمكنك الاستعانة بمترجم. ويمكنك المطالبة بأن تُقرأ لك بعض المستندات وأن يُرسل بعضها بلغتك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة التعريف الخاصة بك أو على الرقم 1-888-254-2721.
للحصول على مزيد من المساعدة، يُرجى الاتصال بإدارة كاليفورنيا للتأمين على الرقم 1-800-927-4357. (TTY/TDD: 711)

Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Armenian

Թարգմանչական անվճար ծառայություններ: Մենք կարող ենք Ձեզ թարգմանչի ծառայություններ առաջարկել Կարող ենք տրամադրել ինչ-որ մեկին, ով փաստաթղթերը կկարդա Ձեզ համար և կուղարկի դրանք Ձեր լեզվով: Օգնություն ստանալու համար զանգահարեք մեզ Ձեզ ID քարտի վրա նշված հեռախոսահամարով կամ 1-888-254-2721 համարով: Լրացուցիչ օգնության համար զանգահարեք Կալիֆոռնիայի ապահովագրության նախարարություն հետևյալ հեռախոսահամարով՝ 1-800-927-4357: (TTY/TDD: 711)

Chinese

免費語言服務。您能獲得免費的譯員。您能聽到以您的語言讀出的文件內容，也能獲得以您的語言而寫的部分文件。如需協助，請撥打您的 ID 卡上的號碼或者1-888-254-2721聯絡我們。如需更多協助，請撥打1-800-927-4357 聯絡CA Dept. of Insurance。(TTY/TDD: 711)

Farsi

خدمات رایگان زبانی. می‌توانید یک مترجم شفاهی بگیرید. می‌توانید بخواهید اسناد را برای شما بخوانند و برخی اسناد نیز به زبان خودتان برایتان ارسال شود. برای دریافت کمک، از طریق شماره فهرست شده در کارت شناسایی‌تان و یا از طریق 1-888-254-2721 با ما تماس بگیرید. برای دریافت کمکهای بیشتر با اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید. (TTY/TDD:711)

Hindi

बिना लागत की भाषा सेवाएँ। आप दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेज़ पढ़वा सकते हैं और कुछ दस्तावेज़ आपको आपकी भाषा में भेजे जा सकते हैं। मदद के लिए, हमें अपने ID कार्ड पर सूचीबद्ध नंबर पर या 1-888-254-2721 पर कॉल करें। अधिक मदद के लिए 1-800-927-4357 पर CA बीमा विभाग कोकॉल करें। (TTY/TDD: 711)

Hmong

Tsis Xam Tus Nqi Cov Kev Pab Cuam Ntsig Txog Hom Lus. Koj muaj peev xwm tau txais ib tus neeg txhais lus. Koj muaj peev xwm tau txais cov ntaub ntawv nyeem ua koj hom lus rau koj mloog thiab yuav xa ib co ntaub ntawv sau ua koj hom lus tuaj rau koj. Txog rau kev pab, hu rau peb tus nab npawb xov tooj teev tseg cia nyob rau ntawm koj daim ID los sis 1-888-254-2721. Txog rau kev pab

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ntxiv, hu xov tooj rau Pab Kas Phais Lub Chaw Ua Hauj Lwm CA tus xov tooj 1-800-927-4357. (TTY/TDD: 711)

Japanese
無料言語サービス。通訳サービスを受けられます。希望する言語で文書を読み上げたり、文書を送るサービスも可能です。支援を受けるには、IDカードに記載された番号、または 1-888-254-2721 にお電話ください。支援の詳細は、カリフォルニア州保険局（1-800-927-4357）にお電話ください。(TTY/TDD: 711)

Khmer
សេវាភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលអ្នកបកប្រែម្នាក់។ អ្នកអាចឲ្យគេអានឯកសារផ្សេងៗជូនអ្នក
និងផ្ញើឯកសារជូនអ្នកជាភាសារបស់អ្នក។ ដើម្បីទទួលជំនួយ សូមហៅទូរស័ព្ទមកយើងតាមលេខដែលបានរាយនៅលើប័ណ្ណ ID របស់អ្នក ឬក៏លេខ 1-888-254-2721។ ដើម្បីទទួលជំនួយបន្ថែម សូមហៅទូរស័ព្ទទៅ CA Dept. of Insurance តាមលេខ 1-800-927-4357។(TTY/TDD: 711)

Korean
무료 언어 서비스. 번역사를 이용하실 수 있습니다. 귀하의 언어로 녹음되어 작성된 문서를 받아보실 수 있습니다. 도움을 받으시려면 ID 카드에 기재된 번호 또는 1-888-254-2721로 전화하십시오. 다른 도움이 필요하시면 1-800-927-4357로 보험 CA 부서에 문의 주십시오. (TTY/TDD: 711)

Punjabi
ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਦੇ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਕੋਈ ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਪੜ੍ਹ ਕੇ ਸੁਣਾ ਸਕਦਾ ਹੈ ਅਤੇ ਕੁਝ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਤੁਹਾਨੂੰ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਸਾਨੂੰ ਤੁਹਾਡੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਸੂਚੀਬੱਧ ਨੰਬਰ ਜਾਂ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। ਜ਼ਿਆਦਾ ਮਦਦ ਲਈ, ਸੀਏ ਡਿਪਾਰਟਮੈਂਟ ਔਫ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 ਤੇ ਕਾਲ ਕਰੋ।(TTY/TDD: 711)

Russian
Бесплатные языковые услуги. Вы можете получить услуги устного переводчика. Вам могут прочитать документы или направить некоторые из них на вашем языке. Для получения помощи звоните нам по телефону, указанному на вашей идентификационной карте, или по номеру 1-888-254-2721. Для получения дополнительной помощи звоните в Департамент страхования штата Калифорния по номеру 1-800-927-4357. (TTY/TDD: 711)

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Tagalog
Mga Libreng Serbisyo para sa Wika. Maaari kayong kumuha ng interpreter. Maaari ninyong ipabasa ang mga dokumento at ipadala ang ilan sa mga ito sa inyo sa wikang ginagamit ninyo. Para sa tulong, tawagan kami sa numerong nakalista sa inyong ID card o sa 1-888-254-2721. Para sa higit pang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. (TTY/TDD: 711)

Thai
ไม่มีค่าบริการเกี่ยวกับภาษา ท่านสามารถขอใช้บริการล่ามได้ ท่านสามารถขอให้เจ้าหน้าที่อ่านเอกสารได้ท่านฟังและเอกสารบางอย่างจะส่งถึงท่านโดยใช้ภาษาของท่าน หากต้องการความช่วยเหลือ โปรดโทรหาเราตามหมายเลขที่ระบุอยู่บนบัตรประจำตัวของท่านหรือที่หมายเลข 1-888-254-2721 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรติดตามแผนก CA Dept. of Insurance ที่หมายเลข 1-800-927-4357. (TTY/TDD: 711)

Vietnamese
Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có thông dịch viên. Quý vị có thể yêu cầu đọc tài liệu cho quý vị nghe và yêu cầu gửi một số tài liệu bằng ngôn ngữ của quý vị cho quý vị. Để được trợ giúp, hãy gọi cho số được ghi trên thẻ ID của quý vị hoặc số 1-888-254-2721. Để được giúp đỡ thêm, hãy gọi cho Sở Bảo Hiểm California (California Department of Insurance) theo số 1-800-927-4357. (TTY/TDD: 711)

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It’s important we treat you fairly

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