COUNTY OF SAN DIEGO

January 1, 2016

Your Anthem Blue Cross HMO Plan

Combined Evidence of Coverage and Disclosure Form

Anthem Blue Cross
21555 Oxnard Street
Woodland Hills, California 91367
Phone Number: 800-999-3643
www.anthem.com/ca

This booklet, called the "Combined Evidence of Coverage and Disclosure Form", gives you important information about your health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage. If you have special health care needs, you should read those sections of the Evidence of Coverage that apply to those needs. You can get a copy of the health plan contract from your employer.

Many words used in this booklet are explained in the "Important Words to Know" section. When reading through this booklet, check that section to be sure that you understand what these words mean. Each time these words are used they are *italicized*.

Anthem Blue Cross is the trade name of Blue Cross of California. 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.

Table of Contents

Welcome to Anthem Blue Cross HMO 1

Getting Started 2

Choosing Your Primary Care Doctor 2
If You Need Help Choosing 3
Changing Your Medical Group or Primary Care Doctor 3
Reproductive Health Care Services 5

When You Need Care 6

When You Need Routine Care 6
When You Need a Referral 6
Ready Access 8
Obstetrical and Gynecological Care 9
Care for Mental or Nervous Disorders or Substance Abuse and Pervasive Developmental Disorder or Autism 10
Transgender Services 11
When You Want a Second Opinion 11
When You Need a Hospital Stay 13
When There is an Emergency 14
You Need Urgent Care 15
Triage and Screening Services 16
Telehealth 17
Getting Care When You Are Outside of California 17
Care Outside the United States-BlueCard Worldwide 18
Revoking or Modifying a Referral or Authorization 21
If You and Your Doctor Don't Agree 21
We Want You to Have Good Health 21

Your Benefits at Anthem Blue Cross HMO 22

What are Copays? 23
Here are the Copay Limits 23
Crediting Prior Plan Coverage 24
What We Cover 25

Benefits for Pervasive Developmental Disorder or Autism 51

Medical Management Programs 56

Utilization Review Program 56
Request Categories 59
Decision and Notice Requirements 60
Authorization Program 61

Exceptions to the Medical Management Program 62
Revoking or Modifying an Authorization 63

What We Do Not Cover 64

Kinds of Services You Cannot Get with this Plan 64
Other Services Not Covered 66

Getting Prescription Drugs 71

Preventive Prescription Drugs and Other Items 76
Getting Your Medicine at a Drugstore 81
Getting Your Medicine Through the Mail 84
Getting Your Medicine Through the Specialty Pharmacy 84
What You Will Need to Pay 85
Preferred Generic Program 89
Special Programs 89
Half-tab Program 89
Split Fill Dispensing Program 90
We Cover These Drug Services and Supplies 90
Drug Services and Supplies Not Covered 92

What You Should Know about Your Coverage 97

How Coverage Begins 97
When Are You Covered? 98
If You Want to Enroll a New Child 100
When You Can Enroll Without Waiting. You may enroll without waiting for your employer's next open enrollment period if all of the following are true: 100
Open Enrollment 104
When We Cannot Cancel Your Coverage 104

How Your Coverage Ends 105

A Medical Group Can End its Services to You 110
If You Believe Your Coverage Has Been Cancelled Unfairly 111

Keeping Anthem Blue Cross HMO After Your Coverage Status Changes 112

You or Your Family Members May Choose *COBRA* 112
If You Want to Keep Your Health Plan 113
How Long You Can Be Covered 114
Other Coverage Options Besides COBRA Continuation Coverage 116
Retirement and COBRA 116
If You or a Family Member is Disabled 116

What About After COBRA? 118
CalCOBRA 118
Extension 122

How to Make a Complaint 123

Independent Medical Review of Denials of Experimental or Investigative Treatment 126
Independent Medical Review of Complaints Involving a Disputed Health Care Service 129
Department Of Managed Health Care 131
Arbitration 132

Other Things You Should Know 135

Using a Claim Form to Get Benefits 135
Getting Repaid by a Third Party 135
Coordination of Benefits 137
If You Qualify for Medicare 141
Other Things You Should Know 143

Important Words to Know 157

For Your Information 171

Welcome to Anthem Blue Cross HMO

Thank you for choosing our health plan.

Anthem Blue Cross HMO is here to serve you. This booklet tells you all about your health care plan and its benefits.

- It tells you about what kinds of care this *plan* covers and doesn't cover.
- It tells you what you have to do, or what has to happen so you can get benefits.
- It tells you what kinds of *doctors* and other *health care providers* you can go to for care.
- It tells you about options you may have if your coverage ends.

Take some time to read it now.

- Keep this booklet handy for any questions you may have later on.

We're here to help you!!

We want to give you the help you need. If you have any questions,

- Please call us at the 800 number on your Member ID card for Anthem Blue Cross HMO Customer Service.
- Or write us at:

Anthem Blue Cross

Attn.: Anthem Blue Cross HMO

P.O. Box 4089

Woodland Hills, CA. 91365

website: www.anthem.com/ca

We can help you get the health care you need.

Getting Started

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

Choosing Your Primary Care Doctor

When you enroll you should choose a *primary care doctor*. Your *primary care doctor* will be the first *doctor* you see for all your health care needs. If you need special kinds of care, this *doctor* will refer you to other kinds of *health care providers*.

Your *primary care doctor* will be part of an Anthem Blue Cross HMO contracting *medical group*. There are two types of Anthem Blue Cross HMO *medical groups*.

- A *primary medical group (PMG)* is a group practice staffed by a team of *doctors*, nurses, and other *health care providers*.
- An *independent practice association (IPA)* is a group of *doctors* in private offices who usually have ties to the same *hospital*.

You and your family members can enroll in whatever *medical group* is best for you, that is accepting new patients.

- You must live or work within fifteen (15) miles or thirty minutes (30) of the *medical group.*
- You and your family members do not have to enroll in the same *medical group*.
- For a child, you may choose a *primary care doctor* who is a pediatrician.

We publish a directory of *Anthem Blue Cross HMO providers*. You can get a directory from your plan administrator (usually your employer) or from us. The directory lists all *medical groups, IPAs*, and the *primary care doctors* and *hospitals* that are affiliated with each *medical group* or *IPA*. You may call our *Customer Service number* on your Member ID card or you may write to us and ask us to send you a directory. You may also search for an *Anthem Blue*

Cross HMO provider using the "Provider Finder" function on our website at **www.anthem.com/ca**. The listings include the credentials of our *primary care doctors* such as specialty designations and board certification.

If You Need Help Choosing

We can help you choose a *doctor* who will meet your needs. We can also answer questions about a *health care provider's* license or training.

- Call our *Customer Service number* on your Member ID card.
- Talk to the *Anthem Blue Cross HMO coordinator* at your *medical group*. Your *Anthem Blue Cross HMO coordinator* can also help you:
  - Understand the services and benefits you can get through Anthem Blue Cross HMO.
  - Get answers to any questions you may have about your *medical group*.

Changing Your Medical Group or Primary Care Doctor

You may find out later on that you need to change your *medical group*. You may move or you may have some other reason. Here's what you can do:

- Ask your employer for a *membership change form*. Fill out the form, sign it and turn it in to your employer.

OR

- Call our *Customer service number* on your Member ID card. We will need to know why you want to change your *medical group*.

If you let us know you want to change your *medical group* by the fifteenth of the month, the change will take place on the first day of the next month as long as you aren't still getting treatment from your *doctor* or *specialist* within the *medical group*. If you let us

know you want to change your *medical group* after the fifteenth of the month, the change will take place on the first day of month following the next month as long as you aren't still getting medical treatment from your *doctor* or *specialist* within the *medical group*.

We will approve your request for a change if the *primary care doctor* within the new *medical group* you've picked is accepting new patients or is accepting new patients who are in the course of treatment. As when you first enroll, you must live or work within fifteen (15) miles or thirty minutes (30) of the new *medical group.*

We will ask you to explain any treatment you are currently receiving.

If you change your *medical group*, any referrals given to you by your previous *medical group* will not be accepted by your new *medical group*. If you still require a referral for care, you will need to request a referral from your new *primary care doctor* within your new *medical group*. This means your referral may require evaluation by your new *medical group* or us.

Please note that we or your new *medical group* may refer you to a different provider than the one approved by your prior *medical group*.

If you are changing *medical groups*, you may help the change go more smoothly by notifying your HMO Coordinator, if you currently have one assigned.

Anthem must approve your request to transfer and you must be assigned to the new *medical group* or *primary care doctor* before you obtain medical care from the new *medical group* or *primary care doctor*. If you obtain medical care from a different *medical group* or *primary care doctor* than you are assigned to, those services may be considered services provided by a non-*Anthem Blue Cross HMO provider*. If they are provided by a non-*Anthem Blue Cross HMO provider*, those services will not be covered and you will be responsible for the billed charges for those services.

When you move your residence or your place of employment more than thirty (30) minutes travel time or fifteen (15) miles from *primary care doctor*s available in your current *medical group*, you must notify Anthem in writing and request a transfer to another

medical group that is located within thirty (30) minutes travel time or fifteen (15) miles of your new residence or place of employment. Anthem must be notified within thirty-one (31) days of your move in order to ensure timely access to services near you.

If you move outside of the Anthem Blue Cross HMO licensed service area, but you continue to reside in the state of California, contact Anthem to enroll in a different type of health care plan.

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 *doctor*, *medical group*, *independent practice association*, or clinic, or call us at the *Customer Service number* listed on your Member ID card to ensure that you can obtain the health care services that you need.

When You Need Care

When You Need Routine Care

- **Call your *primary care doctor's* office.**
- **Make an appointment.**

  When you call:

  - Tell them you are an Anthem Blue Cross HMO *member*.
  - Have your Member ID card handy. They may ask you for:
    - Your group number
    - Member I.D. number
    - Office visit *copay*
  - Tell them the reason for your visit.
- **When you go for your appointment, bring your Member ID card.**
- **Please call your *doctor's office* if you cannot come for your appointment, or if you will be late.**
- **If you need care after normal office hours, call your *primary care doctor's* office for instructions.**

When You Need a Referral

Your *doctor* may refer you to another *doctor* or *health care provider* if you need special care. Your *primary care doctor* must OK all the care you get except for *emergency services.*

Your *doctor's medical group,* or your *primary care doctor* if they are not part of a *medical group*, has to agree that the service or care you will be getting from the other *health care provider* is *medically necessary***.** Otherwise it won't be covered.

- You will need to make the appointment at the other *doctor's* or *health care provider's office*.

- Your *primary care doctor* will give you a referral form to take with you to your appointment. This form gives you the OK to get this care. If you don't get this form, ask for it or talk to your *Anthem Blue Cross HMO coordinator*.

- You may have to pay a *copay*. If your *primary care doctor* refers you to a non-*Anthem Blue Cross HMO provider*, and you have to pay a *copay*, any fixed dollar *copay* will be the same as if you had the same service provided by an *Anthem Blue Cross HMO provider*. But, if your *copay* is other than a fixed dollar *copay*, while your benefits levels will not change, your out-of-pocket cost may be greater if the services are provided by a non-*Anthem Blue Cross HMO provider*. You shouldn't get a bill, unless it is for a *copay*, for this service. If you do, send it to your *Anthem Blue Cross HMO coordinator* right away. The *medical group*, or *primary care doctor* if they are not part of a *medical group*, will see that the bill is paid.

Standing Referrals. If you have a condition or disease that requires continuing care from a specialist or is life-threatening, degenerative, or disabling (including HIV or AIDS), your *primary care doctor* may give you a *standing referral* to a *specialist* or *specialty care center*. The referral will be made if your *primary care doctor*, in consultation with you, and a *specialist* or *specialty care center*, if any, determine that continuing specialized care is *medically necessary* for your condition or disease.

If it is determined that you need a *standing referral* for your condition or disease, a treatment plan will be set up for you. The treatment plan:

- Will describe the specialized care you will receive;

- May limit the number of visits to the *specialist*; or

- May limit the period of time that visits may be made to the *specialist*.

If a *standing referral* is authorized, your *primary care doctor* will determine which *specialist* or *specialty care* center to send you to in the following order:

- First, an Anthem Blue Cross HMO contracting *specialist* or *specialty care center* which is associated with your *medical group*;
- Second, any Anthem Blue Cross HMO contracting *specialist* or *specialty care center*; and
- Last, any *specialist* or *specialty care center*;

that has the expertise to provide the care you need for your condition or disease.

After the referral is made, the *specialist* or *specialty care center* will be authorized to provide you health care services that are within the *specialist's* area of expertise and training in the same manner as your *primary care doctor*, subject to the terms of the treatment plan.

Remember: We only pay for the number of visits and the type of special care that your *primary care doctor* OK's. Call your *doctor* if you need more care. **If your care isn't approved ahead of time, you will have to pay for it (except for *emergency services.)***

Ready Access

There are two ways you may get special care without getting an OK from your *medical group*. These two ways are the "Direct Access" and "Speedy Referral." programs. **Not all medical groups take part in the Ready Access program. See your Anthem Blue Cross HMO Directory for those that do.**

Direct Access. You may be able to get some special care without an OK from your *primary care doctor*. We have a program called "Direct Access", which lets you get special care, without an OK from your *primary care doctor* for:

- Allergy

- Dermatology
- Ear/Nose/Throat

Ask your *Anthem Blue Cross HMO coordinator* if your *medical group* takes part in the "Direct Access" program. If your *medical group* participates in the Direct Access program, you must still get your care from a *doctor* who works with your *medical group*. The *Anthem Blue Cross HMO coordinator* will give you a list of those *doctors*.

Speedy Referral. If you need special care, your *primary care doctor* may be able to refer you for it without getting an OK from your *medical group* first. The types of special care you can get through Speedy Referral depend on your *medical group*.

Obstetrical and Gynecological Care

Obstetrical and gynecological services may be received directly, without obtaining referral from your *primary care doctor*, from an obstetrician and gynecologist or family practice physician who is a member of your *medical group*, or who has an arrangement with your *medical group* to provide care for its patients, and who has been identified by your *medical group* as available for providing obstetrical and gynecological care.

- A *doctor* specializing in obstetrical or gynecological care may refer you to another *doctor* or *health care provider* and order related obstetrical and gynecological items and services if you need additional *medically necessary* care.
- The conditions for a referral from a *doctor* specializing in obstetrical or gynecological care are the same conditions for a referral from your *participating care doctor*. See **When You Need a Referral**.
- Ask your *Anthem Blue Cross HMO coordinator* for the list of OB-GYN health care providers you must choose from.

Care for Mental or Nervous Disorders or Substance Abuse and Pervasive Developmental Disorder or Autism

You may get care for the treatment of *mental or nervous disorders* or substance abuse and pervasive developmental disorder or autism without getting an OK from your *medical group*. In order for this care to be covered, you must go to an *Anthem Blue Cross HMO provider*. Some services require that we review and OK care in advance. Please see "Mental or Nervous Disorders/Substance Abuse" in the section called "Your Benefits At Anthem Blue Cross HMO" and the section "Benefits for Pervasive Developmental Disorder or Autism" for complete information.

You can get an Anthem Blue Cross Behavioral Health Network directory listing these providers from your plan administrator (usually your employer) or from us as follows:

- You can call our *Customer Service number* shown on your Member ID card or you may write to us and ask us to send you a directory. Ask for the Behavioral Health Network directory.
- You can also search for an *Anthem Blue Cross HMO provider* using the "Provider Finder" function on our website at www.anthem.com/ca. Be sure to select the "Behavioral Health Professionals" option on the next screen following your selection of plan category.

In addition, if you are a new *member* and you enrolled in this *plan* because the employer changed health plans, and you are getting care for an acute, serious, or chronic *mental or nervous disorder* or for substance abuse from a *doctor* or other *health care provider* who is not part of the Anthem Blue Cross HMO network, you may be able to continue your course of treatment with that *doctor* or *health care provider* for a reasonable period of time before transferring to an *Anthem Blue Cross HMO provider*. To ask for this continued care or to get a copy of our written policy for this continued care, please call our *Customer Service number* shown on your Member ID card.

Transgender Services

You may get coverage for services and supplies provided in connection with gender transition without getting an OK from your *medical group*. You must obtain our approval in advance for all transgender services in order for these services to be covered by this *plan* (see "Medical Management Programs" for details). No benefits are payable for these services if our approval is not obtained. Please see "Transgender Services" in the section called "Your Benefits At Anthem Blue Cross HMO" for complete information.

When You Want a Second Opinion

You may receive a second opinion about care you receive from:

- Your *primary care doctor*, or
- A *specialist* to whom you were referred by your *primary care doctor*.

Reasons for asking for a second opinion include, but are not limited to:

- Questions about whether recommended surgical procedures are reasonable or necessary.
- Questions about the diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including but not limited to a serious chronic condition.
- The clinical indications are not clear or are complex and confusing.
- A diagnosis is in doubt because of test results that do not agree.
- The first *doctor* or *health care provider* is unable to diagnose the condition.
- The treatment plan in progress is not improving your medical condition within an appropriate period of time.

- You have tried to follow the treatment plan or you have talked with the *doctor* or *health care provider* about serious concerns you have about your diagnosis or plan of care.

To ask for a second opinion about care you received from your *primary care doctor* if your *primary care doctor* is part of a *medical group*, call your *primary care doctor* or your *Anthem Blue Cross HMO coordinator* at your *medical group*. The second opinion will be provided by a qualified *doctor* or *health care provider* of your choice who is part of your *medical group*.

To ask for a second opinion about care you received from:

- Your *primary care doctor* if he or she is an independently contracting *primary care doctor* (not part of a *medical group*), or
- Any *specialist*,

please call the Customer Service number shown on your ID card. The Customer Service Representative will verify your Anthem Blue Cross HMO membership, get preliminary information, and give your request to an RN Case Manager. The second opinion will be provided by a qualified *doctor* or *health care provider* of your choice who is part of the Anthem Blue Cross network. Please note that if your *primary care doctor* is part of a *medical group*, the *doctor* or *health care provider* who provides the second opinion may not necessarily be part of your *medical group*.

For any second opinion, if there is no appropriately qualified *doctor* or *health care provider* in the Anthem Blue Cross network, we will authorize a second opinion by another appropriately qualified *doctor* or *health care provider*, taking into account your ability to travel.

For all second opinions, a decision will be made promptly after your request and any necessary information are received. Decisions on urgent requests are made within a time frame appropriate to your medical condition but no later than 72 hours after you make your request. For non-urgent requests, a decision

will be made within two business days after any necessary information is received.

When approved, your *primary care doctor* or Case Manager helps you with selecting a *doctor* or *health care provider* who will provide the second opinion within a reasonable travel distance and makes arrangements for your appointment at a time convenient for you and appropriate to your medical condition. If your medical condition is serious, your appointment will be scheduled within no more than seventy-two (72) hours. You must pay only your usual *copay* for the second opinion.

An approval letter is sent to you and the *doctor* or *health care provider* who will provide the second opinion. The letter includes the services approved and the date of your scheduled appointment. It also includes a telephone number to call if you have questions or need additional help. Approval is for the second opinion consultation only. It does not include any other services such as lab, x-ray, or additional treatment. You and your *primary care doctor* or *specialist* will get a copy of the second opinion report, which includes any recommended diagnostic testing or procedures. When you get the report, you and your *primary care doctor* or *specialist* should work together to determine your treatment options and develop a treatment plan. Your *medical group* (or your *primary care doctor*, if he or she is an independently contracting *primary care doctor*) must authorize all follow-up care.

You may appeal a disapproval decision by following our complaint process. Procedures for filing a complaint are described later in this booklet (see "How to Make a Complaint") and in your denial letter.

If you have questions or need more information about this program, please contact your *Anthem Blue Cross HMO coordinator* at your *medical group* or call the *Customer Service number* shown on your Member ID card.

When You Need a Hospital Stay

There may be a time when your *primary care doctor* says you need to go to the *hospital*. If it is not an *emergency*, the *medical group*

will look into whether or not it is *medically necessary*. If the *medical group* OK's your *hospital stay*, you will need to go to a *hospital* that works with your *medical group*.

When There is an Emergency

If you need *emergency services*, get the medical care you need right away. In some areas, there is a 9-1-1 emergency response system that you may call for *emergency services* (this system is to be used only when there is an *emergency* that requires an emergency response).

Once you are stabilized, your *primary care doctor* must OK any care you need after that.

- Ask the *hospital* or emergency room *doctor* to call your *primary care doctor*.
- Your *primary care doctor* will OK any other *medically necessary* care or will take over your care.

You may need to pay a *copay* for emergency room services. A *copay* is a set amount you must pay for services. We cover the rest.

If You Are In-Area. You are in-area if you are 15-miles or 30-minutes or less from your *medical group* (or 15-miles or 30-minutes or less from your *medical group's hospital*, if your *medical group* is an *independent practice association*).

If you need *emergency services*, get the medical care you need right away. If you want, you may also call your *primary care doctor* and follow his or her instructions.

Your *primary care doctor* or *medical group* may:

- Ask you to come into their office;
- Give you the name of a *hospital* or emergency room and tell you to go there;
- Order an ambulance for you;

- Give you the name of another doctor or medical group and tell you to go there; or
- Tell you to call the 9-1-1 emergency response system.

If You're Out of Area. You can still get *emergency services* if you are more than 15-miles or 30-minutes away from your *primary care doctor* or *medical group.*

If you need *emergency services*, get the medical care you need right away (follow the instructions above for When There is an Emergency). In some areas, there is a 9-1-1 emergency response system that you may call for *emergency services* (this system is to be used only when there is an *emergency* that requires an emergency response). You must call us within 48 hours if you are admitted to a *hospital*.

Remember:

- We won't cover services that don't fit what we mean by *emergency services.*
- Your *primary care doctor* must OK care you get once you are stabilized, unless Anthem Blue Cross HMO OKs it.
- Once your *medical group* or Anthem Blue Cross HMO give an OK for *emergency services*, they cannot withdraw it.

You Need Urgent Care

If You Are In-Area. You are in-area if you are 15-miles or 30-minutes or less from your *medical group* (or 15-miles or 30-minutes or less from your *medical group's hospital*, if your *medical group* is an *independent practice association*).

If you are in area, call your *primary care doctor* or *medical group.* Follow their instructions.

Your *primary care doctor* or *medical group* may:

- Ask you to come into their office;
- Give you the name of a *hospital* or emergency room and tell you to go there;
- Order an ambulance for you;
- Give you the name of another doctor or medical group and tell you to go there; or
- Tell you to call the 9-1-1 emergency response system.

If You're Out of Area. You can get *urgent care* if you are more than 15-miles or 30-minutes away from your *primary care doctor* or *medical group.*

For *urgent care*, if care can't wait until you get back to make an appointment with your *primary care doctor,* get the medical care you need right away. You must call us within 48 hours if you are admitted to a *hospital*.

If you need a *hospital stay* or long-term care, we'll check on your progress. When you are able to be moved, we'll help you return to your *primary care doctor's* or *medical group's* area.

Remember:

- We won't cover services that don't fit what we mean by *urgent care.*
- Your *primary care doctor* must OK care you get once you are stabilized, unless Anthem Blue Cross HMO OKs it.

Triage and 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, please contact your *primary care doctor*. In addition, triage or screening services are available to you from us by telephone. Triage or screening services are the evaluation of your health by a *doctor* or 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.

Telehealth

This *plan* provides benefits for covered services that are appropriately provided through telehealth, subject to the terms and conditions of the *plan* including the requirement that all care must be provided or authorized by your *medical group* or *primary care doctor*, except as specifically stated in this booklet. In-person contact between a *health care provider* and the patient is not required for these services, and the type of setting where these services are provided is not limited. "Telehealth" is the means of providing health care services using information and communication technologies in the consultation, diagnosis, treatment, education, and management of the patient's health care when the patient is located at a distance from the *health care provider*. Telehealth does not include consultations between the patient and the *health care provider*, or between *health care providers*, by telephone, facsimile machine, or electronic mail.

Getting Care When You Are Outside of California

If you or your family members will be away from home for more than 90 days, you may be able to get a *guest membership* in a *medical group* in the city you are visiting.

- Before you leave home, call the Anthem Blue Cross HMO *Customer service number* on your Member ID card.
- Ask for the Guest Membership Coordinator.
- We will send you forms to fill out.
- If there is a *medical group* taking part in the national network in the city you will be visiting, you'll be a guest member while you're away from home.
- The benefits you will get may not be the same as the benefits you would get at home.

Even without a *guest membership*, you can get *medically necessary* care (*urgent care*, *emergency services*, or follow-up care) when you are away from home.

- **If you are traveling outside California,** and need health care because of a non-emergency illness or injury, call the BlueCard Access 800 number, 1-800-810-BLUE (2583).
- **The BlueCard Access Call Center will tell you if there are *doctors* or *hospitals* in the area** that can give you care. They will give you the names and phone numbers of nearby *doctors* and *hospitals* that you go to or call for an appointment.
- **If it's an *emergency*, get medical care right away.** You or a member of your family must call us within 48 hours after first getting care.
- **The provider may bill you for these services**. Send these bills to us. We will make sure the services were *emergency services* or *urgent care*. You may need to pay a *copay*.

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

Care Outside the United States-BlueCard Worldwide

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

- Before you leave home, call the *Customer Service number* listed on your Member ID card for coverage details. **You have coverage for services and supplies furnished only in connection with *urgent care* or an *emergency* when travelling outside the United States.**
- Always carry your current Member ID card.

- In an *emergency* or if you need *urgent care*, seek medical treatment immediately.
- **The BlueCard Worldwide Service Center is available 24 hours a day, seven days a week toll-free at (800) 810-BLUE (2583) or by calling collect at (804) 673-1177.** An assistance coordinator, along with a medical professional, will arrange a *doctor* appointment or hospitalization, if needed.
- If you are admitted to a *hospital*, you must call us within 48 hours at the *Customer Service number* listed on your Member ID card. This number is different than the phone numbers listed above for BlueCard Worldwide.

Call the BlueCard Worldwide Service Center in these non-emergent situations:

- **You need to find a *doctor* or *hospital* or need medical assistance services.** An assistance coordinator, along with a medical professional, will arrange a *doctor* appointment or hospitalization, if needed.
- **You need to be hospitalized or need inpatient care.** After calling the Service Center, you must also call us at the *Customer Service number* listed on your Member ID card for pre-service review to determine whether the services are covered. Please note that this number is different than the phone numbers listed above for BlueCard Worldwide.

Payment Information.

- **Participating BlueCard Worldwide hospitals.** When you make arrangements for hospitalization through BlueCard Worldwide, you should not need to pay upfront for inpatient care at participating BlueCard Worldwide *hospitals* except for the out-of-pocket costs (noncovered services, deductible, copays and coinsurance) you normally pay. The *hospital* will submit your claim on your behalf.
- **Doctors and/or non-participating hospitals.** You will need to pay upfront for outpatient services, care received from a

doctor, and inpatient care not arranged through the BlueCard Worldwide Service Center. Then you can complete a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim Filing.

- **The hospital will file your claim** if the BlueCard Worldwide Service Center arranged your hospitalization. You will need to pay the hospital for the out-of-pocket costs you normally pay.
- **You must file the claim** for outpatient and *doctor* care, or inpatient care not arranged through the BlueCard Worldwide Service Center. You will need to pay the health care provider and subsequently send an international claim form with the original bills to Anthem.

Additional Information About BlueCard Worldwide 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 BlueCard Worldwide Service Center, or online at:

  www.bcbs.com/bluecardworldwide.

  The address for submitting claims is on the form.

Revoking or Modifying a Referral or Authorization

A referral or authorization for services or care that was approved by your *medical group*, your *primary care doctor*, or by us may be revoked or modified prior to the services being rendered for reasons including but not limited to the following:

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

If You and Your Doctor Don't Agree

If you think you need a certain kind of care, but your *doctor* or *medical group* isn't recommending it, you have a right to the following:

- **Ask for a written notice** of being denied the care you felt you needed. You should get this notice within 48 hours.
- **Your *doctor* should give you a written reason** and another choice of care within 48 hours.
- **You can make a formal appeal** to the *medical group* and to Anthem. See "How to Make a Complaint" on a later page.

We Want You to Have Good Health

Ask about our many programs to:

- Educate you about living a healthy life.
- Get a health screening.
- Learn about your health problem.

For more information, please call us at our *Customer service number* shown on your Member ID card.

Your Benefits at Anthem Blue Cross HMO

It's important to remember:

- The benefits of this *plan* are given only for those services that the *medical group* finds are *medically necessary*.
- Care must be received from your *primary care doctor* or another *Anthem Blue Cross HMO Provider* to be a covered service under this *plan*. If you use a non-*Anthem Blue Cross HMO provider*, your entire claim will be denied unless:
  - The services are for *emergency* or *urgent care*; or
  - The services are approved in advance by us as an *authorized referral*.
- Just because a *doctor* orders a service, it doesn't mean that:
  - The service is *medically necessary*; or
  - This *plan* covers it.
- If you have any questions about what services are covered, read this booklet, or give us a call at the number on your Member ID card.
- All benefits are subject to coordination with benefits available under certain other plans.
- We have the right to be repaid by a third party for medical care we cover if your injury, disease or other health problem is their fault or responsibility.
- Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. *Members* seeking *emergency services*, *urgent care* services or an *authorized referral* in accordance with this *plan* from non-*Anthem Blue Cross HMO provider* could be balanced billed by the non-*Anthem Blue Cross HMO 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.

What are Copays?

A *copay* is a set amount you pay for each medical service or *prescription drug*. You need to pay a *copay* for some services given under this *plan*, but many other supplies and services do not need a *copay*. Usually, you must pay the *copay* at the time you get the services. The *copays* you need to pay for services are shown in the next section.

If you do not pay your *copay* within 31 days from the date it's due, we have the right to cancel your coverage under the *plan*. To find out how your coverage is cancelled if you do not pay your *copay*, see "How Your Coverage Ends", in the section "What You Should Know about Your Coverage", (see Table of Contents).

Here are the Copay Limits

If you pay more than the *Copay Limits* shown below in one calendar year (January through December), you won't need to pay any more *copays* for the rest of the year.

Per Number of Members	Copay Limits

- One *Member*.....**$2,000**
- Two *Members* of the Same Family.....**$4,000***
- Three or More *Members* of the Same Family.....**$6,000***

  *But, not more than $2,000 for any one *Member* in a Family.

The following won't apply to the *Copay Limits*:

- For *infertility*, any *copay* for diagnosis and testing for finding out about it.

- Amounts in excess of the *prescription drug maximum allowed amount.*

Crediting Prior Plan Coverage

If you were covered by your employer's *prior plan* immediately before your employer signs up with us, with no lapse in coverage, then you will get credit for any accrued deductible and, if applicable and approved by us, any *Copay Limit* under the *prior plan*. This does not apply to individuals who were not covered by the *prior plan* on the day before your employer's coverage with us began, or who join your employer later.

If your employer moves from one of our plans to another, (for example, changes its coverage from HMO to PPO), and you were covered by the other product immediately before enrolling in this product with no break in coverage, then you may get credit for any accrued deductible and any *Copay Limit*, if applicable and approved by us.

If your employer offers more than one of our products, and you change from one product to another with no break in coverage, you will get credit for any accrued deductible and, if applicable, any *Copay Limit*.

If your employer offers coverage through other products or carriers in addition to ours, and you change products or carriers to enroll in this product with no break in coverage, you will get credit for any accrued deductible and any *Copay Limit* under this *plan*.

This Section Does Not Apply To You If:

- Your employer moves to this *plan* at the beginning of each year;
- You change from one of our individual policies to a group plan;
- You change employers; or
- You are a new *member* who joins after your employer initial enrollment with us.

What We Cover

We list benefits for the services and supplies in this section. Any *copays* you must pay are shown next to the service or supply. We list things **we do NOT cover in the next section**.

Remember:

Your *primary care doctor* and your *medical group* must give or OK all your care.

Doctor Care (or services of a Health Professional)	Copay
♦ Office visits for a covered illness, injury or health problem	**$30**
♦ Home visits, when approved by your *medical group*, at the *doctor's* discretion	**$30**
♦ Injectable or infused medications* given by the *doctor* in the office	**30%** with a maximum copay of **$150**
*This does not include immunizations prescribed by your *primary care doctor* nor allergy serums.	
♦ Surgery in *hospital, surgery center* or *medical group* and surgical assistants	**No charge**
♦ Anesthesia services	**No charge**
♦ *Doctor* visits during a *hospital stay*	**No charge**
♦ Visit to a *specialist*	**$45**
♦ *Medically necessary* acupuncture OK'd by your *primary care doctor*	**$30**

Preventive Care Services	Copay

Covered *preventive care services* include screenings, services and supplies, when you have no current symptoms or prior history of a medical condition associated with that screening or service.

- Full physical exams and periodic check-ups ordered by your *primary care doctor* including well-woman visits ..... **No charge**
- Vision or hearing screenings* ..... **No charge**
- Immunizations prescribed by your *primary care doctor* ..... **No charge**
- Health education programs given by your *primary care doctor* or the *medical group* ..... **No charge**
- Health screenings as prescribed by your *doctor* or *health care provider*…… ..... **No charge**
  - Health screenings include: mammograms, Pap tests and any cervical cancer screening tests including human papillomavirus (HPV), prostate cancer screenings, and other medically accepted cancer screening tests, screenings for high blood pressure, type 2 diabetes mellitus, cholesterol, and obesity.**
- Preventive services for certain high-risk populations as determined by your *doctor*, based on clinical expertise. ..... **No charge**
- Counseling and intervention services as part of a full physical exam or periodic check-up for the purpose of education or counseling on potential health concerns, including sexually transmitted infections, human immunodeficiency virus (HIV), contraception, and smoking cessation counseling. ..... **No charge**

- HIV testing, regardless of whether testing is related to a primary diagnosis..... **No charge**

- Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following: ..... **No charge**

  - All FDA-approved contraceptive *drugs*, devices, and other products for women, including over-the-counter items, if prescribed by your *doctor*. 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 your *doctor*, the prescribed FDA-approved form of contraception will be covered as preventive care under this section.

    In order to be covered as preventive care, contraceptive *drugs* must be either a *generic* or *single source brand name drug* (those without a *generic* equivalent). *Multi-source brand name drugs* (those with a *generic* equivalent) will be covered as *preventive care services* when *medically necessary*, otherwise they will be covered under your *plan's* prescription drug benefits (see "Getting Prescription Drugs").

- Breast feeding support, supplies, and counseling ordered by your *primary care doctor* or *medical group*. One breast pump will be covered per pregnancy under this benefit.
- Gestational diabetes screening.
- Preventive prenatal care.
- Screening for iron deficiency anemia in pregnant women.
- Breast cancer (BRCA) testing, if appropriate, in conjunction with genetic counseling and evaluation.

* Vision screening includes a vision check by your *primary care doctor* to see if it is *medically necessary* for you to have a complete vision exam by a vision *specialist*. If OK'd by your *primary care doctor*, this may include an exam with diagnosis, a treatment program and refractions. Hearing screenings include tests to diagnose and correct hearing.

** This list is not exhaustive. Preventive tests and screenings with a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF), or those supported by the Health Resources and Services Administration (HRSA) will be covered at no charge.

See the definition of "Preventive Care Services" in the "Important Words to Know" section for more information about services that are covered by this *plan* as *preventive care services*.

Diabetes	**Copay**

♦ Equipment and supplies used for the treatment of diabetes (see below)..... **See "Medical Equipment"**

- Blood glucose monitors, including monitors designed to help the visually impaired, and blood glucose testing strips.
- Insulin pumps

- Pen delivery systems for insulin administration (non-disposable).
- Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin.

♦ Podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes-related complications ..... **See "Prosthetic Devices"**

♦ Diabetes education program services supervised by a *doctor* which include:.....**$30**

- Teaching you and your family members about the disease process and how to take care of it; and
- Training, education, and nutrition therapy to enable you to use the equipment, supplies, and medicines needed to manage the disease.

♦ The following items are covered under your *drug* benefits .....**See "Getting Prescription Drugs"**

- Insulin, glucagon, and other *prescription drugs* for the treatment of diabetes.
- Insulin syringes, disposable pen delivery systems for insulin administration.
- Testing strips, lancets, and alcohol swabs.

Screenings for gestational diabetes are covered under your Preventive Care Services benefit. Please see that provision for further details.

General Medical Care (In a Non-Hospital-Based Facility)	**Copay**

♦ Hemodialysis treatment, including treatment at home if OK'd by the *medical group* **$45**

♦ Medical social services .....**No charge**

- Chemotherapy **$45**
- Radiation therapy **$45**
- Infusion therapy, including but not limited to Parenteral Therapy and Total Parental Nutrition (TPN).....**$45**
- Allergy tests and care **$30**
- X-ray and laboratory tests:
  - *Advanced imaging procedures*.....**$100** per test
  - Genetic testing (not including *medically necessary* genetic testing of the fetus or newborn or BRCA testing) ..... **No charge**
  - All other x-ray and laboratory tests ..... **No charge**
- Smoking cessation programs for nicotine dependency..... **No charge**

  Prescription drugs to help you stop smoking or reduce your dependence on tobacco products, as well as over-the-counter nicotine replacement products (limited to nicotine patches and gum) are covered when obtained with a *doctor's prescription*. These *drugs* and products will be covered as *preventive care services*. See "Getting Prescription Drugs".

Pregnancy or Maternity Care	**Copay**

Medical services for an enrolled *member* are provided for pregnancy and maternity care, including the following services: Prenatal, postnatal, and postpartum care, ambulatory care services (including ultrasounds, fetal non-stress tests, *doctor* 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.

- Office visit.....**$30**
- *Doctor's* services for normal delivery or cesarean section .....**No charge**
- *Hospital* services
  - Inpatient services.....**$200** per admission
  - Outpatient covered services.....**No charge**
- Genetic testing, when *medically necessary*.....**No charge**
- *Hospital* services for routine nursery care of your newborn child if the newborn child's natural mother is an enrolled *member*.....**No charge**

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

Note: For inpatient *hospital* services related to childbirth, we will provide at least 48 hours after a normal delivery or 96 hours after a cesarean section, unless the mother and her *doctor* decide on an earlier discharge. Please see the section called "For Your Information" for a statement of your rights under federal law regarding these services.

Infertility and Birth Control	**Copay**

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive Care Services" benefit.

- Diagnosis and testing for *infertility*.....**50%***

- Sterilization for females ..... **No Charge**

  Sterilizations for females will be covered under the "Preventive Care Services benefit. Please see that provision for further details.

- Sterilization for males **$50**
- Family planning services..... **No charge**
- Shots and implants for birth control** ..... **No charge**
- Intrauterine contraceptive devices (IUDs) and diaphragms, dispensed by a *doctor*** ..... **No charge**
- *Doctor's* services to prescribe, fit and insert an IUD or diaphragm**..... **No Charge**

  ***Note:** The **50%** *copay* made for *infertility* services will not be applied to the "*Copay Limits*."

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

Mastectomy	**Copay**
♦ Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema	**See *copays* that apply**
♦ Reconstructive surgery of both breasts performed to restore symmetry following a mastectomy	**See *copays* that apply**

Reconstructive Surgery	**Copay**
♦ Reconstructive surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of	

improving bodily function, reducing symptoms or creating a normal appearance, including *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 .....**See *copays* that apply**

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

Rehabilitative Care	**Copay**

You may have **up to a 60 day period of care** after an illness or injury. The 60 day period of care starts with the first visit for rehabilitative care. The 60 day limit does not limit the number of visits or treatments you get within the 60 day period. If you need more than the 60 day period of care, your *primary care doctor* must get the OK from your *medical group* or Anthem. It must be shown that more care is *medically necessary*. Your *medical group* or Anthem will OK the extra visits or treatments. While there is no limit on the length of the covered period of care or the number of covered visits for *medically necessary* rehabilitative care, your *medical group* or Anthem must OK the longer time period and extra visits in advance.

Rehabilitative care as described above is also provided for a *member* who is being treated for a *severe mental disorder* or for pervasive developmental disorder or autism. This care is provided even though the *member* may not have suffered an illness or injury. If more than a 60-day period of care is needed, Anthem must OK the longer time period and additional visits in advance.

- Visits for rehabilitation, such as physical therapy, chiropractic services, occupational therapy or speech therapy **$30**

Inpatient Hospital Services	**Copay**

♦ A *hospital* room with two or more beds, or a private room only if *medically necessary*, ordered by your *primary care doctor* and OK'd by your *medical group* .....**$200** per admission

Inpatient hospital services and supplies include the following:

- Operating room and special treatment room;
- Special care units;
- Nursing care;
- *Drugs* and medicines, and supplies you get during your *stay*. This includes oxygen;
- Laboratory, cardiology, pathology and radiology services;
- Physical therapy, occupational therapy, speech therapy, radiation therapy, chemotherapy and hemodialysis; and
- Blood transfusions. This includes the cost of blood, blood products or blood processing.

Outpatient (In a Hospital or Surgery Center)	**Copay**

♦ Emergency room use, supplies, other services, *drugs* and medicines. This includes oxygen **$125***

*You don't have to pay the **$125** if you are admitted as an inpatient.

♦ Care given when surgery is done. This includes operating room use, supplies, *drugs* and medicines, oxygen, and other services.....**$100** per admission

- X-ray and laboratory tests:
  - *Advanced imaging procedures*.....**$100** per test
  - All other x-ray and laboratory tests ..... **No charge**
- Other outpatient *hospital* services and supplies, including physical therapy, occupational therapy, or speech therapy.* ..... **No charge**

  However, for the following outpatient services, your copay will be:
  - Chemotherapy ..... **No charge**
  - Radiation therapy ..... **No charge**
  - Hemodialysis treatment ..... **No charge**
  - Infusion therapy, including but not limited to Parenteral Therapy and Total Parental Nutrition (TPN) ..... **No charge**

  *These rehabilitative services are limited to a 60 day period of care after an illness or injury. If you need more than the 60 day period of care, your *primary care doctor* must get the OK from your *medical group* or Anthem. (See "Rehabilitative Care" above.)

Urgent Care	**Copay**

If you are more than 15-miles or 30-minutes away from your *primary care doctor* or *medical group* and require *urgent care*, get it right away. *Urgent care* is not an *emergency*. It is care that is needed right away to relieve pain, find out what is wrong, or treat the health problem. You must call us within 48 hours if you are admitted to a *hospital*.

- *Doctor's* office visit or urgent care facility use, supplies, other services, *drugs* and medicines. This includes oxygen.....**$45***

  *You don't have to pay the **$45** if you are admitted as an inpatient to a *hospital*.

- Care given when surgery is done. This includes operating room use, supplies, *drugs* and medicines, oxygen, and other services. .....**No charge**

Skilled Nursing Facility Services	**Copay**

You can get these kinds of care in a *skilled nursing facility* for **up to 100 days in a calendar year**.

- Services and supplies provided by a *skilled nursing facility*.....**No charge**

  - A room with two or more beds;
  - Special treatment rooms;
  - Regular nursing services;
  - Laboratory tests;
  - Physical therapy, occupational therapy, speech therapy, or respiratory therapy;
  - *Drugs* and medicines given during your *stay*. This includes oxygen;
  - Blood transfusions; and
  - Needed medical supplies and appliances.

Home Health Care	**Copay**

We will cover home health care furnished by a *home health agency* (HHA*)* for **up to 100 visits in a calendar year**.

- Home health care services provided by a *home health agency*.....**No charge**

Home health care services include the following:

- Care from a registered nurse or licensed vocational nurse who works under a registered nurse or a *doctor*
- Physical therapy, occupational therapy, speech therapy, or respiratory therapy
- Visits with a medical social service worker
- Care from a health aide who works under a registered nurse with the HHA (one visit equals four hours or less)

♦ *Medically necessary* supplies from the HHA..... **No charge**

Hospice Care	**Copay**

We will cover *hospice* care services shown below for the palliative care of pain and other symptoms if you have an illness that may lead to death. Palliative care is care that controls pain and relieves symptoms but is not intended to cure the illness. Your *primary care doctor* will work with the *hospice* and help develop your care plan. The *hospice* must send a written care plan to your *medical group* every 30 days.

♦ Interdisciplinary team care to develop and maintain a plan of care ..... **No charge**

♦ Short-term inpatient *hospital* care in periods of crisis or as respite care. Respite care is provided on an occasional basis for up to five consecutive days per admission..... **No charge**

♦ Physical therapy, occupational therapy, speech therapy and respiratory therapy..... **No charge**

♦ Social services and counseling services..... **No charge**

♦ Skilled nursing services given by or under the supervision of a registered nurse. ..... **No charge**

- Certified home health aide services and homemaker services given under the supervision of a registered nurse. ..... **No charge**
- Diet and nutrition advice; nutrition help such as intravenous feeding or hyperalimentation ..... **No charge**
- Volunteer services given by trained *hospice* volunteers directed by a *hospice* staff member ..... **No charge**
- *Drugs* and medicines prescribed by a *doctor* ..... **No charge**
- Medical supplies, oxygen and respiratory therapy supplies ..... **No charge**
- Care which controls pain and relieves symptoms ..... **No charge**
- Bereavement services, including assessing the needs of the bereaved family and developing a care plan to meet those needs, both before and after death. Bereavement services are available to covered members of the immediate family (spouse, children, step-children, parents, brothers and sisters) for up to one year after the employee's or covered family *member's* death ..... **No charge**

Dental Care	**Copay**

- Inpatient *hospital* services ..... **$200** per admission

  Inpatient *hospital* services are limited to 3 days when the *stay* is:

  - Needed for dental care because of other medical problems you may have.
  - Ordered by a *doctor* (M.D.) or a dentist (D.D.S. or D.M.D.)
  - Approved by the *medical group*.

- General anesthesia and facility services when dental care must be provided in an outpatient *hospital* or *surgery center* .....**$100** per admission

  These services are covered when:

  - You are less than seven years old;
  - You are developmentally disabled; or
  - Your health is compromised and general anesthesia is *medically necessary*.

  Note: No benefits are provided for the dental procedure itself or for the professional services of a dentist to do the dental procedure.

- Emergency care for accidental injury to natural teeth.....**No charge**

  - The care is not covered if you hurt your teeth while chewing or biting unless the chewing or biting results from a medical or mental condition.
  - This *plan* does not cover any other kind of dental care.

- 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.....**No charge**

- *Medically necessary* dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures.....**No charge**

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

Important: If you decide to receive dental services that are not covered under this *plan*, a dentist who participates in an Anthem

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

Transgender Services	**Copay**

Services and supplies provided in connection with gender transition when you have been diagnosed with gender identity disorder or gender dysphoria by a *doctor*. 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, medical management, and exclusions for cosmetic services, except as specifically stated in this provision. 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).

Services that are excluded on the basis that they are cosmetic include, but are not limited to, liposuction, facial bone reconstruction, voice modification surgery, breast implants, and hair removal.

You must obtain our approval in advance in order for transgender services to be covered. Please refer to "Medical Management Programs" for information on how to obtain the proper reviews.

We will also pay for 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. 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 **$10,000** per transgender surgery, or series of surgeries (if multiple surgical procedures are performed), for travel expenses listed below, incurred by you and one companion. This travel expense benefit is not available for non-surgical transgender services.

- 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.

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

You must obtain our approval in advance in order for travel expenses to be covered. Please refer to "Medical Management Programs" for information on how to obtain the proper reviews.

- Transgender services ..... **See *copays* that apply**
- Transgender travel expense ..... **No charge***

*Our maximum payment will not exceed **$10,000** per transgender surgery, or series of surgeries (if multiple surgical procedures are performed).

Diabetic Supplies	**Copay**

- Diabetic supplies (test strips, lancets, alcohol swabs, and syringes for insulin – insulin itself is not covered) ..... **No charge**

Special Food Products	**Copay**

- Special food products and formulas that are part of a diet prescribed by a *doctor* for the treatment of phenylketonuria (PKU) ..... **No charge**

  You can get most formulas used in the treatment of PKU from a *drugstore*. These are covered under your *plan's* benefits for *prescription drugs* (see "Getting Prescription Drugs"). Special food products that are not available from a *drugstore* are covered as medical supplies under your *plan's* medical benefits.

Medical Equipment	**Copay**

- Medical equipment and supplies ..... **No charge**

You can get long-lasting medical equipment (called durable medical equipment) and supplies that are rented or bought for you if they are:

– Ordered by your *primary care doctor*.

– Used only for the health problem.

– Used only by the person who needs the equipment or supplies.

– Made only for medical use.

Equipment and supplies are **not** covered if they are:

– Only for your comfort or hygiene.

– For exercise.

– Only for making the room or home comfortable, such as air conditioning or air filters.

Pediatric Asthma Equipment and Supplies	**Copay**

♦ Nebulizers, including face masks and tubing..... **No charge**

These items are not subject to any limits or maximums that apply to coverage for Medical Equipment.

♦ Inhaler spacers and peak flow meters .....**See "Getting Prescription Drugs"**

These items are subject to the copay for *brand name drugs*.

♦ Pediatric asthma education program services to help you use the items listed above.....**$30**

Organ and Tissue Transplants	**Copay**

Services and supplies are given if:

– You are receiving the organ or tissue, or

– You are the organ or tissue donor, if the person who is receiving it is a *member* of Anthem Blue Cross HMO. If you are not a *member*, the benefits are lowered by any amounts paid by your own health plan.

♦ Services given with an organ or tissue transplant.....**See *copays* that apply**

Clinical Trials	**Copay**

Routine patient costs, as described below, for an approved clinical trial.....**See *copays* that apply**

Coverage is provided for routine patient care costs you receive as a participant in an approved clinical trial. The services must be those that are listed as covered by this *plan* for *members* who are not enrolled in a clinical trial.

Routine patient care costs include items, services, and drugs provided to you in connection with an approved clinical trial that would otherwise be covered by the *plan*.

An "approved clinical trial" is a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or another life-threatening disease or condition, from which death is likely unless the disease or condition is treated. Coverage is limited to the following clinical trials:

- Federally funded trials approved or funded by one or more of the following:
  - The National Institutes of Health,
  - The Centers for Disease Control and Prevention,
  - The Agency for Health Care Research and Quality,
  - The Centers for Medicare and Medicaid Services,
  - A cooperative group or center of any of the four entities listed above or the Department of Defense or the Department of Veterans Affairs,
  - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants, or
  - Any of the following departments if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines (1) to be comparable to the system of peer review of investigations and studies used by the National Institutes of Health, and (2) assures unbiased review of the highest scientific standards by qualified

individuals who have no interest in the outcome of the review:

- The Department of Veterans Affairs,
- The Department of Defense, or
- The Department of Energy.

- Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration.
- Studies or investigations done for drug trials that are exempt from the investigational new drug application.

Participation in the clinical trial must be recommended by your *primary care doctor* after deciding it will help you. If the clinical trial is not provided by or through your *medical group*, your *primary care doctor* will refer you to the *doctor* or *health care provider* who provides the clinical trial. Please see "When You Need a Referral" in the section called "When You Need Care" for information about referrals. You will only have to pay your normal copays for the services you get.

All requests for clinical trials services, including requests that are not part of approved clinical trials, will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

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

- The investigational item, device, or service.
- Any item or service provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.
- Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

- Any item, device, or service that is paid for by the sponsor of the trial or is customarily provided by the sponsor free of charge for any enrollee in the trial.

Note: You will pay for costs of services that are not covered.

If you do not agree with the coverage or medical necessity of possible clinical trial services, please read the "Independent Medical Review of Complaints Involving a Disputed Health Care Service" (see Table of Contents).

Ambulance	**Copay**

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.

Ambulance services are subject to medical necessity reviews by us or your *medical group*. When using an air ambulance in a non-emergency situation, we or your *medical group* reserve the right to select the air ambulance provider. If you do not use the air ambulance selected 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*. 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 *doctor* are not a covered service.

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

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

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*.

Your copays for covered ambulance services are:

- Base charge and mileage ..... **No charge**
- Disposable supplies ..... **No charge**
- Monitoring, EKG's or ECG's, cardiac defibrillation, CPR, oxygen, and IV solutions ..... **No charge**

IN SOME AREAS, THERE IS A 9-1-1 EMERGENCY RESPONSE SYSTEM. THIS SYSTEM IS TO BE USED ONLY WHEN THERE IS AN *EMERGENCY*.

IF YOU REASONABLY BELIEVE THAT YOU ARE EXPERIENCING AN EMERGENCY, YOU SHOULD CALL 9-1-1 OR GO DIRECTLY TO THE NEAREST HOSPITAL EMERGENCY ROOM. PLEASE USE THE 9-1-1 SYSTEM FOR MEDICAL EMERGENCIES ONLY.

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 if you are taken to a *doctor'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 *doctor* prefers a specific *hospital* or *doctor*.

Prosthetic Devices	**Copay**

You can get devices to take the place of missing parts of your body.

- Surgical implants..... **No charge**

- Artificial limbs or eyes ..... **No charge**
- The first pair of contact lenses or eye glasses when needed after a covered and *medically necessary* eye surgery ..... **No charge**
- Breast prostheses following a mastectomy ..... **No charge**
- *Prosthetic devices* to restore a method of speaking when required as a result of a laryngectomy ..... **No charge**
- Therapeutic shoes and inserts designed to treat foot complications due to diabetes ..... **No charge**
- Orthopedic footwear used as an integral part of a brace; shoe inserts that are custom molded to the patient ..... **No charge**
- Colostomy supplies ..... **No charge**
- Supplies needed to take care of these devices ..... **No charge**

Hearing Aid Services	**Copay**

- Covered hearing aids ..... **No charge**

  The following hearing aid services are covered when ordered by or purchased as a result of a written recommendation from:

  - an otolaryngologist; or
  - a state-certified audiologist.

  Services include:

  - Audiological evaluations to:
    - measure the extent of hearing loss; and
    - determine the most appropriate make and model of hearing aid.

These evaluations will be covered under the *plan* benefits for office visits to *doctors*.

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

No benefits will be provided for the following:

- Charges for a hearing aid which exceeds specifications prescribed for the correction of hearing loss;
- Surgically implanted hearing devices (i.e., cochlear implants, audient bone conduction devices). *Medically necessary* surgically implanted hearing devices may be covered under your *plan's* benefits for *prosthetic devices* (see "Prosthetic Devices").
- Charges for a hearing aid which is not determined to be *medically necessary*, or for more than one hearing aid per ear every 3 years.

Mental or Nervous Disorders/ Substance Abuse	**Copay**

You can get services for the *medically necessary* treatment of *mental or nervous disorders* or substance abuse or to prevent the deterioration of chronic conditions. These services do not include programs to stop smoking, or to help with nicotine or tobacco abuse.

♦ Inpatient *facility-based care* for the treatment of *mental or nervous disorders* or substance abuse.....**$200**

per admission

- Outpatient *facility-based care*, including partial hospitalization and intensive outpatient programs, for the treatment of *mental or nervous disorders* or substance abuse..... **No charge**

Before you get services for *facility-based care* for the treatment of *mental or nervous disorders* or substance abuse, you must get our approval first. Read "Medical Management Programs" to find out how to get approvals.

- Inpatient *doctor* visits during a *stay* for the treatment of *mental or nervous disorders* or substance abuse..... **No charge**

- Office visits to a *doctor* for outpatient psychotherapy or psychological testing for the treatment of *mental or nervous disorders* or substance abuse.....**$30**

- Nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa **$30**

- Behavioral health treatment for pervasive developmental disorder or autism. **$30**

  See the section "Benefits for Pervasive Developmental Disorder or Autism" for a description of the services that are covered. You must get our approval first for all behavioral health treatment services for the treatment of pervasive developmental disorder or autism in order for these services to be covered by this *plan*. Read "Medical Management Programs" to find out how to get approvals. No benefits are payable for these services if our approval is not obtained.

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 the same deductibles, coinsurance, and copayments, if any, that apply to services provided for other covered medical conditions. Services provided by Qualified Autism Service Providers, Qualified Autism Service Professionals, and Qualified Autism Service Paraprofessionals (see the "Definitions" below) will be covered under *plan* benefits for office visits to *doctors*, whether services are provided in the provider's office or in the patient's home. Services provided in a facility, such as the outpatient department of a *hospital*, will be covered under *plan* benefits that apply to such facilities.

You must obtain our approval in advance for all behavioral health treatment services for the treatment of Pervasive Developmental Disorder or autism in order for these services to be covered by this *plan* (see "Medical Management Programs" for details). No benefits are payable for these services if our approval is not obtained. You must receive services from an *Anthem Blue Cross HMO provider* in order for these services to be covered, unless you obtain an *authorized referral* to a non-*Anthem Blue Cross HMO provider* (see "Medical Management Programs" 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, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, includes Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified.

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

Intensive Behavioral Intervention means any form of Applied Behavioral Analysis that is comprehensive, designed to address all domains of functioning, and provided in multiple settings, depending on the individual's needs and progress. Interventions can be delivered in a one-to-one ratio or small group format, as appropriate.

Qualified Autism Service Provider is either of the following:

- A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for Pervasive Developmental Disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified; or

- A person licensed as a physician and surgeon (M.D. or D.O.), physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to state law, who designs, supervises, or provides treatment for Pervasive Developmental Disorder or autism, provided the services are within the experience and competence of the licensee.

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

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

- Provides behavioral health treatment,
- Is employed and supervised by a Qualified Autism Service Provider,
- Provides treatment according to a treatment plan developed and approved by the Qualified Autism Service Provider,
- Is a behavioral service provider approved as a vendor by a California regional center to provide services as an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program as defined in state regulation, and
- Has training and experience in providing services for Pervasive Developmental Disorder or autism pursuant to applicable state law.

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

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

Behavioral Health Treatment Services Covered

The behavioral health treatment services covered by this *plan* for the treatment of Pervasive Developmental Disorder or autism are

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

- The treatment must be prescribed by a licensed physician and surgeon (an M.D. or D.O.) or developed by a licensed psychologist,
- The treatment must be provided under a treatment plan prescribed by a Qualified Autism Service Provider and administered by one of the following: (a) Qualified Autism Service Provider, (b) Qualified Autism Service Professional supervised and employed by the Qualified Autism Service Provider, or (c) Qualified Autism Service Paraprofessional supervised and employed by a Qualified Autism Service provider, and
- The treatment plan must have measurable goals over a specific timeline and be developed and approved by the Qualified Autism Service Provider for the specific patient being treated. The treatment plan must be reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate, and must be consistent with applicable state law that imposes requirements on the provision of Applied Behavioral Analysis services and Intensive Behavioral Intervention services to certain persons pursuant to which the Qualified Autism Service Provider does all of the following:
    - Describes the patient's behavioral health impairments to be treated,
    - Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the intervention plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported,

- Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Pervasive Developmental Disorder or autism,
- Discontinues Intensive Behavioral Intervention services when the treatment goals and objectives are achieved or no longer appropriate, and
- The treatment plan is not used for purposes of providing or for the reimbursement of respite care, day care, or educational services, and is not used to reimburse a parent for participating in the treatment program. No coverage will be provided for any of these services or costs. The treatment plan must be made available to us upon request.

Medical Management Programs

In order to be covered by this *plan*, most services must be provided or coordinated by your *primary care doctor* and OK'd by your *medical group*. Exceptions to this rule are explained in the section "When You Need Care" earlier in this booklet. You may get care for the treatment of certain conditions directly, without getting an OK from your *medical group*. Some of these services must however be reviewed and approved by us in advance, through our Medical Management Programs, which consist of the Utilization Review Program and the Authorization Program.

The services that need to be reviewed and approved by us are indicated as such in the "What We Cover" section. You're also welcome to call the *Customer Service number* on your *member* ID card for a list of services that need to be reviewed.

We will provide benefits only if you are covered at the time you get services, and our payment will follow the terms and requirements of this *plan*.

Utilization Review Program

The utilization review program looks at whether care is *medically necessary* and appropriate, and the setting in which care is provided. We will let you and your *doctor* know if we have

determined that services can be safely provided in an outpatient setting, or if we recommend an inpatient *stay*. We certify and monitor services so that you know when it is no longer *medically necessary* and appropriate to continue those services.

The purpose of utilization review is to promote the delivery of cost-effective medical care by reviewing the use of services and, where appropriate, the setting or place of service where care is provided. Covered services must be *medically necessary* in order for benefits to be provided.

- *Anthem Blue Cross HMO providers* will initiate the review on your behalf.
- You may ask a non-*Anthem Blue Cross HMO provider* to call the toll free number on your Member ID card to initiate the review for you. Remember that services provided by a non-*Anthem Blue Cross HMO provider* are covered only if they are emergency services, urgent care, or services for which you received an *authorized referral*.

In both cases, it is your responsibility to initiate the process and ask your *doctor* to request pre-service review. You may also call us directly. Pre-service review criteria are based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. We may determine that a service that was initially prescribed or requested is not *medically necessary* if you have not previously tried alternative treatments that are more cost effective.

You need to make sure that your *doctor* contacts us before scheduling you for any service that requires utilization review. If you get any such service without following the directions under “How to Get Utilization Reviews", no benefits will be provided for that service.

Effect on Benefits

- When you don’t get the required pre-service review before you get services that require it, we **will not provide benefits** for those services.

- We will approve services only when the type and level of care requested is *medically necessary* and appropriate for your condition. If you go ahead with any services that have been determined to be not *medically necessary* and appropriate at any stage of the utilization review process, we **will not provide benefits** for those services.

- When services are not reviewed before or during the time you receive the services, we will review those services when we receive the claim for benefit payment. If that review determines that part or all of the services were not *medically necessary* and appropriate, we **will not provide benefits** for those services.

How to Get Utilization Reviews

- You must tell your *doctor* that this *plan* requires pre-service review. *Doctors* who are *Anthem Blue Cross HMO providers* will ask for the review for you. The toll-free number for pre-service review is on your Member ID card. Remember, you must make sure the review has been done.

- For all scheduled services that require utilization review, you or your *doctor* must ask for the pre-service review at least five working days before you are to get services. See more timeframes at "Decision and Notice Requirements" under this "Medical Management Programs" section.

- We will certify services that are *medically necessary* and appropriate. For inpatient care, we will, if appropriate, certify the type and level of services, as well as a specific length of *stay*. You, your *doctor* and the provider of the service will get a written notice showing this information.

- If you do not get the certified service within 60 days of the certification, or if the type of the service changes, you must get a new pre-service review.

- If pre-service review was not done, such as for an *emergency* admission or procedure, you need to let us know within 48 hours of the admission or procedure, unless your condition

prevented you from telling us or a member of your family was not available to tell us for you within that time period. If we decide that the service is not *medically necessary* and appropriate, we will tell your *doctor* by telephone no later than 24 hours after the decision. We will send written notice to you and your *doctor* within two business days after our decision. But care will not be stopped until your *doctor* has been notified and a plan of care that meets your needs has been agreed upon.

Request Categories

- Urgent – A request for review that in the view of the treating or any *doctor* with knowledge of your medical condition, could without such care or treatment, seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

- Pre-service – A request for review that is conducted before the service, treatment or admission.

- Care coordination – A medical necessity review to determine whether services are *medically necessary* and appropriate when we are notified while service is ongoing, for example, an *emergency* admission to the *hospital*.

- Retrospective – A medical necessity review performed to review services that have already been provided. This applies in cases when pre-service or care coordination review was not completed, or in order to evaluate and audit medical documentation subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified. Services that are not reviewed prior to or during service delivery will be reviewed retrospectively when the bill is submitted for benefit payment. If that review results in the determination that part or all of the services were not *medically necessary* and appropriate, benefits will not be provided for those services. Remaining benefits will be subject to previously noted reductions that apply when the required reviews are not obtained.

Decision and Notice Requirements

Requests for medical necessity will be reviewed 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, state laws will be followed. If you live in and/or get services in a state other than the state where your *plan* was issued other state-specific requirements may apply. You may call the phone number on the back of your ID card for more details.

Request Category	**Timeframe Requirement for Decision**
Pre-service urgent	72 hours from the receipt of the request
Pre-service non-urgent	5 business days from the receipt of the request
Care coordination review when hospitalized at the time of the request and no previous authorization exists	72 hours from the receipt of the request
Care coordination review urgent when request is received at least 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Care coordination review urgent when request is received less than 24 hours before the end of the previous authorization	72 hours from the receipt of the request

Care coordination review non-urgent	5 business days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If more information is needed to make a decision, state and federal laws will be followed. The requesting *doctor* will be told and a written notice will be sent to you or your authorized representative of the specific information needed to finish the review. If the specific information is not received or if the information is not complete by the timeframe identified in the written notice, a decision will be made based upon the information we have.

Notice of the decision will be given as required by state and federal law. Notice may be given by the following methods:

- Verbal: Oral notice given to the requesting *doctor* by phone or by electronic means if agreed to by the *doctor*.
- Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting *doctor* and you or your authorized representative.

Authorization Program

The authorization program provides prior approval for medical care or service by a non-*Anthem Blue Cross HMO provider*. The service you receive must be a covered benefit of this *plan*.

You must get approval before you get any non-emergency or non-urgent service from a non-*Anthem Blue Cross HMO provider*.

The toll-free number to call for prior approval is on your Member ID card.

If you do not follow the procedures set forth in this section, no benefits will be provided for that service.

Authorized Referrals. In order for the benefits of this *plan* to be provided, you must get approval **before** you get services from non-*Anthem Blue Cross HMO providers*. When you get proper approvals, these services are called *authorized referral* services.

Effect on Benefits. If you receive *authorized referral* services from a non-*Anthem Blue Cross HMO provider*, the applicable *Anthem Blue Cross HMO provider* copays will apply. When you do not get a referral, **no benefits are provided** for services received from a non-*Anthem Blue Cross HMO provider*.

How to Get an Authorized Referral. You or your *doctor* must call the toll-free telephone number on your Member ID card **before** scheduling an admission to, or before you get the services of, a non-*Anthem Blue Cross HMO provider*.

When an Authorized Referral Will be Provided. Referrals to non-*Anthem Blue Cross HMO providers* will be approved only when all of the following conditions are met:

- There is no *Anthem Blue Cross HMO provider* who practices the specialty you need, provides the required services or has the necessary facilities within 50-miles of your home; AND
- You are referred to the non-*Anthem Blue Cross HMO provider* by a *doctor* who is an *Anthem Blue Cross HMO provider;* AND
- We authorize the services as *medically necessary* before you get the services.

Exceptions to the Medical Management Program

From time to time, we may waive, enhance, modify, or discontinue certain medical management processes (including utilization review) if, in our discretion, such a change furthers the provision of cost effective, value based and quality services. In addition, we may select certain qualifying health care providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt claims from medical review if certain conditions apply.

If we exempt a process, health care provider, or claim from the standards that would otherwise apply, we are in no way obligated to do so in the future, or to do so for any other health care provider, claim, or *member*. We may stop or modify any such exemption with or without advance notice.

We also may identify certain providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a provider is selected under this program, then we may use one or more clinical utilization management guidelines in the review of claims submitted by this provider, even if those guidelines are not used for all providers delivering services to this *plan's members*.

You may determine whether a health care provider participates in certain programs by checking our online provider directory on our website at **www.anthemcom/ca** or by calling us at the customer service telephone number listed on your ID card.

Revoking or Modifying an Authorization

An authorization for services or care that was approved through either the Utilization Review Program or the Authorization Program may be revoked or modified prior to the services being rendered for reasons including but not limited to the following:

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

For a copy of the review processes outlined in this section, please call us at the customer service telephone number on the back of your ID card.

What We Do Not Cover

It's important for you to know that we are not able to cover all the care you may want. Some services and supplies are not covered and some have limited benefits.

Remember:

In most cases, you cannot get any care that has not been OK'd by your *primary care doctor*, your *medical group*, or Anthem.

Kinds of Services You Cannot Get with this Plan

- **Care Not Approved.** Care you got from a health care provider without the OK of your *primary care doctor* or a *doctor* specializing in OB-GYN in your *medical group*, except for *emergency services* or *urgent care.*
- **Care Not Covered.** Services you got before you were on the *plan*, or after your coverage ended.
- **Care Not Listed.** Services not listed as being covered by this *plan*.
- **Care Not Needed.** Any services or supplies that are not *medically necessary*.
- **Crime or Nuclear Energy.** Any health problem caused: (1) while you were committing or trying 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) by nuclear energy, when the government can pay for treatment.
- **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 ask that the denial be reviewed by an external independent medical review organization. (See the section "Review of Denials of

Experimental or Investigative Treatment" for how to ask for a review of your benefit denial.)

- **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 this *plan's* benefits, must be provided by 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*.

- **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 *doctor*, 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 Given by Providers Who Are Not With Anthem Blue Cross HMO.** We will not cover these services unless your *primary care doctor* refers you, except for *emergencies* or *urgent care*.

- **Services Not Needing Payment.** Services you are not required to pay for or are given to you at no charge, except services you got at a charitable research *hospital* (not with the government). This *hospital* must:

  - Be known throughout the world as devoted to medical research.

  - Have at least 10% of its yearly budget spent on research not directly related to patient care.

  - Have 1/3 of its income from donations or grants (not gifts or payments for patient care).

- Accept patients who are not able to pay.
- Serve patients with conditions directly related to the *hospital*'s research (at least 2/3 of their patients).

♦ **Waived Cost-Shares non-*Anthem Blue Cross HMO provider*.** For any service for which you are responsible under the terms of this booklet to pay a copayment, coinsurance or deductible, and the copayment, coinsurance or deductible is waived by a non-*Anthem Blue Cross HMO provider*.

♦ **Work-Related.** Care for health problems that are work-related if such health problems are or can be covered by workers' compensation, an employer's liability law, or a similar law. We will provide care for a work-related health problem, but, we have the right to be paid back for that care. See "Other Things You Should Know: Getting Repaid by a Third Party" on a later page.

Other Services Not Covered

♦ **Acupressure.** Acupressure, or massage to help pain, treat illness or promote health by putting pressure to one or more areas of the body.

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

♦ **Birth Control Devices.** Any devices needed for birth control which can be obtained without a doctor's prescription, such as condoms. This does not apply to FDA-approved over the counter contraceptive methods for women, that are prescribed by a *doctor*, as specifically stated in "Preventive Care Services" under the section What We Cover.

♦ **Blood.** Benefits are not provided for the collection, processing and storage of self-donated blood unless it is specifically collected for a planned and covered surgical procedure.

♦ **Braces or Other Appliances or Services** for straightening the teeth (orthodontic services) except as specifically stated in

"Reconstructive Surgery" and "Dental Care" under the section What We Cover.

- **Clinical Trials.** Services and supplies in connection with clinical trials, unless specifically stated in "Clinical Trials" under the section, What We Cover.

- **Commercial Weight Loss Programs.** Weight loss programs, whether or not they are pursued under medical or *doctor* supervision, unless specifically listed as covered in this *plan*.

  This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

  This exclusion does not apply to *medically necessary* treatments for morbid obesity or for treatment of anorexia nervosa or bulimia nervosa.

- **Consultations** given using telephones, facsimile machines, or electronic mail.

- **Cosmetic Surgery.** Surgery or other services done only to make you:

  - Look beautiful:
  - To improve your appearance; or
  - To change or reshape normal parts or tissues of the body.

This does not apply to reconstructive surgery you might need to:

- Give you back the use of a body part.
- Have for breast reconstruction after a mastectomy.
- Correct or repair a deformity caused by birth defects, abnormal development, injury or illness in order to improve function, symptomatology or create a normal appearance.

Cosmetic surgery does not become reconstructive because of psychological or psychiatric reasons.

- **Custodial Care or Rest Cures.** Room and board charges for a *hospital stay* mostly for a change of scene or to make you feel good. Services given by a rest home, a home for the aged, or any place like that.

- **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.

- **Eye Exercises or Services and Supplies for Correcting Vision.** Optometry services, eye exercises, and orthoptics, except for eye exams to find out if your vision needs to be corrected. Eyeglasses or contact lenses are not covered. Contact lens fitting is not covered.

- **Eye Surgery for Refractive Defects.** Any eye surgery just for correcting vision (like nearsightedness and/or astigmatism). Contact lenses and eyeglasses needed after this surgery.

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

- **Health Club Membership.** Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a *doctor*. This exclusion also applies to health spas.

- **Hearing Aids.** Hearing aids or services for fitting or making a hearing aid.

- **Immunizations.** Immunizations needed to travel outside the USA.

- **Infertility Treatment.** Any *infertility* treatment including artificial insemination or in vitro fertilization, and sperm banks.

- **Lifestyle Programs.** Programs to help you change how you live, like fitness clubs, or dieting programs. This does not apply to cardiac rehabilitation programs approved by your *medical group*.

- **Educational or Academic Services.** This plan does not cover:

  - Educational or academic counseling, remediation, or other services that are designed to increase academic knowledge or skills.

  - Educational or academic counseling, remediation, or other services that are designed to increase socialization, adaptive, or communication skills.

  - Academic or educational testing.

  - Teaching skills for employment or vocational purposes.

  - Teaching art, dance, horseback riding, music, play, swimming, or any similar activities.

  - Teaching manners and etiquette or any other social skills.

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

This exclusion does not apply to the *medically necessary* treatment of pervasive developmental disorder or autism, to the extent stated in the section "Benefits for Pervasive Developmental Disorder or Autism".

- **Nicotine Use.** Programs to stop smoking or the treatment of nicotine or tobacco use if the program is not affiliated with Anthem.
- **Non-Prescription Drugs.** Non-prescription, over-the-counter drugs or medicines, except as specifically stated in this booklet.
- **Orthopedic Shoes.** Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes, as specifically stated in "Prosthetic Devices" under the section What We Cover.
- **Outpatient Drugs.** Outpatient *prescription drugs* or medications including insulin except *drugs* for abortion or contraception when taken in the *doctor's* office. (Also see Getting Prescription Drugs and Preventive Care Services for what is covered)
- **Personal Care and Supplies.** Services for your personal care, such as: help in walking, bathing, dressing, feeding, or preparing food. Any supplies for comfort, hygiene or beauty purposes.
- **Private Contracts.** Services or supplies provided pursuant to a private contract between the *member* and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.
- **Routine Exams.** Routine physical or psychological exams or tests asked for by a job or other group, such as a school, camp, or sports program.

- **Scalp hair prostheses.** Scalp hair prostheses, including wigs or any form of hair replacement.
- **Sexual Problems.** Treatment of any sexual problems unless due to a medical problem, physical defect, or disease.
- **Sterilization Reversal.** Surgery done to reverse an elective sterilization.
- **Surrogate Mother Services.** For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
- **Transgender Services.** Services and supplies in connection with transgender services, except as specifically stated in "Transgender Services" under the section What We Cover.
- **Varicose Vein Treatment.** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.

Getting Prescription Drugs

In addition to the *drugs* or medicines you may need while you are in the *hospital*, the *plan* also cover *drugs* or medicines you buy from a *drugstore*, through the home delivery program, or through the specialty drug program. The *drug* or medicine must:

- Be prescribed by a health care provider licensed to prescribe, and be given to you within one year of being prescribed. It must be a *drug* that may only be sold with a *prescription* under federal and state law. This rule doesn't apply to pneumonia, shingles, or seasonal flu vaccinations provided at a *member drug store*, or those covered by the PreventiveRx program, if included.

  Note: Specified over-the-counter items are covered under this *plan* only when obtained with a *doctor's prescription* as specified under "Preventive Prescription Drugs and Other

Items", subject to all terms of this *plan* that apply to those benefits.

- Smoking cessation and nicotine replacement products.
- FDA-approved contraceptives for women.
- Vitamins, supplements, and health aids.

♦ Be approved for general use by the Food and Drug Administration (FDA).

♦ Be for the direct care and treatment of your illness, injury, or health problem. Dietary supplements, health aids, or *drugs* for cosmetic purposes are not covered. However the following items are covered:

- Formulas prescribed by a *doctor* for the treatment of phenylketonuria.
- Vaccinations given at a *member drugstore*.
- Vitamins, supplements, and health aids specifically listed in this *plan* as covered.
- *Drugs* that may be prescribed for cosmetic purposes, but are *medically necessary* and prescribed for the treatment of a medical condition other than one that is cosmetic.

♦ Be dispensed from a licensed retail *drugstore,* by the home delivery program or through the specialty pharmacy program.

♦ **If it is an approved *compound medication*, be dispensed by a *member drugstore*.** Call 1-800-700-2541 (or TTY/TDD 1-800-905-9821) to find out where to take your prescription for an approved *compound medication* to be filled. (You can also find a *member drugstore* at www.anthem.com/ca.) **Some *compound medications* must be approved before you can get them (see "Drugs that need to be approved," under Prescription Drug Formulary). You will have to pay the full cost of the *compound medications* you get from a *drugstore* that is not a *member drugstore*.**

- **If it is a specified *specialty drug*, be obtained by using the specialty pharmacy program.** See "Getting Your Medicine Through the Specialty Pharmacy" for how to get your *drugs* by using the specialty pharmacy program. **You will have to pay the full cost of *specialty drugs* you get from a retail *drugstore* that you should have obtained from the specialty pharmacy program. If you order a *specialty drug* that must be obtained using the specialty pharmacy program through the home delivery program, it will be forwarded to the specialty pharmacy program for processing and will be processed according to specialty pharmacy program rules.**

  Exceptions to specialty pharmacy program. This requirement does not apply to:

  a. The first month's supply of a specified *specialty pharmacy drug* which is available through a *member drugstore*;

  b. *Drugs*, which due to medical necessity, must be obtained immediately; or

  c. A *member* for whom, according to the Coordination of Benefit rules, this *plan* is not the primary plan.

  How to obtain an exception to the specialty pharmacy program. If you believe that you should not be required to get your medication through the specialty pharmacy program, for any of the reasons listed above, except for c., you must complete an Exception to Specialty Drug Program form to request an exception and send it to us. The form can be faxed or mailed to us. If you need a copy of the form, you may call us at 1-800-700-2541 (or TTY/TDD 1-800-905-9821) to request one. You can also get the form on-line at www.anthem.com/ca. If we have given you an exception, it will be good for a limited period of time. The exception period will be determined based on the reason for the exception. When the exception period ends, if you believe that you should still not be required to get your medication through the specialty pharmacy program, you must again request an exception. If we deny your request for an exception, it will be in writing and will tell you why we did not approve the exception.

Urgent or emergency need of a *specialty drug* subject to the specialty pharmacy program. If you are out of a *specialty drug* which must be obtained through the specialty pharmacy program, the *pharmacy benefits manager* will authorize an override of the specialty pharmacy program requirement for 72-hours, or until the next business day following a holiday or weekend, to allow you to get an emergency supply of medication if your *doctor* decides that it is appropriate and *medically necessary*. You may have to pay the applicable *copay* shown in "What You Will Need to Pay" for the 72-hour supply of your *drug*.

If you order your *specialty pharmacy drug* through the specialty pharmacy program and it does not arrive, if your *doctor* decides that it is *medically necessary* for you to have the *drug* immediately, we will authorize an override of the specialty pharmacy program requirement for a 30-day supply or less, to allow you to get an emergency supply of medication from a *member drug store* near you. A Dedicated Care Coordinator from the specialty pharmacy program will coordinate the exception and you will not be required to make an additional *copay*.

- Not be dispensed while you are an inpatient in any facility. It must not be dispensed in or administered by an outpatient facility. While not covered under this *prescription drug* benefit, if you need these *drugs*, they are covered as specified in "Inpatient Hospital Services," "Outpatient (In a Hospital or Surgery Center)," "Preventive Care Services," "Home Health Care," "Hospice Care" and "Skilled Nursing Facility Services," subject to all terms of this *plan* that apply to those benefits.

- Not typically more than a 30-day supply if you get it at the *drugstore* or the specialty pharmacy program. However, a *doctor* can prescribe an additional 30-day supply of your medication for you to receive at a retail *drugstore* or specialty pharmacy. If you receive more than a 30-day supply of medication, you will have to pay the applicable copay for each additional 30-day supply of medication you receive.

You can get a 60-day supply of *drugs* at the *drugstore* for treating attention deficit disorder if they:

- Are FDA approved for treating attention deficit disorder;
- Are federally classified as Schedule II *drugs*; and
- Require a triplicate *prescription* form.

♦ Not be more than a 90-day supply if you get it from our home delivery program.

♦ If the *doctor* prescribes a 60-day supply for *drugs* classified as Schedule II for the treatment of attention deficit disorders, you have to pay double the amount of *copay* for retail *drugstores.* If you get the *drugs* through our home delivery program, the *copay* will be the same as for any other *drug*.

♦ FDA-approved smoking cessation products and over-the-counter nicotine replacement products are limited as specified under "Preventive Prescription Drugs and Other Items".

♦ *Drugs* for the treatment of impotence and/or sexual dysfunction are:

- Limited to six tablets (or treatments) for a 30-day period; and
- Available at retail *drugstores* only.

You must give us proof that a medical condition has caused the problem.

If such *drugs* are prescribed for *medically necessary* purposes, other than the treatment of impotence and/or sexual dysfunction, they will be provided in quantities as *medically necessary*.

Certain *drugs* are dispensed in specific amounts based on our analysis of *prescription drug* dispensing trends and the Food and Drug Administration dosing recommendations. But, *medically necessary drugs* will be provided based on the *plan's* review

consistent with professional practice and Food and Drug Administration guidelines.

Preventive Prescription Drugs and Other Items

Your *prescription drug* benefits include certain preventive *drugs*, medications, and other items as listed below that may be covered under this *plan* as *preventive care services*. In order to be covered as a *preventive care service*, these items must be prescribed by a *doctor* or *health care provider* and obtained from a member *drugstore* or through the home delivery program. This includes items that can be obtained over the counter for which a *doctor* or *health care provider* prescription is not required by law.

When these items are covered as *preventive care services*, the Calendar Year Deductible, if any, will not apply and no co-payment will apply. In addition, any separate deductible that applies to *prescription drugs* will not apply.

- All FDA-approved contraceptives for women, including oral contraceptives, diaphragms, patches, and over-the-counter contraceptives. In order to be covered as a *preventive care service*, in addition to the requirements stated above, contraceptive *prescription drugs* must be *generic drugs* or *single source brand name drugs*.
- Vaccinations prescribed by a *physician* and obtained from a member *drugstore*.
- Tobacco cessation *drugs*, medications, and other items for *members* age 18 and older as recommended by the United States Preventive Services Task Force including:
    - *Prescription drugs* to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products.
    - FDA-approved smoking cessation products including over-the-counter (OTC) nicotine gum, lozenges and patches when obtained with a *doctor's* prescription and you are at least 18 years old.

Prescription drugs and OTC items are limited to a no more than 180 day supply per *year*.

- Aspirin to reduce the risk of heart attack or stroke, for men ages 45-79 and women ages 55-79.
- Aspirin after 12 weeks of gestation in pregnant women who are at high risk for preeclampsia.
- Folic acid supplementation for women age 55 years and younger (folic acid supplement or a multivitamin).
- Vitamin D for women over age 65.
- Medications for risk reduction of primary breast cancer in women (such as tamoxifen or raloxifene) for women who are at increased risk for breast cancer and at low risk for adverse medication effects.
- Bowel preparations when prescribed for a preventive colon screening.
- Iron supplements for children from birth through 12 months old.
- Fluoride supplements for children from birth through 6 years old (drops or tablets).
- Dental fluoride varnish to prevent tooth decay of primary teeth for children from birth to 5 years old.

Prescription Drug Formulary

A *prescription drug formulary* is used to help your *doctor* make prescribing decisions. The fact that a *drug* is on this list doesn't guarantee that your *doctor* will prescribe you that *drug*. This list, which includes both *generic drugs* and *brand name drugs*, is updated quarterly so that the list includes *drugs* that are safe and effective in the treatment of disease.

Some *drugs* need to be approved - the *doctor* or *drugstore* will know which *drugs* they are. If you have a question regarding whether a particular *drug* is on our *formulary drug* list or requires

prior authorization please call us at 1-800-700-2541 (or TTY/TDD 1-800-905-9821). Information about the *drugs* on our *formulary drug* list is also available on our internet website www.anthem.com/ca.

Exception request for a drug not on the prescription drug formulary (non-formulary). Your *prescription drug* benefit covers those *drugs* listed on our *prescription drug formulary*. This *prescription drug formulary* contains a limited number of *prescription drugs*, and may be different than the *prescription drug formulary* for other Anthem products. **In cases where your *doctor* prescribes a medication that is not on the *prescription drug formulary*, it may be necessary to obtain a non-formulary exception in order for the *prescription drug* to be a covered benefit. Your *doctor* must complete a non-formulary exception form and return it to us. You or your *doctor* can get the form online at www.anthem.com/ca or by calling the number listed on the back of your ID card.**

When we receive a non-formulary exception request, we will make a coverage decision within a certain period of time, depending on whether exigent circumstances exist.

Exigent circumstances exist if you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if you are undergoing a current course of treatment using a drug not covered by the *plan*. In this case, we will make a coverage decision within 24 hours of receiving your request. If we approve the coverage of the *drug*, coverage of the *drug* will be provided for the duration of the exigency. If we deny coverage of the *drug*, you have the right to request an external review by an IRO. The IRO will make a coverage decision within 24 hours of receiving your request. If the IRO approves the coverage of the *drug*, coverage of the *drug* will be provided for the duration of the exigency.

When exigent circumstances do not exist, we will make a coverage decision within 72 hours of receiving your request. If we approve the coverage of the *drug*, coverage of the *drug* will be provided for the duration of the *prescription*, including refills. If we deny

coverage of the *drug*, you have the right to request an external review by an Independent Review Organization (IRO). The IRO will make a coverage decision within 72 hours of receiving your request. If the IRO approves the coverage of the *drug*, coverage of the *drug* will be provided for the duration of the *prescription*.

Requesting a non-formulary exception or having an IRO review your request for a non-formulary exception does not affect your right to submit a grievance or request an Independent Medical Review. Please see the section entitled "How to Make a Complaint" for details.

Coverage of a *drug* approved as a result of your request or your *physician's* request for an exception will only be provided if you are a *member* enrolled under the *plan*.

Drugs that need to be approved. Some *drugs* need to be approved in writing before you can get them. Prior authorization criteria will be based on medical policy and the *Pharmacy and Therapeutics Process* established by our review committees. You may need to try a *drug* other than the one originally prescribed if we determine that it should be clinically effective for you. But, if we determine through prior authorization that the *drug* originally prescribed is *medically necessary*, you will be provided the *drug* originally requested at the applicable copay. (If, when you first become a *member*, you are already being treated for a medical condition by a *drug* that has been appropriately prescribed and is considered safe and effective for your medical condition, and you underwent a prior authorization process under the prior plan which required you to take different drugs, we will not require you to try a *drug* other than the one you are currently taking.). If the *drugs* are approved you will be able to get them after you make the required *copay*.

In order for you to get a *drug* that needs to be approved, your *doctor* must send us a request in writing using the required uniform prior authorization request form. The request can be sent to us by mail, facsimile, or it can be submitted electronically. If your *doctor* needs a copy of the request form, he or she may call us at 1-

800-700-2541 (or TTY/TDD 1-800-905-9821) to request one. You can also get the form on-line at www.anthem.com/ca.

Upon receiving the completed uniform prior authorization request form, we will review the request and respond within the following time periods:

- 72 hours for nonurgent requests, and
- 24 hours if exigent circumstances exist. Exigent circumstances exist if you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if you are undergoing a current course of treatment using a drug not covered by the *plan*.

While we are reviewing the request, a 72-hour emergency supply of medication may be dispensed to you if your *doctor* or pharmacist decides that it is appropriate and *medically necessary*. You may have to pay the applicable *copay* shown for the 72-hour supply of your *drug*. If we approve the request for the *drug* after you have received a 72-hour supply, you will receive the remainder of the 30-day supply of the *drug* with no additional *copay*.

If you have any questions regarding whether a *drug* is on our *prescription drug formulary*, or needs to be approved, please call us at 1-800-700-2541 (or TTY/TDD 1-800-905-9821). Information about the *drugs* on our *formulary drug* list is also available on our internet website www.anthem.com/ca.

If we don't approve a request for a *drug* that is not part of our *prescription drug formulary*, you or your *doctor* can appeal the decision by calling us at **1-800-700-2541 (or TTY/TDD 1-800-905-9821)**. If you are not happy with the result, please see the section called "How to Make a Complaint".

Revoking or modifying a prior authorization. A prior authorization of benefits for *prescription drugs* may be revoked or modified prior to your receiving the *drugs* for reasons including but not limited to the following:

- Your coverage under this *plan* ends;

- The *agreement* with the *group* terminates;
- You reach a benefit maximum that applies to *prescription drugs*, if the *plan* includes such a maximum;
- Your *prescription drug* benefits under the *plan* change so that *prescription drugs* are no longer covered or are covered in a different way.

A revocation or modification of a prior authorization of benefits for *prescription drugs* applies only to unfilled portions or remaining refills of the *prescription*, if any, and not to *drugs* you have already received.

New *drugs* and changes in the *prescription drugs* covered by the plan. The outpatient *prescription drugs* are to be included on the list of *formulary drugs* covered by the *plan* and is decided by the *Pharmacy and Therapeutics Process* which is comprised of independent *doctors* and pharmacists. The *Pharmacy and Therapeutics Process* meets quarterly and decides on changes to make in the *prescription drug formulary* list based on our recommendations and a review of relevant information, including current medical literature.

Getting Your Medicine at a Drugstore

To get medicine your *doctor* has prescribed:

- Go to a *member drugstore*.
- For help finding a *member drugstore*, call us at **1-800-700-2541 (or TTY/TDD 1-800-905-9821)**.
- Show your Member ID card.
- Pay the *copay* when you get the medicine. You must also pay for any medicine or supplies that are not covered under the *plan*.

Please note that taking a *prescription* to a *drugstore* or pharmacist does not mean it is a claim for benefit coverage. If you take a *prescription* to a *member drugstore*, and the *member drugstore*:

- Says they cannot give you your medicine; or
- Must have an additional *copay*;

this is not considered an adverse claim decision. If you want your medicine now, you will have to pay the cost for it and submit a claim to Prescription Drug Program (see "Submitting a claim" below). (Please note that we contract with a *pharmacy benefit manager* to provide prescription drug benefits. Neither they nor their *member drugstores* are employees of Anthem. They are independent contractors.)

Important Note: If we determine that you may be using *prescription drugs* in a harmful or abusive manner, or with harmful frequency, your selection of member *drugstores* may be limited. If this happens, we may require you to select a single member *drugstore* that will provide and coordinate all future pharmacy services. Benefits will only be paid if you use the single member *drugstore*. We will contact you if we determine that use of a single member *drugstore* is needed and give you options as to which member *drugstore* you may use. If you do not select one of the member *drugstores* we offer within 31 days, we will select a single member *drugstore* for you. If you disagree with our decision, you may ask us to reconsider it as described in the section called "How to Make a Complaint".

Submitting a claim. If you believe you should get some *plan* benefits for the medicine that you have paid the cost for, have the pharmacist fill out a claim form and sign it. Send the claim form to us (within 90 days) to:

Prescription Drug Program
ATTN: Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872

If the *member drugstore* doesn't have claims forms, or if you have questions, call **1-800-700-2541 (or TTY/TDD 1-800-905-9821)**.

It will cost you more if you go to a non-*member drugstore.*

- Take a claim form with you to the *non-member drugstore*. If you need a claim form or if you have questions, call **1-800-700-2541 (or TTY/TDD 1-800-905-9821)**.
- Have the pharmacist fill out the form and sign it.
- Then send the claim form (within 90 days) to:

Prescription Drug Program
ATTN: Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872

  - When the *pharmacy benefit manager* first gets your claim, they take out:
  - Costs for medicine or supplies not covered under the *plan*,
  - Then any cost more than the *limited fee schedule* we use for *non-member drugstore*, except when the *drugs* are related to *urgent care* or *emergency services*; and
  - Then your *copay*.

The rest of the cost is covered.

If you are out of state, and you need medicine,

- Call **1-800-700-2541 (or TTY/TDD 1-800-905-9821)** to find out where there is a *member drugstore*.
- If there is no *member drugstore*, pay for the *drug* and send the *pharmacy benefit manager* a claim form.

Getting Your Medicine Through the Mail

When you order medicines through the mail, here's what to do:

- **Get your *prescription* from your health care provider.** He or she should be sure to sign it. It must have the *drug* name, how much and how often to take it, how to use it, the provider's name and address and telephone number along with your name and address.
- **Fill out the order form.** The **first time** you use the home delivery program, you must also send a filled out Patient Profile questionnaire about yourself**.** Order forms and a Patient Profile questionnaire can be obtained by contacting us at 1-800-700-2541 (or TTY/TDD 1-800-905-9821) to request one. The forms are also available on-line at www.anthem.com/ca.
- **Be sure to send the *copay*** along with the *prescription* and the order form and the Patient Profile. You can pay by check, money order, or credit card.
- **There may be some medicines you cannot order through this program, for example, *drugs* to treat sexual dysfunction, are not available. Call 1-800-700-2541 (or TTY/TDD 1-800-905-9821) to find out if you can order your medicine through the Home Delivery Program.**

Getting Your Medicine Through the Specialty Pharmacy

Certain specified *specialty drugs* must be obtained through the specialty pharmacy program unless you are given an exception from the specialty drug program (see the introduction of this section, Getting Prescription Drugs). These specified *specialty drugs* that must be obtained through the Specialty Pharmacy Program are limited up to a 30-day supply. The Specialty Pharmacy Program will deliver your medication to you by mail or common carrier (you cannot pick up your medication from them).

You or your *doctor* may order your *specialty drug* by calling 1-800-700-2541 (or TTY/TDD 1-800-905-9821). When you call the

Specialty Pharmacy Program, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your *specialty drug* to you. (If you order your *specialty drug* by telephone, you will need to use a credit card or debit card to pay for it.) You may also submit your *specialty drug* prescription with the appropriate payment for the amount of the purchase (you can pay by check, money order, credit card or debit card), and a properly completed order form to the Specialty Pharmacy Program at the address shown below. Once you have met your deductible, if any, you will only have to pay your *copay*.

With few exceptions, most orally administered anti-cancer medications are considered *specialty drugs*. For orally administered anti-cancer medications, the *prescription drug* deductible, if any, will not apply and the copayment will not exceed the lesser of the applicable copayment shown below or $200 for a 30-day supply for medications obtained at a retail *drugstore* or $600 for a 90-day supply for medications obtained through home delivery.

The first time you get a *prescription* for a *specialty drug* you must also include a completed Intake Referral Form. The Intake Referral Form is to be completed by calling the toll-free number below. You need only enclose the *prescription* or refill notice, and the appropriate payment for any subsequent *specialty drug* prescriptions, or call the toll-free number. *Copay*s can be made by check, money order, credit card or debit card.

You or your *physician* may obtain order forms or a list of *specialty drugs* that must be obtained through specialty pharmacy program by contacting Member Services at the number listed on your ID card or online at www.anthem.com/ca.

Specified *specialty drugs* must be obtained through the Specialty Pharmacy Program. When these specified *specialty drugs* are not obtained through the Specialty Pharmacy Program, and you do not have an exception, you will not receive any benefits for these *drugs* under this plan.

What You Will Need to Pay

You will need to pay the following *copays* for each *prescription*.

Member Drugstores	**Copay**

The following co-payments apply for a 30-day supply of medication. If you receive more than 30-day supply of medication at a *drugstore*, you will have to pay the applicable copay shown below for each additional 30-day supply of medication.

Note: Specified *specialty drugs* must be obtained through the specialty pharmacy program. However, the first month supply of a *specialty drug* is obtained through a retail *drugstore*, after which the *drug* is available only through the specialty pharmacy program unless an exception is made.

- *Tier 1 drugs*.....**$10**
- Diabetic Supplies **$10**
- *Tier 2 drugs*.....**$20**
- *Tier 3 drugs*.....**$35**
- *Compound Medication*.....**$35**
- *Tier 4 drugs*.....**$35**

Non-Member Drugstores (inside and outside California)	**Copay**

The following co-payments apply for a 30-day supply of medication. If you receive more than 30-day supply of medication at a *drugstore*, you will have to pay the applicable copay shown below for each additional 30-day supply of medication.

Note: Specified *specialty drugs* must be obtained through the specialty pharmacy program. However, the first month supply of a *specialty drug* may be obtained through a retail *drugstore*, after which the *drug* is available only through the specialty pharmacy program unless an exception is made.

- *Tier 1 drugs*.....**$10**

plus **50%** of the
remaining *prescription drug*
maximum allowed amount

- Diabetic Supplies **$10**
  plus **50%** of the
  remaining *prescription drug*
  maximum allowed amount

- *Tier 2 drugs*.....**$20**
  plus **50%** of the
  remaining *prescription drug*
  maximum allowed amount

- *Tier 3 drugs*.....**$35**
  plus **50%** of the
  remaining *prescription drug*
  maximum allowed amount

- *Tier 4 drugs*.....**$35**
  plus **50%** of the
  remaining *prescription drug*
  maximum allowed amount

Home Delivery Program: You need to pay the following co-pays for a 90-day supply of medication:

Home Delivery Prescriptions	**Copay**

- *Tier 1 drugs*.....**$20**
- Diabetic Supplies **$20**
- *Tier 2 drugs*.....**$40**
- *Tier 3 drugs*.....**$60**
- *Tier 4 drugs*.....**$60**

Exceptions to Prescription Drug Co-Payments

- "Preventive Prescription Drugs and
  Other Items" covered under Getting

Prescription Drugs ..... **No charge**

In addition, the copayment for orally-administered anti-cancer medications will not exceed the lesser of any applicable copayment listed above or:

- For a 30-day supply from a retail *drugstore* **$200**
- For a 90-day supply through home delivery **$600**

Note: If your *drugstore's* retail price for a drug is less than the copay shown above, you will not be required to pay more than that retail price.

You will always have to pay for costs that this *plan* does not cover.

Preferred Generic Program

Prescription drugs will always be dispensed by a *pharmacist* as prescribed by your *doctor*. Your *doctor* may order a *drug* in a higher or lower *drug* copay tier for you. You may request your *doctor* to prescribe a *drug* in a higher copay tier for you or you may request the *pharmacist* to give you a *drug* in a higher copay tier instead of a *drug* in a lower copay tier. Under this *plan*, if a drug in a lower copay *drug* tier is available, and it is not determined that a higher copay tier *drug* is *medically necessary* for you to have) see "Prescription Drug Formulary, Drugs That Need to Be Approved," above), you will have to pay the copay for the lower copay *drug* tier plus the difference in cost between the *prescription drug maximum allowed amount* for the lower copay *drug* tier and the higher copay *drug* tier, but, not more than 50% of our average cost for the tier that the *drug* is in. If your *doctor* specifies "dispense as written," in lieu of paying the copay for the lower copay *drug* tier plus the difference, as previously stated, you will pay just the applicable copay shown for the *drug* in the higher copay tier you get. For certain higher cost *generic drugs*, we may make an exception and not require you to pay the difference in cost between the *generic drug* and *brand name drug*.

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*, home delivery *drugs*, over-the-counter *drugs* or *preferred drug* products. Such programs may involve reducing or waiving co-payments for those *generic drugs*, over-the counter *drugs*, or the *preferred drug* products for a limited time. 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.

Half-tab Program

The Half-Tablet Program allows you to pay a reduced co-payment on selected "once daily dosage" medications. The Half-Tablet Program allows you to obtain a 30-day supply (15 tablets) of a

higher strength version of your medication when the prescription is written by the *doctor* to take "½ tablet daily" of those medications on an list approved by us. The *Pharmacy and Therapeutics Process* will determine additions and deletions to the approved list. The Half-Tablet Program is strictly voluntary and your decision to participate should follow consultation with and the concurrence of your *doctor*. To obtain a list of the products available on this program call 1-800-700-2541 (or TTY/TDD 1-800-905-9821) or go to our internet website www.anthem.com/ca.

Split Fill Dispensing Program

The split fill program is designed to prevent and/or minimize wasted *prescription drugs* if your *prescription* or dose changes between fills, by allowing only a portion of your *prescription* to be obtained through the specialty pharmacy program. This program also saves you out-of-pocket expenses.

The *drugs* that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and potential reactions or side-effects. This program allows you to get your *prescription drug* in a smaller quantity and at a prorated copay so that if your dose changes or you have to stop taking the *prescription drug*, you can save money by avoiding costs for *prescription drugs* you may not use. You can access the list of these *prescription drugs* by calling the toll-free number on your member ID card or log on to the website at www.anthem.com/ca.

For your health and safety

For your health and safety, we check the medicines you are using. Some *drugs* may need our OK. If we see that too many *drugs* are being used, we will let your *doctor* and the *drugstore* know. We may also limit the benefits to prevent over-use.

We Cover These Drug Services and Supplies

- *Drugs* and medicines which need a *prescription* by law, except as specifically stated in this booklet. Formulas prescribed by a

doctor for the treatment of phenylketonuria. These formulas are subject to the *copay* for *brand name drugs*.

- Insulin.
- Syringes for use with insulin and other medicines you inject yourself.
- All FDA-approved contraceptives for women, including oral contraceptives, diaphragms, patches, and over-the-counter contraceptives prescribed by a *doctor*. Diaphragms are limited to one per year (unless it is determined that more than one per year is *medically necessary*) and are subject to the *copay* for *brand name drugs*.

  Contraceptives may be covered as *preventive care services.* In order to be covered as *preventive care* contraceptive *prescription drugs* must be *generic drugs* or *single source brand name drugs* that you get from a member *drugstore* or through the home delivery program.
- *Drugs* with Food and Drug Administration (FDA) labeling for self-administration.
- AIDS vaccine (when approved by the federal Food and Drug Administration and that is recommended by the US Public Health Services).
- Disposable diabetic supplies (such as test strips and lancets).
- *Prescription drugs* for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.
- Inhaler spacers and peak flow meters for the treatment of pediatric asthma. These items are subject to the copay for *brand name drugs*.
- *Prescription drugs* that help you stop smoking or reduce your dependence on tobacco products. These *drugs* will be covered as specified under "Preventive Prescription Drugs and Other Items", subject to all terms of this *plan* that apply to those benefits.

- FDA-approved smoking cessation products and over-the-counter nicotine replacement products when obtained with a *doctor's prescription*. These products will be covered as *preventive care services* when obtained from a *member drugstore*. Coverage is provided as specified under "Preventive Prescription Drugs and Other Items", subject to all terms of this *plan* that apply to those benefits.

- Vitamins, supplements, and health aids specifically listed in this *plan* as covered under "Preventive Prescription Drugs and Other Items", subject to all terms of this *plan* that apply to those benefits.

Drug Services and Supplies Not Covered

Besides the services and supplies listed under "What We Do Not Cover," when you buy *drugs* or medicines from a *drugstore*, or through the home delivery program, we do not cover:

- *Drugs* and medicines used to induce spontaneous and non-spontaneous abortions. While not covered under this *prescription drug* benefit, FDA approved medications that may only be dispensed by or under direct supervision of a *doctor*, such as *drugs* and medications used to induce non-spontaneous abortions, are covered as specified in "Pregnancy or maternity care," under "Your Benefits At Anthem Blue Cross HMO," (see Table of Contents) subject to all terms of this *plan* that apply to those benefits.

- Professional charges for giving and injecting *drugs*. While not covered under this *prescription drug* benefit, they are covered as specified in "Doctor Care" and "Preventive Care Services" under "Your Benefits At Anthem Blue Cross HMO," (see Table of Contents) subject to all terms of this *plan* that apply to those benefits.

- *Drugs* and medicines you can get without a *doctor's prescription*, except insulin or niacin for reducing cholesterol.

  Note: Vitamins, supplements, and certain over-the-counter items as specified under "Preventive Prescription Drugs and

Other Items" are covered under this *plan* only when obtained with a *doctor's prescription*, subject to all terms of this *plan* that apply to those benefits.

- *Drugs* labeled "Caution, Limited by Federal Law to Investigational Use," or Non-FDA approved investigational *drugs*. *Drugs* and medicines prescribed for *experimental* indications. If you are denied a *drug* because we determine that the *drug* is *experimental* or *investigative*, you may ask that the denial be reviewed by an external independent medical review organization. (See the section "Independent Medical Review of Denials of Experimental or Investigative Treatment" for how to ask for a review of your *drug* denial.)

- Any cost for a *drug* or medicine that is higher than what we cover. Your *copay*, shown above, is the only cost you have when you get your *drugs* at a *member drug store*. But, when you get your *drugs* at a *non-member drug store*, your cost may be higher. At a *non-member drug store*, you have to pay the *copay* that applies plus any amount over the *prescription drug maximum allowed amount*, except when the *drugs* are related to *urgent care* or *emergency services*.

- *Drugs* which haven't been approved for general use by the Food and Drug Administration (FDA). This does not apply to *drugs* that are *medically necessary* for a covered condition.

- *Drugs* and medicines dispensed or given in an outpatient setting; including, but not limited to inpatient facilities and *doctors*' offices. While not covered under this *prescription drug* benefit, if you need these *drugs*, they are covered as specified in "Outpatient (In a Hospital or Surgery Center)," "Preventive Care Services," "Home Health Care," "Hospice Care" and "Skilled Nursing Facility Services," subject to all terms of this *plan* that apply to those benefits.

- *Drugs* and medicines dispensed by or while you are confined in a *hospital*, *skilled nursing facility*, rest home, sanitarium, convalescent hospital or similar facility. While not covered under this *prescription drug* benefit, if you need these *drugs*,

they are covered as specified under the section describing benefits for "Inpatient Hospital Services," "Skilled Nursing Facility Services" and "Hospice Care," subject to all terms of this *plan* that apply to those benefits.

- Durable medical equipment, devices, appliances and supplies even if ordered by a *doctor*. This does not apply to covered birth control devices that can only be obtained with a *prescription*. While not covered under this *prescription drug* benefit, if you need any of these items, they are covered as specified in "Diabetes" and "Medical Equipment" under "Your Benefits at Anthem Blue Cross HMO," subject to all terms of this *plan* that apply to those benefits.

- Oxygen. While not covered under this *prescription drug* benefit, if you need oxygen, it is covered as specified in "Inpatient Hospital Services," "Outpatient (In a Hospital or Surgery Center)," "Skilled Nursing Facility Services," and "Hospice Care" under "Your Benefits at Anthem Blue Cross HMO," subject to all terms of this *plan* that apply to those benefits.

- Cosmetics, health and beauty aids. While not covered under this *prescription drug* benefit, if a health aid is *medically necessary* and meets the requirements of "Medical Equipment" under "Your Benefits at Anthem Blue Cross HMO," they are covered subject to all terms of this *plan* that apply to those benefits.

- *Drugs* used mainly for cosmetic purposes (for example, Retin-A for wrinkles). But, this will not apply to the use of this type of *drug* for *medically necessary* treatment of a medical condition other than one that is cosmetic.

- *Drugs* used mainly for treating *infertility* (for example, Clomid, Pergonal, and Metrodin) unless *medically necessary* for another covered condition.

- *Drugs* for losing weight, except when needed to treat morbid obesity (for example, diet pills and appetite suppressants). This

rule does not apply to *drugs* used for weight loss which are listed as covered under the PreventiveRx program, if included.

- *Drugs* you get outside the United States unless related to *emergency services* or *urgent care*.
- Allergy serum. While not covered under this *prescription drug* benefit, if you need this item, it is covered as specified in "General Medical Care (In a Non-Hospital-Based Facility)" under the section "Your Benefits at Anthem Blue Cross HMO," subject to all terms of this *plan* that apply to those benefits.
- Infusion *drugs*, except *drugs* you inject under the skin yourself. While not covered under this *prescription drug* benefit, these *drugs* are covered as specified in "Doctor Care," "Inpatient Hospital Services," "Outpatient (In a Hospital or Surgery Center)," "Skilled Nursing Facility Services," and "Hospice Care" under the section "Your Benefits at Anthem Blue Cross HMO," subject to all terms of this *plan* that apply to those benefits.
- Herbal, nutritional and diet supplements. But, formulas prescribed by a *doctor* for the treatment of phenylketonuria that are obtained from a *pharmacy* are covered as specified in "We Cover These Drug Services and Supplies." Special food products that are not available from a *drug store* are covered as specified in "Special Food Products" under the section "Your Benefits at Anthem Blue Cross HMO," subject to all terms of this *plan* that apply to the benefit. In addition, vitamins, supplements, and certain over-the-counter items as specified under "Preventive Prescription Drugs and Other Items" are covered under this *plan* only when obtained with a *doctor's prescription*, subject to all terms of this *plan* that apply to those benefits.
- *Prescription drugs* with an over-the-counter equivalent (the same chemical or active ingredient) other than insulin. This does not apply if an over-the-counter equivalent was tried and it didn't work.

- Onychomycosis (toenail fungus) *drugs* except to treat *members* who are immuno-compromised or diabetic.
- *Compound medications* unless all the ingredients are FDA-approved and require a prescription to dispense, and the *compound medication* is not essentially the same as an FDA-approved product from a *drug* manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants. *Compound medications* must be obtained from a *member drugstore*. **You will have to pay the full cost of the *compound medications* you get from a *non-member drugstore***. If you are denied a *compound medication* because you obtained it from a *non-member drugstore*, you may file a complaint with us according to the procedures described in the section called "How to Make a Complaint".
- *Specialty drugs* that must be obtained from the specialty pharmacy program, but, which are obtained from a retail *drugstore* or through the home delivery program. Unless you qualify for an exception, these *drugs* are not covered by this *plan* (please see the section Getting Prescription Drugs). **You will have to pay the full cost of the *specialty drugs* you get from a retail *drugstore* that you should have obtained from the specialty pharmacy program**. **If you order a *specialty drug* through the home delivery program, it will be forwarded to the specialty pharmacy program for processing and will be processed according to specialty pharmacy program rules.**

What You Should Know about Your Coverage

How Coverage Begins

You can enroll in Anthem Blue Cross HMO if you are a permanent full-time employee. That means you work at least 20 hours a week for your employer.

You can enroll the following family members in Anthem Blue Cross HMO:

- Your spouse as recognized under state or federal law. This includes same sex spouses when legally married in a state that recognizes same-sex marriages.
- Your domestic partner if you are in a legally registered and valid domestic partnership.
- Your, your spouse's, or your domestic partner's natural children, step children, legally adopted children, or children for whom you, your spouse, or domestic partner have been appointed legal guardians by a court of law, who are:
  - Under 26 years old, or
  - 26 years old or more if they are not capable of getting a self-sustaining job due to a physical or mental condition, and
    - They are unmarried.
    - They must depend chiefly on you, your spouse, or domestic partner for support and maintenance. A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.
    - A *doctor* certifies in writing that the child is incapable of getting a self-sustaining job due to a physical or mental condition. We must receive the certification, at no expense to us, within 60-days of the date you receive 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.

– They were covered under the *prior plan*, they were covered as a family member of the employee under another health plan or health insurer, or have six or more months of other *creditable coverage*.

The child may remain covered under the *plan* until he or she is no longer chiefly dependent on you, your spouse, or domestic partner for support and maintenance due to a continuing physical or mental condition.

You can't enroll as a spouse or domestic partner:

- If you are also covered as an employee under the same plan.
- If you are now on active duty in the armed services.

You and your family members must live or work in the Anthem Blue Cross HMO service area. You and your family members must live in the United States to be covered under this *plan*.

When Are You Covered?

You are eligible to enroll with this *plan* in accordance with rules established by your employer. For specific information about your employer's eligibility rules for coverage, please contact your Human Resources or Benefits Department.

Your family members are eligible to be covered:

- For all existing family members, on the date you are covered; or
- For a new spouse and step child, if any, the first day of the month after the date your spouse and step child, if any, become a family member(s) due to marriage;
- For a new domestic partner and his or her child, if any, the first day of the month after the date your domestic partner and his or

her child, if any, become a family member(s) due to the start of a domestic partnership;

- For an over age child, the first day of the month after the date your child again becomes a family member;
- The date a child becomes your family member due to birth or adoption; or
- For a child for whom you, your spouse or domestic partner is a legal guardian, the first day of the month after the date of the court decree.

To enroll, you must give your employer a signed Enrollment Form within 60 days after the day you are eligible.

- If you enroll before, on, or within 60 days after the date you were eligible, then your coverage will start on your eligibility date.
- If you do not enroll within 60 days of your eligibility date, you cannot enroll. Your next chance to enroll is your employer's next *Open Enrollment*. Sometimes, you may be able to enroll earlier. See "When You Can Enroll Without Waiting."

If you choose to leave this *plan*, you will be eligible to enroll again during your employer's next *Open Enrollment*. You may be able to enroll earlier. See "When You Can Enroll Without Waiting."

Your employer must pay the subscription charges every month in order for you to be covered. Your employer may ask you to pay all or part of these charges. Talk to your employer about how much you must pay.

For you to get benefits we must have an *agreement* with your employer and you must be covered at the time you got the service. The benefits you get will be the benefits in effect at the time the services are provided. Your employer's health plan *agreement* with us may change from time to time, or end, without your consent.

If You Want to Enroll a New Child

Here's how new children are enrolled if you are already covered:

- ♦ Any child born to you will be enrolled from the moment of birth for 31 days; and
- ♦ Any child being adopted by you will be covered for 31 days from the date:
  - You have financial responsibility for the child OR
  - You have the right to control the child's health care.

  You will need to give us legal papers or other proof for either one.

For the child's enrollment to continue beyond this 31-day period, you must submit a *membership change form* to the *group* within this 60-day period. You will need to pay subscription charges, if any, for them from the date their coverage began.

When You Can Enroll Without Waiting. You may enroll without waiting for your employer's next open enrollment period if all of the following are true:

- ♦ **You meet all of the following requirements:**
  - You were covered as an individual or dependent under either:
    - ⇒ Another employer group health plan or health insurance coverage, including coverage under a COBRA or CalCOBRA continuation; or
    - ⇒ 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.
  - Your coverage under the other health plan wherein you were covered as an individual or dependent ended as follows:

⇒ 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 a signed Enrollment Form with the *group* within 60 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, no longer living or working in the Anthem Blue Cross HMO service area (whether or not by your choice), and any loss of eligibility for coverage after a period of time that is measured by reference to any of the foregoing.

⇒ 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 a signed Enrollment Form with the *group* within 60 days after the date your coverage ended.

♦ A court has ordered that your spouse, domestic partner or child be covered under your employee health plan, and you give your employer a signed Enrollment Form within 60 days from the date the court order was issued.

- We don't have a written statement from your employer stating that before you chose not to enroll or not be enrolled you were given and signed a notice that told you:
  - If you choose not to enroll for coverage within 60 days after you become eligible; or
  - If you choose to cancel your coverage; and
  - Later choose to enroll;

  Your coverage may not begin until the first day of the month following the end of your employer's *open enrollment*.

- You have a change in family status through either marriage or domestic partnership, or the birth, adoption or placement for adoption of a child:
  - If you enroll following marriage or domestic partnership, you and your new spouse or domestic partner must enroll within 60 days of the date of marriage or domestic partnership. Your new spouse or domestic partner's children may also enroll, but your other children may not enroll unless they qualify under another one of these conditions listed above.
  - If you enroll following the birth, adoption or placement for adoption of a child, your spouse (if you are already married) or domestic partner may also enroll at that time. Other children may not enroll at that time unless they qualify under another one of these conditions listed above. Application must be made within 60 days of the birth or date of adoption or placement for adoption.

- All of the following conditions are met:
  - You finished the waiting period under the *plan*, if any, but ceased to be eligible due to the end of your employment;
  - You again become eligible to enroll within 6 months of the date your employment ended; and

- You enroll within 60 days of your return to work.

- You met or went beyond a lifetime limit on all benefits of another health plan. Your application must be made within 60 days of the date a claim or a portion of a claim is denied because you met or went beyond a lifetime limit on all benefits of another health plan.

- 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 a signed Enrollment Form with the *group* within 60 days after the date you are determined to be eligible for this assistance.

- You are an employee who is a reservist as defined by state or federal law, who terminated coverage as a result of being ordered to military service as defined under state or federal law, and apply for reinstatement of coverage following reemployment with your employer. Your coverage will be reinstated without any waiting period. The coverage of any dependents whose coverage was also terminated will also be reinstated. For dependents, this applies only to dependents who were covered under the plan and whose coverage terminated when the employee's coverage terminated. Other dependents who were not covered may not enroll at this time unless they qualify under another of the circumstances listed above.

The effective date of coverage for enrollments during a special enrollment period as described above will be on the first day of the month following the date you file the signed Enrollment Form, except as specified below:

- If a court has ordered that coverage be provided for a dependent child, coverage will become effective for that child on the earlier of:

  - The first day of the month following the date you file the signed Enrollment Form; or

- 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.

- For reservists and their dependents applying for reinstatement of coverage following reemployment with the employer, coverage will be effective as of the date of reemployment.
- 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.

Open Enrollment

If you are eligible to be covered, *Open Enrollment* is a time you can enroll yourself or your family members. Your employer has this time once a year.

You or your family members will be covered on January 1 following the end of the *Open enrollment* period. If you had another plan, it would end when this one starts.

When We Cannot Cancel Your Coverage

We cannot cancel your coverage while:

- This *plan* is in effect;
- You're eligible;
- Your subscription charges are paid;
- You live or work within a *medical group's* service area;
- You follow your *primary care doctor's* advice and treatment and you work with the *medical group*; and
- You pay all *copays* within 31 days after you get a bill.

The benefits of this *plan* are only for *medically necessary* services as decided by your *medical group* or Anthem.

We are not responsible for any costs you have to pay over the *plan's* benefits.

Only *members* may get benefits under this *plan*. You cannot transfer the right to benefits to another person.

How Your Coverage Ends

We are not required to send you a notice that coverage is ending if you decide, or your employer decides, to end coverage. Coverage may end:

- **If our *agreement* with your employer ends.** Coverage ends on the date the *agreement* is terminated or cancelled. If we decide to end the coverage provided to you by your employer for any of the reasons shown in the *agreement*, we will give written notice of termination, cancellation or non-renewal to your employer. Your employer will send or give you a copy of the termination, cancellation or non-renewal notice at least seven days prior to the date coverage ends.

- **If the subscription charges are not paid**. If your employer fails to pay the subscription charges as they become due, we may terminate the *agreement* as of the last day of the Grace Period described below. Nevertheless, we will terminate the *agreement* only upon first giving the employer a written Notice of Cancellation that is delivered to them at least 30-days prior to that cancellation (or any longer period of time required by applicable federal law, rule, or regulation).

- The Notice of Cancellation shall state that the *agreement* shall not be terminated if the employer makes appropriate payment in full within 30-days after we issue the Notice of Cancellation (or any longer period of time required by applicable federal law, rule, or regulation). The Notice of Cancellation shall also inform the employer that, if the *agreement* is terminated for non-payment and the employer wishes to apply for reinstatement, the employer shall be required to submit a new application for coverage, and that Anthem either may decline to permit reinstatement in its sole discretion or may permit reinstatement upon terms and conditions as it shall determine

appropriate in its sole discretion, as set forth in the *agreement*. Per the *agreement*, your employer will mail a copy of our notice to them to you. If you have any questions about your coverage ending, and how it will affect you, please call the customer service phone number on your I.D. card.

Grace Period. For every Subscription Charge Due Date except the first, there is a 30-day grace period in which to pay subscription charges. The grace period begins after the last day of paid coverage. The *agreement* remains in force during the grace period, and coverage is maintained during the grace period. The employer is liable for payment of subscription charges covering any period of time that the *agreement* remains in force, including any grace period. If your employer fails to pay us the subscription charges due during the grace period, we will not end your coverage until the end of the grace period. You will not be required by us to pay the subscription charges for your employer nor will you be required to pay more than your copay for any services received during the grace period.

If subscription charges due are not paid by the end of the grace period, the *agreement* will be canceled as described above.

- **If the *agreement* is changed at your employer's request to stop covering the class of employees to which you belong.** We will no longer cover you or your family members on the date of that change.
- **If the *agreement* is changed at your employer's request to stop covering family members.** We will no longer cover your family members on the date of that change.
- **If you are no longer covered.** Your family members will no longer be covered.
- **If you do not pay your copay.** If you do not pay your *copay* to a provider within 31-days from the date that you are sent a bill by a provider to make your *copay* payment, if requested in writing to us by the provider, Anthem will send you a written notice to let you know that you have not paid your *copay*. If you

do not pay your *copay* to the provider within 15-days from the date we sent our notice to you, we will terminate your coverage at 12:00 midnight on the fifteenth day following the date we sent notice to you telling you of this. If your coverage is terminated, Anthem will tell your employer not to pay any further subscription charges for you. Within 30-days, we will return the pro-rata portion of any monies paid to us by your employer for your coverage for the unexpired period for which payment has been received together with amounts due on claims, if any, less any amounts due us. Your employer will return your portion of the money returned to them to you.

If your coverage was ended because you didn't pay your *copay*, and you have now paid it, you may have your coverage reinstated by re-enrolling as follows:

- If you paid your *copay* and re-enroll on, or within 31-days after the date your coverage was ended, then your coverage will be reinstated to the date your coverage ended. (There will be no lapse of coverage.)

- If you do not pay your *copay* within 31-days after your coverage would end due to failure to make the required *copay*, but subsequently paid your *copay* and re-enroll within 31-days after you paid your *copay*, then your coverage will start on the next subscription charge due date shown in the *agreement* under the same terms that apply to others in your classification. (There will be a lapse of coverage for the time period between when we ended your coverage and the date your employer again pays subscription charges for your coverage.)

- If you did not pay your *copay* within 31-days after the date your coverage ended, and you do not re-enroll within 31-days of the date you paid your *copay*, you will be eligible to enroll again during your employer's next *Open Enrollment.*

♦ **If you decide to cancel at any time.** Your coverage ends on the next subscription charge due date after we receive written

notice from your employer that you have ended your coverage. You must give your employer written notice to end your coverage.

- **If you or a family member are no longer eligible**. Your coverage ends on the next subscription charge due date following the date you are no longer eligible for coverage, except in these cases:

  - **Leave of Absence.** If your employer pays the subscription charges to us, you may be covered while you take a short-term leave of absence your employer allows.

  - **Handicapped Children.** If your child has a physical or mental condition that prevents him or her from getting a self-sustaining job and reaches the upper age limit in this *plan* for a child (26 years), your child can still qualify if he or she is:

    ⇒ Covered under this *plan*.

    ⇒ Still chiefly dependent on you, your spouse or your domestic partner for support and maintenance.

    ⇒ Not able to get a job to self-support himself or herself because of the physical or mental condition.

    A *doctor* must certify in writing that your child is incapable of self-sustaining employment due to a physical or mental condition.

    We will notify you that your child's coverage will end when your child reaches the *plan's* upper age limit at least 90 days prior to the date the child reaches that age. You must send proof of the child's physical or mental condition within 60 days of the date you receive our request. If we do not complete our determination of your child's continuing eligibility by the date your child reaches the plan's upper age limit, your child will remain covered pending our determination.

After two years have passed since you gave us the first certification, you may need to send us proof that your child is still chiefly dependent on you, your spouse or your domestic partner for support and maintenance and that a physical or mental condition still exists, but we will not ask for this proof more than once a year.

We will cover your child until he or she no longer has a physical or mental condition that prevents him or her from getting a job or he or she is no longer dependent on you, your spouse or your domestic partner for support and maintenance.

A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

♦ **Fraud or misrepresentation by you or a family member.** Termination is effective upon the later of: (1) the date shown in the written notice to you; or (2) the date the written notice was mailed to you:

- **Fraud or deception in the use of services or facilities.** You or a family member may individually have your coverage terminated if any of you commits fraud or deception in the use of services or facilities. If you, as the employee, have your coverage terminated for such fraud or deception, coverage for all other family members will also end.

- **Intentional misrepresentation of material fact under the terms of the *agreement*.** If you or a family member purposely gives us incorrect or incomplete material information, and we rely on such information in providing health care services to that member, we may end coverage to that member. If you, the employee, furnish incorrect or incomplete material information, you and all family members may have your coverage ended. No statement made by you, unless it is fraudulent and in writing, will be used in any contest to end your coverage under this *plan*.

After your coverage under this plan has been in force for 24 months, no statement made by you will be used to end your coverage.

Note: If your marriage or domestic partnership ends, you must give or send to your employer written notice that it has ended. Coverage for former spouses and domestic partners, and their dependent children, if any, ends according to the "What You Should Know about Your Coverage" provisions. If Anthem has a loss, because you fail to tell your employer your marriage or domestic partnership ended, Anthem may recover any actual loss from you. If you fail to give your employer notice in writing that your marriage or domestic partnership ended, it will not delay or prevent the end of your marriage or domestic partnership. If you notify your employer in writing to cancel coverage for a former spouse or domestic partner, and the children of the former spouse or domestic partner, if any, right away at the end of your 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 Keeping Anthem Blue Cross HMO After Your Coverage Status Changes, and Extension.

A Medical Group Can End its Services to You

- **If you move away from the area it serves.** You will need to ask to transfer to another *medical group*. If you move outside the Anthem Blue Cross HMO service area, you won't be eligible for Anthem Blue Cross HMO.
  - Call the *Customer service number* on your Member ID card, or ask your employer for a *membership change form.*
  - The change in your *medical group* will happen on the first day of the month after we get your request.
- **If you refuse to follow a treatment** your *doctor* recommends when there is no other better choice, your coverage may end with that *doctor* and/or *medical group*. We will help you get coverage with another *doctor* and/or *medical group*.

- **If your conduct threatens others.** If you act in a way that threatens the safety of Anthem employees, providers, other plan members, or other patients, or repeatedly behave in a manner that substantially impairs Anthem's ability to furnish or arrange services for you or other *members* or substantially impairs a provider's ability to provide services to other patients, your *medical group* may ask us to move you to another *medical group*. You will have the opportunity to respond to any allegations that any such behavior has occurred.

If You Believe Your Coverage Has Been Cancelled Unfairly

If you believe your coverage has been or will be improperly cancelled, you may file a complaint with us according to the procedures described in the section called "How to Make a Complaint". You should file your complaint as soon as possible after you receive notice that your coverage will end. You may also ask for a review of the matter by the Director of the Department of Managed Health Care. If your coverage is still in effect when you file a complaint, we will continue to provide coverage to you under the terms of this *plan* until a final determination of your request for review has been made, including any review by the Director of the Department of Managed Health Care (this does not apply if your coverage is cancelled because the subscription charges have not been paid). If your coverage is maintained in force pending the outcome of the review, subscription charges must still be paid to us on your behalf.

Keeping Anthem Blue Cross HMO After Your Coverage Status Changes

If your employer employs 20 or more people, you may be able to keep on being covered even after you no longer work for that employer. This is called *COBRA*. Ask your employer for more information.

You or Your Family Members May Choose *COBRA*

You can go on being covered by Anthem:

- When your job ends, for any reason other than gross misconduct.
- When you lose coverage under an employer's plan because your work hours have reduced.
- When, as a retiree, your benefits are canceled or reduced because your former employer filed for Chapter 11 bankruptcy.

Your family members, other than a domestic partner, or the child of a domestic partner, can go on being covered by Anthem even.

- If your job ends, for any reason other than gross misconduct.
- If you lose coverage under an employer's plan because your work hours have reduced.
- If you were to die.
- If you are divorced or legally separated.
- If your domestic partnership ends.
- If your child is no longer qualifies as a dependent. For example, your child reaches the upper age limit of the *plan*.
- If you become entitled to Medicare.

Your employer will let you or your family members know that you have a right to keep your health plan under *COBRA*. If you marry, enter a domestic partnership, or have a new child

during this time, your new spouse, domestic partner or child can be enrolled as a family member. But only a child born to or placed for adoption with you will have the same rights as someone who was covered under the *plan* just before *COBRA* was elected.

Your employer will notify you or your family members if you can continue your coverage under *COBRA* when:

- You lose your job or your work hours are reduced.
- Your benefits as a retiree are canceled or reduced because your former employer filed for Chapter 11 bankruptcy.
- You die or become entitled to Medicare. Your employer will notify your family members.

You must inform your employer if your family members want *COBRA* coverage within 60 days from the date:

- You get a divorce or legal separation.
- If your domestic partnership ends.
- Your child is no longer a dependent.

If You Want to Keep Your Health Plan

- ♦ Tell your employer within 60 days of the date you get your notice of your right to keep your health plan.
- ♦ You can have coverage for all the *members* of the family, or only some of them.
- ♦ If you don't choose *COBRA* during those 60 days, you cannot have it later.
- ♦ Your employer must send your payment and the *COBRA* forms to keep you covered within 45 days after you choose to keep it.

You may have to pay the whole cost. You should know that you may have to pay the whole cost of staying on the health plan.

- ♦ You must send your payment to the employer every month.

- Your employer must send it to Anthem. This will keep your coverage going.

The subscription charge that applies to the employee will also apply to:

- A spouse, because of divorce, separation or death.
- A domestic partner, because of the end of your domestic partnership or death.
- A child, even if you or your spouse do not choose *COBRA* (if more than one child enrolls, subscription charges for the number enrolling will apply).

How Long You Can Be Covered

You can go on being covered until the first of the following events takes place:

- The end of eighteen months (18) if you lost your job or your hours were lowered. (Note: If your *COBRA* began on or after January 1, 2003 and ends after 18 months, you can keep your medical coverage only under CalCOBRA for up to another 18 months, making a total of 36 months under *COBRA* and CalCOBRA combined. You must completely use up your eligibility under *COBRA* first. Your CalCOBRA rights are explained later in this section.)
- The date our *agreement* with your employer ends.
- The date you stop paying the monthly charges.
- The date you first become covered under another group health plan.
- The date you first become entitled to Medicare.

Your family members can go on being covered until the first of the following events takes place:

- Eighteen months (18) if you lost your job, or your hours were lowered. However, this does not apply if coverage did not end

when you became entitled to Medicare before you lost your job or your work hours were lowered. *COBRA* coverage ends 36 months from the date you became entitled to Medicare if entitlement occurred within the 18 months before the date your job ended or your work hours were lowered. (Note: If your *COBRA* began on or after January 1, 2003 and ends after 18 months, or some longer period if you became entitled to Medicare before you lost your job or your work hours were lowered but sooner than 36 months, you can keep your medical coverage only under CalCOBRA for the balance of 36 months under *COBRA* and CalCOBRA combined. You must completely use up your eligibility under *COBRA* first. Your CalCOBRA rights are explained later in this section.)

- Thirty-six months (36) if there was a death, divorce, or legal separation.
- Thirty-six months (36) if the child is no longer dependent.
- Thirty-six months (36) from your entitlement to Medicare.
- The date our *agreement* with your employer ends.
- The date they first become eligible under another group health plan.
- They stop paying monthly charges.
- They first become entitled to Medicare.

Your family members may be able to get extended *COBRA* coverage if they experience another event described above. If a second event occurs, your family members may extend *COBRA* up to 36 months from the date of the first event if:

- Your family members were originally covered under the first event; and
- Your family members were covered under the *plan* when the second event occurred.

This period may not go beyond 36 months from the date of the first event.

Other Coverage Options Besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through the conditions listed under "When You Can Enroll Without Waiting". Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Retirement and COBRA

If you are a retiree and your benefits are canceled or reduced because your former employer filed for Chapter 11 bankruptcy, you may be covered for the remainder of your life. Your covered family members may continue coverage for 36 months after your death. Coverage ends when:

- Our *agreement* with your former employer ends.
- You or your family member stops paying the monthly charges.
- You or your family member first becomes covered under another group health plan.

If You or a Family Member is Disabled

If you or a family member is determined by Social Security to be disabled, your whole family may be able to be covered for up to 29 months. This is an additional 11 months following the 18 months of *COBRA* coverage due to your job loss or reduction of work hours. You may be covered for the additional 11 months if you or a family member is determined to be disabled by Social Security before the job loss or reduction of work hours or during the first 60 days of *COBRA* continuation.

You must show your employer proof that the Social Security Administration (SSA) found that you or your family member was disabled. You must show your employer this proof during the first

18 months of your *COBRA* continuation and no later than 60 days after the later of the following:

- The date of the Social Security Administration's finding of the disability.
- The date the original qualifying event happened.
- The date you lost coverage.
- The date you are told you must show your employer the disability notice.

For the 19th through 29th months that the disability goes on, the employer must send the monthly charges.

- This will be **150%** of the applicable rate for the length of time the disabled person is covered, depending on how many family members are being covered.
- If the disabled person is not covered during this additional 11 months, the charge will stay at **102%** of the applicable rate.
- The employer must send the charges to us every month.
- You may have to pay the whole cost.

This coverage will last until the first of the following events takes place:

- The end of the month following a period of 30 days after the SSA finds that the family member is no longer disabled.
- The end of 29 months. (Note: If your *COBRA* began on or after January 1, 2003 and ends after 29 months, you can keep your medical coverage only under CalCOBRA for up to another seven (7) months, making a total of 36 months under *COBRA* and CalCOBRA combined. You must completely use up your eligibility under *COBRA* first. Your CalCOBRA rights are explained later in this section.)
- You stop paying the monthly charges.
- The *agreement* with your employer ends.

- You get another health plan that will cover the disability.
- The disabled person becomes entitled to Medicare.

You must let your employer know within 30 days that the SSA found that you or your family member is no longer disabled.

If a second event occurs during this additional 11 months, *COBRA* may extend for up to 36 months from the date of the first event. The charge will be **150%** of the applicable rate for the 19th through 36th months if the disabled person is covered. This charge will be **102%** of the applicable rate for any periods of time the disabled person is not covered after the 18th month.

What About After COBRA?

After *COBRA* ends, you may be able to keep your coverage through another program called "CalCOBRA", which is explained in the next section.

CalCOBRA

If your coverage under federal *COBRA* started on or after January 1, 2003, you can keep on being covered under CalCOBRA if your federal *COBRA* ended:

- 18 months after your qualifying event, if your job ended or your work hours were reduced; or
- 29 months after your qualifying event if you qualified for the additional 11 months of federal *COBRA* because of a disability.

You must completely use up your eligibility under federal *COBRA* before you can get coverage under CalCOBRA. You are not eligible for CalCOBRA if:

- You have Medicare;
- You have or get coverage under another group plan; or
- You are eligible for or covered under federal *COBRA*.

Coverage under CalCOBRA is for medical benefits only.

You will be told about your rights. Within 180 days before your federal *COBRA* ends, we will tell you that you have a right to keep your coverage under CalCOBRA. If you want to keep your coverage, you must tell us in writing within 60 days before the date your federal *COBRA* ends or when you are told of your right to keep your coverage under CalCOBRA, whichever is later. If you don't tell us in writing during this time period you will not be able to keep your coverage.

You can add family members to your CalCOBRA coverage. For dependents acquired while you are covered under CalCOBRA, coverage begins according to the enrollment provisions of this *plan*.

You may have to pay the whole cost of your CalCOBRA coverage. This cost will be:

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

We must receive your payment every month to keep your coverage going. You must send your payment to us, along with your enrollment form, within 45 days after you tell us you want to keep your coverage. You must send us the payment by first class mail or some other reliable means. Your payment must be enough to pay the amount required and the entire amount due. If we don't get the correct payment within this 45 day period, you won't be able to get coverage under CalCOBRA. After you make the first payment, all other payments are due on the first day of each following month.

If your payment of the subscription charge is not received when due, your coverage will be cancelled. We will cancel your coverage only after sending you written notice of cancellation at least 30 days before 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 this payment in full

within this time period, your coverage will be cancelled as of 12:00 midnight on the thirtieth day after the date the cancellation notice is sent (or any longer period of time required by applicable federal law, rule, or regulation) and will not be reinstated. Any payment we get after this time period runs out will be refunded to you within 20 business days. You are still responsible for any unpaid subscription charges that you owe to us, including subscription charges that apply during any grace period.

We may change the amount of your payment as of any payment due date. If we do, we will tell you in writing at least 60 days before the increase takes effect.

You must give us current information. We will rely on the eligibility information you give us as correct without checking on it, but we maintain the right to check any information you give us.

Coverage through a *prior plan*. If you were covered through CalCOBRA under the *prior plan*, you can keep your coverage under this plan for the rest of the continuation period. But your coverage will end if you don't follow the enrollment rules and make the payments within 30 days of being told your CalCOBRA coverage under the *prior plan* will end.

When CalCOBRA starts. When you tell us in writing that you want to keep your coverage through CalCOBRA and pay the first payment, we will reinstate your coverage back to the date federal *COBRA* ended. If you enroll a family member while you are covered through CalCOBRA, the family member's coverage begins according to the enrollment provisions of this *plan*.

When CalCOBRA ends. Your coverage under CalCOBRA will end when the first of the following events takes place:

- The end of 36 months after the date of your qualifying event under federal *COBRA**.
- The date our *agreement* with your employer ends.
- The date your employer stops providing coverage to the class of *members* you belong to.

- The date you stop paying the monthly charges. Your coverage will be cancelled after written notification, as explained above.
- The date you become covered under another group health plan.
- The date you become entitled to Medicare.
- The date you become covered under federal *COBRA*.

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

* If your coverage under CalCOBRA started under a *prior plan*, the 36 month period will be dated from the time of your qualifying event under that *prior plan*.

Note. 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.

Extension

If our *agreement* with your employer ends. Your coverage can be canceled or changed without us telling you.

But, if you or a family member is *totally disabled* and getting the care of a *doctor*, your benefits for treating the totally disabling condition will go on, if:

- The disabled person is staying in a *hospital* or *skilled nursing facility* as long as the *stay* is *medically necessary*. You will get your benefits until you are no longer staying in the *hospital*.
- If you are not now in a *hospital* or nursing facility, you may still be able to get total disability benefits. Your *doctor* must send us a written statement of your disability. It must be sent within 90 days and every 90 days after that.

If you get coverage under another health *plan* that provides benefits, without limitation, for your disability, this extension of benefits is not available.

Your benefits will end when:

- You are no longer disabled.
- Your *plan* has paid the most it can.
- You get another health plan which will cover your disability.
- Twelve (12) months have passed.

How to Make a Complaint

While Anthem Blue Cross HMO helps you get the care you need, we don't actually give the care.

We contract with *medical groups*, *doctors*, and other *health care providers*. They are not employees of Anthem. The *hospitals*, nursing facilities and other health agencies are independent contractors.

However, we want to help you get the care and service you need. Here's how:

- **Talk to your *Anthem Blue Cross HMO coordinator*.** If you have questions about your services, call your *Anthem Blue Cross HMO coordinator*. He or she may be able to help you right away. You may also call the *Customer Service number* on your member ID card.

- **Filing a Complaint.** If you are still unhappy and wish to file a complaint, you should fill out a "Member Issue Form." You can get this form from your *Anthem Blue Cross HMO coordinator* or from us. Complete the form and mail it to us or you may call us at the *Customer Service number* on your member ID card and ask one of our customer service representatives to fill out the Member Issue Form for you. You may also file a complaint with us online or print the Member Issue Form through the Anthem Blue Cross website at **www.anthem.com/ca**.

- **If you believe your coverage has been cancelled unfairly.** If you believe your coverage has been or will be improperly cancelled, you may also file a complaint with us.

  In filing a complaint, you must:

  - Include the following information from your Member ID Card:

    – Your group number.

    – Your member identification number.

- Explain what happened or what you would like help with.

You must file your complaint with us no later than 180 days after the date you get a denial notice from us or your *medical group* or any other incident or action you are not satisfied with.

When you mail in the Member Issue form or file your complaint online, you are starting the formal complaint process. If you have an acute or urgent condition, you have the right to ask for an expedited review of an appeal for service that has been denied by your *medical group*. Expedited appeals must be resolved within three days.

♦ **Get help from Anthem.** You may ask for a review from Anthem.

- Just call us at the *Customer Service number* shown on your Member ID card.
- Or write to us at the following address:

Anthem Blue Cross

Grievance and Appeal Management

P.O. Box 4310

Woodland Hills, CA 91367

- Tell us all about your complaint.
- Send this along with any bills or records.

Except for complaints that concern the *prescription drug formulary*, we will review and respond to your complaint with the following timeframes:

- 30 days after we get and look at the facts of your complaint, we will send you a letter to tell you how we have solved the problem.
- If your case is urgent and involves an imminent threat to your health, such as severe pain or the loss of life or

limb or major bodily function, we'll expedite the review and resolve your complaint within three days.

- **We will meet with you.** For issues dealing with whether a service is *medically necessary* or appropriate, you may:
  - appear in person before the committee meeting to review your appeal;
  - send someone else to represent you before the committee; or
  - have a telephone conference call with the committee.
- **You have the right to review all documents that are part of your complaint file and to give evidence and testimony as part of the complaint process.**
- **If you don't like what the committee decides or it does not decide what to do within 30 days (or within three days for urgent cases).** You may complain directly to the Department of Managed Health Care (see later page). If your case is urgent and involves an imminent threat to your health as described above, you do not have to go through this complaint process or wait 30 days to complain to the Department of Managed Health Care (DMHC). You may do so right away. You may also, at any time, use *binding arbitration* to resolve your dispute. (See "Arbitration" on a later page.)
- **If your complaint is about the cancellation of your coverage,** you may also complain to the DMHC right away if the DMHC agrees that your complaint requires immediate review. If your coverage is still in effect when you file your complaint, we will continue to provide coverage to you under the terms of the *plan* until a final determination of your request for review has been made, including any review by the Director of the Department of Managed Health Care (this does not apply if your coverage is cancelled because the subscription charges have not been paid). If your coverage is maintained in force pending the outcome of the review, subscription charges must still be paid to us on your behalf. If

your coverage has already ended when you file the complaint, your coverage will not be maintained. If the Director of the Department of Managed Health Care determines that your coverage should not have been cancelled, we will reinstate your coverage back to the date it was cancelled. Subscription charges must be paid current to us on your behalf from the date coverage is reinstated.

- **Questions about your outpatient prescription drug coverage.** If you have questions or concerns about your outpatient prescription drug coverage, please call the Pharmacy Customer Service phone number on your ID card. If you are not happy about how your concerns are taken care of, you may use the complaint process above.

Prescription Drug List Exceptions

Please refer to the "Exception Request for a Drug not on the Prescription Drug Formulary" section in "Getting Prescription Drugs" for the process to submit an exception request for *drugs* not on the *prescription drug formulary*.

Independent Medical Review of Denials of Experimental or Investigative Treatment

If coverage for a proposed treatment is denied because we or your *medical group* determine that the treatment is *experimental* or *investigative*, you may ask that the denial be reviewed by an external independent medical review organization which has a contract with the California Department of Managed Health Care ("DMHC"). Your request for this review may be sent to the DMHC. You pay no application or processing fees of any kind for this review. You have the right to provide information in support of your request for review. A decision not to participate in this review process may cause you to give up 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 ask for 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 Grievance and Appeals Management, P.O. Box 4310, Woodland Hills, CA 91367. To qualify for this review, all of the following conditions must be met:

- You have a life threatening or seriously debilitating condition. The condition meets either or both of the following descriptions:
  - A life threatening condition or a disease is one where the likelihood of death is high unless the course of the disease is interrupted. A life threatening condition or disease can also be one with a potentially fatal outcome where the end point of clinical intervention is the patient's survival.
  - A seriously debilitating condition or disease is one that causes major irreversible morbidity.
- Your *medical group* 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 an *Anthem Blue Cross HMO 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 *doctor* 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:
    - Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized standards;
    - Medical literature meeting the criteria of the National Institute 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);

- Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;
- Either of the following: (i) The American Hospital Formulary Service's Drug Information, or (ii) the American Dental Association Accepted Dental Therapeutics;
- 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;
- 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
- Peer reviewed abstracts accepted for presentation at major medical association meetings.

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

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

Within three business days of receiving notice from the DMHC of your request for review we will send the reviewing panel all relevant medical records and documents in our possession, as well as any additional information submitted by you or your *doctor*. Any newly developed or discovered relevant medical records that we or an *Anthem Blue Cross HMO provider* identifies 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 *doctor* determines that the proposed treatment would be significantly less effective if not provided promptly). This timeframe may be extended by up to three days for any delay in receiving necessary records.

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

Independent Medical Review of Complaints Involving a Disputed Health Care Service

You may ask for an independent medical review ("IMR") of disputed health care services from the Department of Managed Health Care ("DMHC") if you think that we or your *medical group* have wrongly denied, changed, 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, changed, or delayed by us or your *medical group*, 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 you may have. 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 give you an IMR application form and an addressed envelope for you to use to ask for IMR with any complaint disposition letter that denies, changes, or delays health care services. A decision not to participate in the IMR process may cause you to lose any lawful right to pursue legal action against us about the disputed health care service.

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

1. One or more of the following conditions have been met:

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

   (b) You have had *urgent care* or *emergency services* that a provider determined was *medically necessary*, or

   (c) You have been seen by an *Anthem Blue Cross HMO provider* for the diagnosis or treatment of the medical condition for which you want independent review;

2. The disputed health care service has been denied, changed, or delayed by us or your *medical group*, based in whole or in part on a decision that the health care service is not *medically necessary*; and

3. You have filed a complaint with us or your *medical group* and the disputed decision is upheld or the complaint is not resolved after 30 days. If your complaint requires expedited review you need not participate in our complaint process for more than three days. The DMHC may waive the requirement that you follow our complaint 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 complaint or from the end of the 30 day or three day complaint period, whichever applies. This application deadline may be extended by the DMHC for good cause.

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

For non-urgent cases, the IMR organization designated by the DMHC must provide its determination within 30 days of getting 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 ask for an application form, please call us at the *Customer Service number* on your Member ID card.

Department Of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at the **telephone number listed on your identification card** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are

eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's Internet Web site (**http://www.hmohelp.ca.gov**) has complaint forms, IMR applications forms and instructions online.

Arbitration

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to:

- This *plan* or the *agreement*, or breach or rescission thereof; or
- In relation to care or delivery of care, including any claim based on contract, tort or statute;

must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

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

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

California Health & Safety Code section 1363.1 requires that any arbitration agreement include the following notice based on California Code of Civil Procedure 1295(a): **It is understood that any dispute as to medical malpractice, that is, whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings and except for disputes regarding a claim for damages within the jurisdictional limits of the small claims court. Both parties to this contract, by entering into it, acknowledge that they are giving up their constitutional right to have any and all disputes, including medical malpractice claims, decided in a court of law before a jury, and instead are accepting the use of arbitration.**

The *member* and Blue Cross agree to give up the right to participate in class arbitrations against each other. Even if applicable law permits class actions or class arbitrations:

- The *member* waives any right to pursue, on a class basis, any such controversy or claim against Anthem; and
- Anthem waives any right to pursue on a class basis any such controversy or claim against the *member*.

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

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

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

Please send all *binding arbitration* demands in writing to Anthem Blue Cross, 21555 Oxnard Street, Woodland Hills, CA 91367 marked to the attention of the Customer Service Department listed on your identification card.

Other Things You Should Know

Using a Claim Form to Get Benefits

Here's what you or your health care provider must do:

- Fill out the claim form.
- List and describe clearly the services you got and how much they cost.
- Send the form to Anthem within 90 days of the date you got the service.

If you are not able to send the claim in within 90 days, you may have up to 12 more months. We will not pay for your benefits if you or the health care provider do not send the claims within that time. You must use claim forms; we won't accept canceled checks or receipts.

Getting Repaid by a Third Party

Sometimes someone else may have to pay for your medical care if an injury, disease, or other health problem is their fault or their responsibility. Whatever we cover will depend on the following:

- Your *medical group* and Anthem will automatically have a legal claim (lien) to get back the costs we covered, if you get a settlement or judgment from the other person or their insurer or guarantor. We should get back what we spent on your medical care.
    - 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.

♦ You must write to your *medical group* and Anthem about your claim within 60 days of filing a claim against the third party.

- You will need to sign papers and give us the help we need to get back our costs.
- If you don't do this, you will have to pay us back out of your own money.

♦ We will have the right to get our money back, even if what you, or someone acting for you, got back is less than the actual loss you suffered.

Coordination of Benefits

If you're covered by this group health plan, and one or more other medical or dental plans, total benefits may be limited as shown below. These provisions apply separately each calendar year to each person and are based mainly on California law.

Definitions

When used in this section, the following words and phrases have the meanings explained here.

Allowed Expense is any needed, 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, except when by law Medicare's benefits are secondary to those of any private insurance program or another non-governmental program.

Each contract or arrangement for coverage listed above will be considered a separate plan. The rules of these provisions will apply only when the other plan has coordination of benefits provisions.

Primary Plan is the plan which will have its benefits figured first.

This Plan is the part of this *plan* that 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 primary plan, then we will figure out its benefits first without taking into account any other plan.
2. If This Plan isn't the primary plan, then we may reduce its benefits so that the benefits of all the plans aren't more than the allowed expense.
3. The benefits of This Plan will never be more than the benefits we would have paid if you were covered only under this *plan*.

If This Plan isn't the primary plan, you may be billed by a health care provider. If you receive a bill, you should submit it to your *medical group*.

Order of Benefits Determination

The following rules determine the order in which benefits will be paid:

1. A plan with no coordination provision will pay its benefits first. This always includes Medicare except when by law This Plan must pay before Medicare.
2. A plan which covers you through your employer pays before a plan which covers you as a family member. But if you have Medicare and are also a dependent of an active employee under another employer plan, this rule might change. If Medicare's rules say that Medicare pays after the plan that covers you as a dependent but before your employer's plan, then the plan that covers you as a dependent pays before a plan which covers you through your employer. This might happen if you are covered under This Plan as a retiree.
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 year. But if one plan doesn't have a birthday rule provision, that plan's provisions will determine the order of benefits.

Exception to rule 3: If a dependent child's parents are divorced or separated, the following rules will be used instead of rule 3:

a. The plan of the parent who has custody, will pay first, unless he or she has remarried.

b. If the parent with custody has remarried, then the order is 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. However, if there is a court decree which holds one parent responsible for that child's health care coverage, the plan which covers that child as a dependent of the responsible parent pays first.

4. The plan covering you as a laid-off or retired employee or as such employee's dependent pays after another plan covering you. But if either plan doesn't have a rule about laid-off or retired employees, rule 6 applies.

5. A plan covering you under a state or federal continuation of coverage pays after another plan. However, if the other plan doesn't have this rule, this rule won't apply.

6. When the rules above don't apply, the plan that has covered you longer pays first unless two of the plans have the same

effective date. In this case, allowed expense is split evenly between the two plans.

Our Rights Under This Provision

Responsibility For Timely Notice. We aren't responsible for coordination of benefits unless we get information from the asking party.

Reasonable Cash Value. If you get benefits from another plan in the form of services, the value of services in cash will be considered allowed expense and a benefit paid.

Facility of Payment. If another plan pays benefits that this plan should have paid, we will pay the other plan an amount determined by us. This will be considered a benefit paid under this *plan*, and will fully satisfy what we are responsible for.

Right of Recovery. If we pay benefits that are more than we should have paid under this provision, the *medical group* and we may recover the extra amounts from one or more of the following:

- The persons to or for whom payments were made;
- Insurance companies or service plans; or
- Other organizations.

If You Qualify for Medicare

Members Age 65 or Over Who Are Eligible for Medicare

If you are:

- Age 65 or over; AND
- An Employee who is not retired; OR
- A Dependent of the Employee above who is not retired; AND
- Eligible for Part A of Medicare; AND
- Eligible and enrolled under this *plan*;

you will get the benefits of this *plan* without taking into account Medicare unless you've chosen Medicare as your primary plan. If you've chosen Medicare as your primary health plan, you won't be able to get any benefits under this *plan*.

Other Members Who are Eligible for Medicare

If you are:

- Getting treatment for end-stage renal disease after the first 30 months you are entitled to end-stage renal disease benefits under Medicare; OR
- Entitled to Medicare benefits as a disabled person, unless you have a current employment status (as determined by Medicare's rules) and are enrolled in this *plan* through a group of 100 or more employees;

Medicare is your primary health plan. You will get the benefits of this *plan* if and only if you have actually enrolled in Medicare and completed any consents, assignments, releases, and other documents needed to get Medicare repayments for this *plan* or its *medical groups*. This applies to services covered by those parts of Medicare that you can enroll in without paying any premium. If you must pay any premium for any part of Medicare, this applies to that part of Medicare only if you are enrolled in that part.

If you are enrolled in Medicare, your Medicare coverage will not affect the services provided or covered under this *plan* except as follows:

- Medicare must provide benefits first for any services covered both by Medicare and under this *plan*.
- For services you receive that are covered both by Medicare and under this *plan*, that are not prepaid by us, coverage under this *plan* will apply only to Medicare deductibles, coinsurance, and other charges for covered services over and above what Medicare pays.

- For services you received that are covered both by Medicare and under this *plan*, that are prepaid by us, we make no additional payment.
- For any given claim, the combination of benefits provided by Medicare and the benefits provided under this *plan* will not be more than what is considered allowed expense for the covered services.

If you have questions about how your benefits will be coordinated with Medicare, please call our *Customer Service number* on your Member ID card.

Other Things You Should Know

Transition Assistance for New *Members*: Transition Assistance is a process that allows for completion of covered services for new *members* receiving services from a *doctor* who is not an *Anthem Blue Cross HMO provider*. If you are a new *member*, you may request Transition Assistance if any one of the following conditions applies:

- 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.
- A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Anthem in consultation with you and the *doctor* who is not an *Anthem Blue Cross HMO provider* and consistent with good professional practice. Completion of

covered services shall not exceed twelve (12) months from the time you enroll with Anthem.

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

Call us at the *customer service number* listed on your ID card to ask for transition assistance or to get a copy of the written policy. Eligibility is based on your clinical condition and is not determined by diagnostic classifications. Transition assistance does not provide coverage for services not otherwise covered under the *plan*.

We will notify you by telephone, and the provider by telephone and fax, as to whether or not your request for Transition Assistance is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the *plan*. Financial arrangements with doctors who are not *Anthem Blue Cross HMO providers* are negotiated on a case-by-case basis. We will ask that the *doctor* agree to accept reimbursement and contractual requirements that apply to *Anthem Blue Cross HMO providers*, including payment terms, who are not capitated. If the *doctor* does not agree to accept said reimbursement and contractual requirements, we are not required to continue that *doctor's*

services. If you do not meet the criteria for Transition Assistance, you are afforded due process including having your request reviewed.

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

You must be under the care of the *medical group* at the time the *medical group's* contract terminates. The terminated *medical group* must agree in writing to provide services to you in accordance with the terms and conditions of the agreement with Anthem prior to termination. The terminated *medical group* must also agree in writing to accept the terms and reimbursement rates that apply to *Anthem Blue Cross HMO providers* who are not capitated. If the terminated *medical group* does not agree with these contractual terms and conditions, we are not required to continue the terminated *medical group's* services beyond the contract termination date.

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

- 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.

- A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or

prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Anthem in consultation with you and the terminated *medical group* and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the date the *medical group's* contract terminates.

- 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.
- 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.
- 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 *medical group's* contract terminates.
- 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 *medical group's* contract terminates.

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

Please call us at the *Customer Service number* listed on your ID card to ask for continuity of care or to get a copy of the written policy. Eligibility is based on the *member's* clinical condition and is not determined by diagnostic classifications. Continuity of care does not provide coverage for services not otherwise covered under the *plan*.

We will notify you by telephone, and the *medical group* 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 *medical groups* are negotiated on a case-by-case basis. We will ask that the terminated *medical group* agree to accept reimbursement and contractual requirements that apply to *Anthem Blue Cross HMO providers*, including payment terms, who are not capitated. If the terminated *medical group* does not agree to accept the same reimbursement and contractual requirements, we are not required to continue that *medical group's* services. If you disagree with our determination regarding continuity of care, you may file a complaint with us by following the procedures described in the section called "How to Make a Complaint".

This provision also applies if the contractual or employment relationship between your *medical group* or us and the *primary care doctor* or *specialist* from whom you are receiving care terminates. In this situation, please request continuity of care through your *Anthem Blue Cross HMO coordinator*.

Transition Assistance and Continuity of Care may be revoked or modified prior to the services being rendered for reasons including but not limited to the following:

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

How we pay your providers. Your *medical group* is paid a set amount for each *member* per month. Your *medical group* may also get added money for some kinds of special care or for overall efficiency, and for managing services and referrals. *Hospitals* and

other health care facilities are paid a set amount for the kind of service they give you or an amount based on a negotiated discount from their standard rates. If you want more information, please call us at the telephone number listed on your Member ID Card, or you may call your *medical group*.

You do not have to pay any *Anthem Blue Cross HMO provider* for what we owe them, even if we don't pay them. But you may have to pay a non-*Anthem Blue Cross HMO provider* any amounts not paid to them by us.

Inter-Plan Programs.

- **Out of Area Services.** We have a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter-Plan Programs". Whenever you obtain healthcare services outside of our service area, the claims for these services may be processed through one of these Inter-Plan Programs.Typically, when accessing care outside of our service area and the service area of our corporate parent, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating healthcare providers.

  Our payment practices in both instances are described below.

  We cover only limited healthcare services received outside of our corporate parent's service area. As used in this provision, "Out-of-Area Covered Healthcare Services" consist of *urgent care*, *emergency services*, or follow-up care obtained outside the geographic area our corporate parent serves (see "Getting Care When You Are Outside of California" in the section "When You Need Care"). Any other services will not be covered when processed through any Inter-Plan Programs arrangements. These "other services" must be provided or authorized by your *primary care doctor*.

- **BlueCard® Program.** Under the BlueCard® Program, when you obtain Out-of-Area Covered Healthcare Services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations. However the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

  The BlueCard® Program enables you to obtain Out-of-Area Covered Healthcare Services, as defined above, from a healthcare provider participating with a Host Blue, where available. The participating healthcare provider will automatically file a claim for the Out-of-Area Covered Healthcare Services provided to you, so there are no claim forms for you to fill out. You will be responsible for any *copay* amount, as stated in this *plan*.

  If you need *emergency services*, get the medical care you need right away (see "When There is an Emergency" in the section "When You Need Care"). In some areas, there is a 9-1-1 emergency response system that you may call for *emergency services* (this system is to be used only when there is an *emergency* that requires an emergency response).

  Whenever you access covered healthcare services outside our and, if applicable, our corporate parent's service area and the claim is processed through the BlueCard® Program, the amount you pay for covered healthcare services, if not a flat dollar copayment, is calculated based on the lower of:

  - The billed covered charges for your 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 your healthcare provider. Sometimes it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

Federal laws or the laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

- **Non-participating healthcare providers outside of our service area:**

  Member liability calculation. When out-of-area covered healthcare services are received from non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the covered services as set forth in this paragraph.

Exceptions. In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount we will pay for services rendered by non-participating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the covered services as set forth in this paragraph.

If you obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If you see a provider who is not part of an exclusive network arrangement, that provider's services will be considered non-network care, and you may be billed the difference between the charge and the maximum allowable amount. You may call the *Customer Service number* on your ID card or go to **www.anthem.com/ca** for more information about such arrangements.

When you can't get care. If there is an epidemic or public disaster and you can't get care for covered services, we'll refund the unearned part of the subscription charge paid for you. We must receive a request for the refund in writing and along with proof of the need for care within 31 days. This payment meets our duty under this *plan*.

Right of Recovery. Whenever payment has been made in error, or the reasonable cash value of benefits provided under this *plan* exceeds the maximum amount for which we are liable, we and your *medical group* will have the right to recover such payment or excess amount 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.

Who takes care of your COBRA or ERISA coverage. Anthem is not the *plan* administrator of your *COBRA* or ERISA coverage. Your employer, or someone your employer hires, most often takes care of administrating your employer's health plan. The employer must let you know about any changes, give you notices, or let you know about the details of the health plan.

Workers' Compensation. Our health plan *agreement* with your employer doesn't change your coverage by the Workers' Compensation program. It doesn't take the place of Workers' Compensation.

Renewing our *agreement* with your employer. We can renew our *agreement* at certain times. We may change the subscription charges, or other terms of the *plan* from time to time without your consent.

Terms of Coverage

- In order for you to be entitled to benefits, both the *agreement* and your coverage under it must be in effect on the date the expense giving rise to a claim for benefits is incurred.
- Your benefits will depend on what is covered on the date you get the service or supply for which the charge is made.
- The *agreement* can be amended, modified or terminated without your consent.

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.

Consumer Relations Committee. We have a special committee made up of people who are covered by our plan, health care providers taking part in Anthem Blue Cross HMO, and a member of our Board of Directors. This committee reviews information about finances and any complaints of *members* among other things. It advises the Board of Directors about how to make sure *members* are served well and with respect.

Confidential Information. We will make every effort and take care to keep your medical data secret. We may use data about services provided to you and others for statistical study and research. If the data is released to a third party, it will not identify you. Medical data about you can only be given to others if you agree to it in writing or if required by law. A consent to release medical data must be signed, dated and describe the kind of data and to who it may be disclosed. You may access your own medical records.

We may release your medical data to:

- professional peer review organizations; and
- your employer.

This will only be done to report claims experience to them or for them to audit our operation. We will only give them data that is needed to do the review or audit.

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

Medical Policy and New Technology. Anthem reviews and evaluates new technology. It does this using criteria set by its medical directors. The criteria it uses helps it decide if:

- the new technology is still investigational; or
- has medical necessity.

A committee called Medical Policy and Technology Assessment Committee (MPTAC) gives Anthem guidance. They also validate Anthem's medical policy. MPTAC is made up of about 20 doctors. They come from various medical specialties and geographic areas. They include Anthem's medical directors, doctors in academic medicine and doctors who practice managed care medicine. Anthem's conclusions, based on MPTAC guidance, are incorporated into Anthem's medical policy used to:

- form decision protocols for particular diseases and injuries; or
- treatments for particular disease or injuries; and
- determine what is *medically necessary*.

Conformity with Laws. Any provision of the *agreement* 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.

Voluntary Clinical Quality Programs. We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get

certain care when you need it and are separate from covered services under your *plan*. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards or retailer coupons, which we encourage you to use for health and wellness related activities or items. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may also be offered a home visit appointment to collect such specimens and complete biometric screenings. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit or the home visit. If you have any questions about whether receipt of a gift card or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

Voluntary Wellness Incentive Programs. We may offer health or fitness related program options for purchase by your *group* to help you achieve your best health. These programs are not covered services under your *plan*, but are separate components, which are not guaranteed under this *plan* and could be discontinued at any time. If your *group* has selected one of these options to make available to all employees, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options a *group* may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact us at the customer service number on your ID card and we will work with you (and, if you wish, your *doctor*) to find a wellness program with the same reward that is right for you in light of your health status. If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result

in taxable income to you. For additional guidance, please consult your tax advisor.

Payment Innovation Programs. We pay HMO network providers through various types of contractual arrangements. Some of these arrangements – Payment Innovation Programs (Program(s)) – may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner.

These Programs may vary in methodology and subject area of focus and may be modified by us from time to time, but they will be generally designed to tie a certain portion of an HMO network provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, HMO network providers may be required to make payment to us under the Program as a consequence of failing to meet these pre-defined standards.

The Programs are not intended to affect your access to health care. The Program payments are not made as payment for specific covered services provided to you, but instead, are based on the HMO network provider's achievement of these pre-defined standards. You are not responsible for any copayment or coinsurance amounts related to payments made by us or to us under the Program(s), and you do not share in any payments made by HMO network providers to us under the Program(s).

New Programs 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*. These incentives may be offered in various forms (such as discounts on fees, and/or retailer coupons) and are intended to encourage you to try the new programs and services. 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.

Important Words to Know

The meanings of key terms used in this booklet are shown below.

Advanced imaging procedures are imaging procedures, including, but not limited to, Magnetic Resonance Imaging (MRI), Computerized Tomography (CT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography, and nuclear cardiac imaging.

For a complete list of *advanced imaging procedures* or if you need more information, please contact your *medical group*.

Agreement is the Group Benefit Agreement between Anthem and the *group* (your employer). In it, we agree to what benefits will be given to you.

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

Anthem Blue Cross HMO coordinator is the person at your *medical group* who can help you with understanding your benefits and getting the care you need.

Anthem Blue Cross HMO providers are licensed health care providers who have an agreement with Anthem to provide services to you.

Authorized referral occurs when you, because of your medical needs, require the services of a *specialist* who is a non-*Anthem Blue Cross HMO provider* for the treatment of *mental or nervous disorders* or substance abuse, behavioral health treatment for pervasive developmental disorder or autism, or transgender services, 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:

1. there is no *Anthem Blue Cross HMO provider* who practices in the appropriate specialty, or there is no contracting *hospital* which provides the required services or has the necessary facilities;
2. that meets the adequacy and accessibility requirements of state or federal law; and
3. the *member* is referred to *hospital* or *doctor* that does not have an agreement with Anthem for a covered service by an *Anthem Blue Cross HMO provider*

Binding Arbitration is a process used to resolve complaints. It is used instead of going to a court of law. In binding arbitration, you and Anthem agree to meet with an arbitrator and go by the decision of the arbitrator.

Brand name drug is a *prescription drug* that has been patented and is only made by one manufacturer.

COBRA is a special law that gives you a chance to keep your health plan even if you lose your job, have a reduction in hours or a change in dependents status. You will usually have to pay the monthly charges to keep the *plan* under COBRA.

Compound Medication is a mixture of *prescription drugs* and other ingredients wherein one or more ingredients are FDA-approved, a prescription is required to dispense, and the compound medication is not essentially the same as an FDA-approved product from a *drug* manufacturer.

Copay is the amount you pay to get a *medically necessary* service with an *Anthem Blue Cross HMO provider*. Anthem pays the provider the rest. It is also the amount you pay when you buy *drugs* or medicines from a *drugstore* or through the home delivery program.

Copay Limit is the most you will have to pay in one calendar year in *copays*.

Creditable coverage is:

- Any individual or group plan that provides medical, hospital and surgical coverage, including continuation or conversion coverage.
- Coverage under Medicare or Medicaid, TRICARE, or the Federal Employees Health Benefits Program.
- Programs of the Indian Health Service or of a tribal organization.
- A state health benefits risk pool.
- Coverage through the Peace Corps.
- The State Children's Health Insurance Program.
- A public health plan established or maintained by a state, the United States government, or a foreign country.

Creditable coverage does not include:

- Accident only coverage.
- Credit insurance.
- Coverage for on-site medical clinics.
- Disability income insurance.
- Coverage only for a specified disease or condition.
- Hospital indemnity or other fixed indemnity insurance.
- Medicare supplement coverage.
- Long-term care insurance.
- Dental coverage.
- Vision coverage.
- Workers' compensation insurance
- Automobile insurance, including no-fault automobile insurance.

- Any medical coverage designed to supplement other private or governmental plans.

Creditable coverage is used to set up eligibility for rules for children who cannot get a self-sustaining job due to a physical or mental condition. In addition, eligible children were covered under one of the above types of health coverage on his or her own and not as a dependent child.

If your prior coverage was through an employer, you will receive credit for that coverage if:

- It ended because your employment ended;
- The availability of medical coverage offered through employment or sponsored by the employer terminated; or
- The employer's contribution toward medical coverage terminated;

and any lapse between the date that coverage ended and the date you become eligible under this *plan* is no more than 180 days (not including any waiting period imposed under this *plan* by the employer).

If your prior coverage was not through an employer, you will receive credit for that coverage if any lapse between the date that coverage ended and the date you become eligible under this *plan* is no more than 63 days (not including any waiting period imposed under this *plan* by the employer).

Custodial care is care for 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 giving medicine which you usually do yourself, or any other care for which the services of a health care provider are not needed.

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

Customer Service number is the 800-number you can call at Anthem to answer your questions about Anthem Blue Cross HMO. You will find the number on your Member ID card.

Doctor means a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is given.

Drug means a prescribed drug approved by the State of California or the federal government for use by the public. Under this *plan*, insulin is thought of as a *prescription drug*.

Drugstore means a store where you get medicine from a licensed pharmacist.

Emergency is a sudden, serious, and unexpected illness, injury, or health problem (including sudden and unexpected severe pain), or a *psychiatric emergency medical condition*. This includes any illness, injury or health problem you reasonably believe could endanger your health if you don't get medical care right away. We or your *medical group* will make the final decision about whether services were given for an emergency.

Emergency services are services given because of a medical or psychiatric *emergency*.

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

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

Formulary drug is a *drug* listed on the *Prescription Drug Formulary*.

Generic drug is the same as one or more *brand name drugs* and is approved by the government. It must be as safe, pure, strong, and work as well as the *brand name drug*.

Group refers to the business entity to which we have issued this *agreement*. The name of the group is COUNTY OF SAN DIEGO.

Guest membership is a special way you can get care when you go out of town for more than 90 days. If you know ahead of time, you can apply for a guest membership in a *medical group* in the city you are going to visit. Call the Anthem Blue Cross HMO *Customer service number* on your Member ID card and ask for the Guest Membership Coordinator.

Health care provider means the kinds of providers, other than M.D.s or D.O.s, that take care of your health and are covered under this *plan*. The provider must:

- Have a license to practice where the care is given.
- Provide a service covered by that license.
- Give you a service that is paid for under this *plan*.

A "health care provider" also includes any agency licensed by the state to provide services for the treatment of *mental or nervous disorders* or substance abuse, when we are required by law to cover those services.

For nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa, "health care provider" includes registered dietitians 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.

Home health agencies are licensed providers who give you skilled nursing and other services in your home. Medicare must approve them as home health providers and/or be recognized by the Joint Commission on the Accreditation of Healthcare Organizations.

Hospice is an agency or organization that gives a specialized form of interdisciplinary care that controls pain and relieves symptoms and helps with the physical, emotional, social, and spiritual discomforts of a terminally ill person, as well as giving support to the primary caregiver and the patient's family. A hospice must be currently licensed as a hospice according to Health and Safety Code section 1747 or a licensed *home health agency* with federal

Medicare certification according to Health and Safety Code sections 1726 and 1747.1. You may ask for a list of *hospices*.

Hospital is a place which provides diagnosis, treatment and care supervised by *doctors*. It must be licensed as a general acute care hospital.

The term hospital will also include *psychiatric health facilities* (only for acute care of a *mental or nervous disorder* or substance abuse) and *residential treatment centers*.

Independent practice association (IPA) is a *medical group* made up of a group of *doctors* who practice in private offices. The IPA has an agreement with Anthem to provide health care.

Infertility means: (1) you have a health problem your *doctor* sees as the reason you are unable to have a baby; or (2) you are unable to get pregnant or to carry a pregnancy to a live birth after a year or more of having sex without birth control or after 3 cycles of artificial insemination.

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

Medical group is a group of *doctors* with an agreement with Anthem to provide health care.

Medically necessary procedures, services, supplies or equipment are those that your *medical group* or Anthem decides are:

- Appropriate and necessary for the diagnosis or treatment of the medical condition.
- Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease.
- Provided for the diagnosis or direct care and treatment of the medical condition.

- Within standards of good medical practice within the organized medical community.
- Not primarily for your convenience, or for the convenience of your *doctor* or another provider.
- Not more costly than an alternative service 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.
- 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:
  - There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, equipment, service or supply 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
  - Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable.

Member is the person who gets the health plan from his or her employer or an enrolled family member. An employee may enroll in only one health plan provided by Anthem, or any of its affiliates, which is sponsored by the *group*.

Membership Change Form is a form you need to make changes in your health plan. You may need a new *medical group*, or to add a new family member. Ask your employer for the form if you need it.

Member drugstore means a drugstore that has a contract and works with Anthem to give you services. Call your local drugstore

and ask if it works with Anthem. Or call the toll-free customer service telephone number to find a drugstore with Anthem.

Mental or nervous disorders, including substance abuse, are conditions that are listed in the most current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders

Mental or nervous disorders include *severe mental disorders* as defined in this plan (see definition of "severe mental disorders").

Multi-source brand name drugs are drugs with at least one generic substitute.

Non-member drugstores mean drugstores that are not part of the Anthem network. Most of the time, you will have to pay more out of your pocket when you go to one of these drugstores.

Open Enrollment is a period of time each year that you can change your *plan* options. You can also add or drop eligible family members if you need to. Talk to your employer about when Open Enrollment takes place.

Pharmacy and Therapeutics Process is a process in which health care professionals including nurses, pharmacists, and *physicians* determine the clinical appropriateness of *drugs* and promote access to quality medications. The process also reviews *drugs* to determine the most cost effective use of benefits and advise on programs to help improve care. Our programs include, but are not limited to, *drug* utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and *drug* profiling initiatives.

Pharmacy Benefits Manager (PBM) is the entity with which Anthem has contracted with to administer its prescription drug benefits. The PBM is an independent contractor and not affiliated with Anthem.

Plan is the set of benefits talked about in this booklet. From time to time, there may be some changes in what is covered depending on the *agreement* we have with your employer. If changes are made to the plan, you will get a new booklet or a copy of an amendment showing the changes that were made.

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

Prescription Drug Formulary is one which we have made of *prescription drugs* for outpatient use that may be cost-effective, therapeutic choices. Any *drug store* with Anthem can assist you in buying *drugs* listed on the Prescription Drug Formulary. You may also get information about covered formulary drugs by calling 1-800-700-2541 (or TTY/TDD 1-800-905-9821) or going to our internet website anthem.com/ca.

Prescription drug maximum allowed amount is the maximum amount we will allow for any *drug*. The amount is determined by us using prescription drug cost information provided to us by the *pharmacy benefits manager*. The amount is subject to change. You may find out the prescription drug maximum allowed amount of a particular drug by calling 1-800-700-2541 (or TTY/TDD 1-800-905-9821).

Preventive Care Services include routine examinations, screenings, tests, education, and immunizations administered with the intent of preventing future disease, illness, or injury. Services are considered preventive if you have no current symptoms or prior history of a medical condition associated with that screening or service. These services shall meet requirements as determined by federal and state law, and are to become effective in accordance with those laws, including but not limited to, the Patient Protection and Affordable Care Act (PPACA). Sources for determining which services are recommended include the following:

- Services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF);
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

- Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.

Please call us at the customer service number listed on your ID card for additional information about services that are covered by this *plan* as preventive care services. You may also refer to the following websites that are maintained by the U.S. Department of Health & Human Services:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits
- http://www.ahrq.gov
- http://www.cdc.gov/vaccines/acip/index.html

Primary care doctor is a *doctor* who is a member of the *medical group* you have chosen to give you health care. *Primary care doctor*s include general and family practitioners, internists and pediatricians. Certain *specialists* as we may approve may also be designated *primary care doctor*s.

Prescription drug tiers are used to classify *drugs* for the purpose of setting their *co-payment*. Anthem will decide which drugs should be in each tier based on clinical decisions made by the *Pharmacy and Therapeutics Process*. Anthem retains the right at its discretion to determine coverage for dosage formulation in terms of covered dosage administration methods (for example, by mouth, injection, topical or inhaled) and may cover one form of administration and may exclude or place other forms of administration in another tier (if it is *medically necessary* for you to get a *drug* in an administrative form that is excluded will you need to get written prior authorization (see the subsection "Drugs that need to be approved," in the section "Prescription Drug Formulary," above) to get that that administrative form of the *drug*), This is an explanation of what drugs each tier includes:

- **Tier 1 Drugs** are those that have the lowest co-payment. This tier contains low cost *preferred drugs* that may be *generic*,

single source brand name drugs or *multi-source brand name drugs*.

- **Tier 2 Drugs** are those that have higher copayments than Tier 1 Drugs, but, lower than Tier 3 Drugs. This tier may contain *preferred drugs* that may be *generic, single source brand name drugs* or *multi-source brand name drugs*.
- **Tier 3 Drugs** are those that have the higher copayments than Tier 2 Drugs, but, lower than Tier 4 Drugs. This tier may contain higher cost *preferred drugs* and non-*preferred drugs* that may be *generic, single source brand name drugs* or *multi-source brand name drugs*.
- **Tier 4 Drugs** are those that have the higher copayments than Tier 3 Drugs.

Prior plan is a plan sponsored by your employer which was replaced by this *plan* within 60 days of when it ended. You are considered covered under the prior plan if you:

- Were covered under the prior plan on the date that plan ended;
- Properly enrolled for coverage within 31 days of this *plan's* effective date; and
- Had coverage terminate solely due to the prior plan's ending.

Prosthetic devices take the place of a body part that does not work or is missing. These include orthotic devices, rigid or semi-supportive devices which may support the motion of a weak or diseased part of the body.

Psychiatric emergency medical condition is a *mental or nervous disorder* that manifests itself by acute symptoms of sufficient severity that the patient is either:

- An immediate danger to himself or herself or to others, or
- Immediately unable to provide for or utilize food, shelter, or clothing due to the *mental or nervous disorder*.

Psychiatric health facility is a 24-hour facility, that is:

- Licensed by the California Department of Health Services.
- Qualified to provide short-term inpatient treatment.
- Accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHCO).
- Staffed by a professional staff which includes a *doctor* as medical director.

Residential treatment center is an inpatient treatment facility where the *member* resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation of *mental or nervous disorders* or substance abuse. The facility must be licensed to provide psychiatric treatment of *mental or nervous disorders* or rehabilitative treatment of substance abuse according to state and local laws.

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

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

1. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community and is at risk of being removed from the home or has already been removed from the home or the

mental disorder has been present for more than six months or is likely to continue for more than one year without treatment.

2. The child is psychotic, suicidal, or potentially violent.
3. The child meets special education eligibility requirements under California law (Government Code Section 7570).

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

Skilled nursing facility is a place that gives 24-hour skilled nursing services. It must be licensed and be seen as a skilled nursing facility under Medicare.

Stay is when you are admitted as an inpatient to a *hospital* or nursing facility. It starts when you are admitted to a facility and ends when you are discharged from that facility.

Specialist is a *doctor* who is not a general practitioner, internist, family practitioner, pediatrician, gynecologist, or obstetrician.

Specialty care center means a center that is accredited or designated by an agency of the State of California or the federal government or by a voluntary national health organization having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

Specialty drugs are typically high-cost, injectable, infused, oral or inhaled medications that generally require close supervision and monitoring of their effect on the patient by a medical professional. Certain specified *specialty* drugs may require special handling, such as temperature controlled packaging and overnight delivery, and therefore, certain specified *specialty drugs* will be required to be obtained through the specialty pharmacy program, unless you qualify for an exception.

Standing referral means a referral by a *primary care doctor* to a *specialist* for more than one visit to the *specialist*, as indicated in the treatment plan, if any, without the *primary care doctor* having to provide a specific referral for each visit.

Surgery center is a facility (not a *hospital* or *doctor's* office) that does surgery when you do not have to stay overnight. The center must be licensed and meet the standards of JCAHCO.

Totally disabled means because of illness or injury, you cannot work for income at any job that you are trained for and you are unemployed. For your family members, it means they cannot do all the activities usual for persons of their age.

Urgent care means the services you get for a sudden, serious, or unexpected illness, injury or condition to keep your health from getting worse. It is not an *emergency*. Care is needed right away to relieve pain, find out what is wrong, or treat the health problem.

For Your Information

Your Rights and Responsibilities as an Anthem Blue Cross Member

As a *member* 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 a *member*, 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 other *health care providers*
    - Your rights and responsibilities
    - The rules of your health care 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 doctors or other *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.
- Inform our Customer Service department if you have any changes to your name, address or family members covered under your plan.

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

We want to provide high quality benefits and customer service to our *members*. Benefits and coverage for services given under the *plan* benefit program are governed by the Evidence of Coverage and not by this Member Rights and Responsibilities statement.

ORGAN DONATION

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

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

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

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

www.donatelifecalifornia.org/

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

ANTHEM BLUE CROSS WEB SITE

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

LANGUAGE ASSISTANCE PROGRAM

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

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

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

- Spanish
- Chinese
- Vietnamese
- Korean
- Tagalog

Oral interpretation services are available in additional languages.

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 also sends/receives TDD/TTY messages at **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.

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 *doctor* (e.g., your *doctor*, 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 *doctor* or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

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 contact your *medical group* or call us at the customer service telephone number listed on your ID card.