COUNTY OF SAN DIEGO

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Prudent Buyer ®

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COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

Anthem Blue Cross
21555 Oxnard Street
Woodland Hills, California 91367

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

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TYPES OF PROVIDERS

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

Participating Providers in California. We have established a network of various types of "Participating Providers". These providers are called "participating" because they have agreed to participate in our preferred provider organization program (PPO), which we call the Prudent Buyer Plan. *Participating providers* have agreed to a rate they will accept as reimbursement for covered services. The amount of benefits payable under this *plan* will be different for *non-participating providers* than for *participating providers*. See the definition of "Participating Providers" in the DEFINITIONS section for a complete list of the types of providers which may be *participating providers*.

We publish a directory of Participating Providers. You can get a directory from your plan administrator (usually your employer) or from us. The directory lists all *participating providers* in your area, including health care facilities such as *hospitals* and *skilled nursing facilities*, *physicians*, laboratories, and diagnostic x-ray and imaging providers. You may call us at the customer service number listed on your ID card or you may write to us and ask us to send you a directory. You may also search for a *participating provider* using the "Provider Finder" function on our website at **www.anthem.com/ca**. The listings include the credentials of our *participating providers* such as specialty designations and board certification.

If you need details about a provider's license or training, or help choosing a *physician* who is right for you, call the customer service number on the back of your ID card.

How to Access Primary and Specialty Care Services

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

To make an appointment call your *physician's* office:

- Tell them you are a Prudent Buyer Plan member.
- Have your Member ID card handy. They may ask you for your group number, member I.D. number, or office visit copay.
- Tell them the reason for your visit.

When you go for your appointment, bring your Member ID card.

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

Participating Providers Outside of California

The Blue Cross and Blue Shield Association, of which we are a member, has a program (called the "BlueCard Program") which allows our *insured persons* to have the reciprocal use of participating providers contracted under other states' Blue Cross and/or Blue Shield Licensees (the Blue Cross and/or Blue Shield Plan).

If you are outside of our California service areas, please call the toll-free BlueCard Provider Access number on your ID card to find a *participating provider* in the area you are in. A directory of PPO Providers for outside of California is available. You can get a directory from your plan administrator (usually your employer).

Non-Participating Providers. *Non-participating providers* are providers which have not agreed to participate in our Prudent Buyer Plan network or the Blue Cross and/or Blue Shield Plan. They have not agreed to the reimbursement rates and other provisions of a Prudent Buyer Plan contract nor the Blue Cross and/or Blue Shield Plan.

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

Contracting and Non-Contracting Hospitals. Another type of provider is the "contracting hospital." This is different from a *hospital* which is a

participating provider. As a health care service plan, we have traditionally contracted with most hospitals to obtain certain advantages for patients covered by us. While only some *hospitals* are *participating providers*, all eligible California hospitals are invited to be *contracting hospitals* and most--over **90%**--accept.

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

Other Health Care Providers. "Other Health Care Providers" are neither *physicians* nor *hospitals*. They are mostly free-standing facilities or service organizations. See the definition of "Other Health Care Providers" in the DEFINITIONS section for a complete list of those providers. *Other health care providers* are not part of our Prudent Buyer Plan provider network or the Blue Cross and/or Blue Shield 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 *physician* or clinic, or call us at the customer service telephone number listed on your ID card to ensure that you can obtain the health care services that you need.

Participating and Non-Participating Pharmacies. "Participating Pharmacies" agree to charge only the *prescription drug maximum allowed amount* to fill the *prescription*. You pay only your co-payment amount.

"Non-Participating Pharmacies" have not agreed to the *prescription drug maximum allowed amount*. The amount that will be covered as *prescription drug covered expense* is significantly lower than what these providers customarily charge.

Centers of Medical Excellence and Blue Distinction Centers. We are providing access to *Centers of Medical Excellence* (CME) networks and *Blue Distinction Centers for Specialty Care* (BDCSC). The facilities included in each of these networks are selected to provide the following specified medical services:

- **Transplant Facilities.** Transplant facilities have been organized to provide services for the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. Subject to any applicable co-payments or deductibles, *CME* and *BDCSC* have agreed to a rate they will accept as payment in full for covered services. **These procedures are covered only when performed at a *CME* or *BDCSC*.**

- **Bariatric Facilities.** Hospital facilities have been organized to provide services for bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss programs. **These procedures are covered only when performed at a *BDCSC*.**

Benefits for services performed at a designated *CME* or *BDCSC* will be the same as for *participating providers*. A *participating provider* in the Prudent Buyer Plan network or the Blue Cross and/or Blue Shield Plan is not necessarily a *CME* or *BDCSC* facility.

Care Outside the United States—BlueCard Worldwide

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

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

- Always carry your current ID card.

- In an emergency, seek medical treatment immediately.

- **The BlueCard Worldwide Service Center is available 24 hours a day, seven days a week toll-free at (800) 810-BLUE (2583) or by calling collect at (804) 673-1177.** An assistance coordinator, along with a medical professional, will arrange a *physician* appointment or hospitalization, if needed.

<u>Payment Information</u>

- **Participating BlueCard Worldwide hospitals.** In most cases, you should not have to pay upfront for inpatient care at participating BlueCard Worldwide *hospitals* except for the out-of-pocket costs you normally pay (noncovered services, deductible, copays, and coinsurance). The *hospital* should submit your claim on your behalf.

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

Claim Filing

- **Participating BlueCard Worldwide hospitals will file your claim on your behalf.** You will have to pay the *hospital* for the out-of-pocket costs you normally pay.

- **You must file the claim** for outpatient and *physician* care, or inpatient *hospital* care not provided by a participating BlueCard Worldwide *hospital*. You will need to pay the health care provider and subsequently send an international claim form with the original bills to us.

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.

SUMMARY OF BENEFITS

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

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

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

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

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

After Hours Care. After hours care is provided by your *physician* who may have a variety of ways of addressing your needs. You should call your *physician* for instructions on how to receive medical care after their normal business hours, on weekends and holidays, or to receive non-

emergency care and non-*urgent care* within the service area for a condition that is not life threatening but that requires prompt medical attention. If you have an *emergency*, call 911 or go to the nearest emergency room.

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

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

The benefits of this *plan* are subject to the REIMBURSEMENT FOR ACTS OF THIRD PARTIES section.

MEDICAL BENEFITS

DEDUCTIBLES

Calendar Year Deductibles

Participating Providers*

- Member Deductible.....**$ 300**
- Family Deductible .....**$ 600**

Non-Participating Providers*

- Member Deductible.....**$ 600**
- Family Deductible **$1,200**

***NOTE:** The *participating provider* and *non-participating provider Calendar Year* Deductible amounts are combined. Amounts used in the satisfaction of the *participating provider Calendar Year* Deductible can also be applied toward the satisfaction of the *non-participating provider Calendar Year* Deductibles, and vice-versa.

Additional Deductibles

- Emergency Room Deductible **$75**
- Inpatient Deductible for *participating providers* **$150**
- Inpatient Deductible for *non-participating providers* **$300**
- Non-Certification Deductible **$500**

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

– The Calendar Year Deductible will not apply to benefits for Preventive Care Services provided by a *participating provider*.

– The Calendar Year Deductible will not apply to office visits to a *physician* who is a *participating provider*.

  Note: This exception only applies to the charge for the visit itself. It does not apply to any other charges made during that visit, such as for testing procedures, surgery, etc.

– The Calendar Year Deductible will not apply to diabetes education program services provided by a *physician* who is a *participating provider*.

– The Calendar Year Deductible will not apply to transplant travel expenses authorized by us in connection with a specified transplant procedure provided at a designated *CME* or a *BDCSC*.

– The Calendar Year Deductible will not apply to bariatric travel expense in connection with an authorized bariatric surgical procedure provided at a designated *BDCSC*.

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

– The Emergency Room Deductible will not apply if you are admitted as a *hospital* inpatient immediately following emergency room treatment.

– The Inpatient Deductible will not apply to *emergency* admissions.

– The Non-Certification Deductible will not apply to *emergency* admissions or services, nor to services provided by a *participating provider*. See UTILIZATION REVIEW PROGRAM.

– The Additional Deductibles will not apply for the remainder of the *year* once your Out-of-Pocket Amount is reached.

CO-PAYMENTS

Co-Payments*. You are responsible for the following percentages of the *maximum allowed amount* you incur for non-*emergency* services or the *reasonable and customary value* for *emergency* services provided by a *non-participating provider*:

- *Participating Providers*.....**20%**
- *Other Health Care Providers* **20%**
- *Non-Participating Providers*.....**40%**

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

***Exceptions:**

– There will be no Co-Payment for any covered services provided by a *participating provider* under the Preventive Care benefit.

– Your Co-Payment for *non-participating providers* will be the same as for *participating providers* for the following services. You may be responsible for charges which exceed the *maximum allowed amount*.

a. All *emergency services*;

b. An *authorized referral* from a *physician* who is a *participating provider* to a *non-participating provider*;

c. Charges by a type of *physician* not represented in the Prudent Buyer Plan network or the Blue Cross and/or Blue Shield Plan; or

d. Cancer Clinical Trials.

– If you receive services from a category of provider defined in this certificate as an *other health care provider* but such a provider participates in the Blue Cross and/or Blue Shield Plan in that service area, your Co-Payment will be as follows:

a. if you go to a *participating provider*, your Co-payment will be the same as for *participating providers*.

b. if you go to a *non-participating provider*, your Co-Payment will be the same as for *non-participating providers*.

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

- Your Co-Payment for office visits to a *physician* who is a *participating provider* and **who is not a *specialist*** will be **$20.** This Co-Payment will not apply toward the satisfaction of any deductible.

  Note: This exception applies only to the charge for the visit itself. It does not apply to any other charges made during that visit, such as testing procedures, surgery, etc.

- Your Co-Payment for office visits to a *physician* who is a *participating provider* and **who is a *specialist*** will be **$40.** This Co-Payment will not apply toward the satisfaction of any deductible.

  Note: This exception applies only to the charge for the visit itself. It does not apply to any other charges made during that visit, such as testing procedures, surgery, etc.

- Your Co-Payment for diabetes education program services provided by a *physician* who is a *participating provider* will be **$20**. This Co-Payment will not apply toward the satisfaction of any deductible.

- Your Co-Payment for specified transplants (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures) determined to be *medically necessary* and performed at a designated *CME* or *BDCSC* will be the same as for *participating providers*. **Services for specified transplants are not covered when performed at other than a designated *CME* or *BDCSC*.** See UTILIZATION REVIEW PROGRAM.

  NOTE: No Co-Payment will be required for the transplant travel expenses authorized by us in connection with a specified transplant performed at a designated *CME* or *BDCSC*. Transplant travel expense coverage is available when the closest *CME* or *BDCSC* is 75 miles or more from the recipient's or donor's residence.

– Your Co-Payment for bariatric surgical procedures determined to be *medically necessary* and performed at a designated *BDCSC* will be the same as for *participating providers*. **Services for bariatric surgical procedures are not covered when performed at other than a designated *BDCSC*.** See UTILIZATION REVIEW PROGRAM.

  NOTE: Co-Payments do not apply to bariatric travel expenses authorized by us. Bariatric travel expense coverage is available when the closest *BDCSC* is 50 miles or more from the *member's* residence.

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

Out-of-Pocket Amount*. After you have made the following total out-of-pocket payments for covered charges incurred during a *calendar year,* you will no longer be required to pay a Co-Payment for the remainder of that *year*, but you remain responsible for costs in excess of the *maximum allowed amount* or the *prescription drug maximum allowed amount*.

- *Participating providers, participating pharmacies,* home delivery and *other health care providers* **$2,300**
- *Non-participating providers and non-participating pharmacies* **$4,600**

Per family:

- *Participating providers, participating pharmacies,* home delivery and *other health care providers* **$4,600****
- *Non-participating providers and non-participating pharmacies* **$9,200****

  **** But not more than the Out-of-Pocket Amount per *member* indicated above for any one enrolled *member* in a family.

***Exception:**

- Expense which is incurred for non-covered services or supplies, which is in excess of the *maximum allowed amount* or which is in excess of the *prescription drug maximum allowed amount,* will not be applied toward your Out-of-Pocket Amount.

Non-Contracting Hospital Penalty. The *maximum allowed amount* is **reduced by 25%** for services and supplies provided by a *non-contracting hospital*. This penalty will be deducted from the *maximum allowed amount* prior to calculating your Co-Payment amount, and any benefit payment by us will be based on such reduced *maximum allowed amount*. You are responsible for paying this extra expense. This reduction will be waived only for *emergency services*. To avoid this penalty, be sure to choose a *contracting hospital*.

MEDICAL BENEFIT MAXIMUMS

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

Skilled Nursing Facility

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

Home Health Care

- For covered home health services .....**100 visits** per *calendar year*

Infusion Therapy

- For all covered services and supplies received during any one day **$600***

  ***Non-participating providers** only

Ambulatory Surgical Center

- For all covered services and supplies **$350***

  ***Non-participating providers** only

Outpatient Hemodialysis

- For all covered services and supplies ..... **$350*** per visit

  ***Non-participating providers** only

Hearing Aid Services

- For covered charges for hearing aids..... One hearing aid per ear every three years

Physical Therapy, Physical Medicine and Occupational Therapy including Chiropractic Services

- For covered outpatient services ..... **24** visits per *calendar year,* additional visits as authorized by us if *medically necessary*

Acupuncture

- For all covered services..... **12 visits** per *calendar year*

Transplant Travel Expense

- For all travel expense authorized by us in connection with a specified transplant performed at a designated *CME* or *BDCSC*..... **$10,000** per transplant

Unrelated Donor Searches

- For all charges for unrelated donor searches for covered bone marrow/stem cell transplants..... **$30,000** per transplant

Bariatric Travel Expense

- For the *member* (limited to three (3) trips – one pre-surgical visit, the initial surgery and one follow-up visit)
  - For transportation to the *CME*..... up to **$130** per trip
- For the companion (limited to two (2) trips – the initial surgery and one follow-up visit)
  - For transportation to the *CME*..... up to **$130** per trip
- For the *member* and one companion (for the pre-surgical visit and the follow-up visit)
  - Hotel accommodations ..... up to **$100** per day, for up to 2 days per trip, limited to one room, double occupancy

- For one companion (for the duration of the *member's* initial surgery stay)
  - Hotel accommodations ..... up to **$100** per day, for up to 4 days, limited to one room, double occupancy
  - For other reasonable expenses (excluding, tobacco, alcohol, drug and meal expenses) ..... up to **$25** per day, for up to **4** days per trip

Transgender Travel Expense

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

Lifetime Maximum

- For all medical benefits ..... **Unlimited**

PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG CO-PAYMENTS. The following co-payments apply for each *prescription*:

Retail Pharmacies: The following co-payments apply for a 30-day supply of medication. If you receive more than 30-day supply of medication at a retail *pharmacy*, you will have to pay the applicable copay shown below for each additional 30-day supply of medication you receive. **Note**: Specified *specialty drugs* must be obtained through the specialty pharmacy program. However, the first one month supply of a *specialty drug* may be obtained through a retail pharmacy, after which the drug is available only through the specialty pharmacy program unless an exception is made.

Participating Pharmacies

- *Tier 1 drugs* **$10**
- Diabetic Supplies **$10**
- *Tier 2 drugs* **$20**
- *Tier 3 drugs* **$35**

- *Compound Medications* **$35**
- *Tier 4 drugs* **$35**

Please note that presentation of a prescription to a pharmacy or pharmacist does not constitute a claim for benefit coverage. If you present a *prescription* to a *participating pharmacy*, and the *participating pharmacy* indicates your *prescription* cannot be filled, your deductible, if any, needs to be satisfied, or requires an additional Co-Payment, this is not considered an adverse claim decision. If you want the *prescription* filled, you will have to pay either the full cost, or the additional Co-Payment, for the *prescription drug.* If you believe you are entitled to some *plan* benefits in connection with the *prescription drug*, submit a claim for reimbursement to the *pharmacy benefits manager*.

Non-Participating Pharmacies*

- *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 Prescriptions: The following co-payments apply for a 90-day supply of medication.

- *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 YOUR PRESCRIPTION DRUG BENEFITS ..... **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 *pharmacy* **$200**
- For a 90-day supply through home delivery **$600**

***Important Note About *Prescription Drug Covered Expense* and Your Co-Payment.**

* The *prescription drug formulary* is a list of outpatient *prescription drugs* which may be particularly cost-effective, therapeutic choices. Your co-payment amount for *non-formulary drugs* is higher than for *formulary drugs*. Any *participating pharmacy* can assist you in purchasing a *formulary drug*. 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 www.anthem.com/ca.

* What we allow for *prescription drug covered expense* for *non-participating pharmacies* is usually significantly lower than what those providers customarily charge, so you will almost always have a higher out-of-pocket expense for your drugs when you use a *non-participating pharmacy* to fill your prescription.

YOU WILL BE REQUIRED TO PAY YOUR CO-PAYMENT AMOUNT TO THE PARTICIPATING PHARMACY AT THE TIME YOUR PRESCRIPTION IS FILLED.

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

Preferred Generic Program

Prescription drugs will always be dispensed by a *pharmacist* as prescribed by your *physician*. Your *physician* may order a *drug* in a higher or lower *drug co-payment* tier for you. You may request your *physician* to prescribe a *drug* in a higher *drug co-payment* tier instead of a *drug* in a lower *co-payment* tier 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* is available in a lower *co-payment drug* tier, and it is not determined that a *drug* in a higher *co-payment drug* tier is *medically necessary* for you to have (see PRESCRIPTION DRUG FORMULARY: PRIOR AUTHORIZATION below), you will have to pay the *co-payment* for the lower tier *drug* plus the difference in cost between the *prescription drug maximum allowed amount* for the lower *co-payment drug* tier and the higher *co-payment drug* tier, but, not more than 50% of our average cost for the tier that the *drug* is in. If your *physician* specifies "dispense as written," in lieu of paying the co-payment for the lower tier *drug* plus the difference, as previously stated, you will pay just the applicable co-payment shown for the higher tier *drug* 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.

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.

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 *physician* 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 *physician*. 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.

YOUR MEDICAL BENEFITS

MAXIMUM ALLOWED AMOUNT

General

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

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

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

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

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

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

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

Provider Network Status

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

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

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

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

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

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

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

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

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

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

***Exceptions:**

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

- **Emergency Ambulance Services Provided by Non-Participating Providers.** For *emergency* ambulance services received from *non-participating providers* outside of California, the *plan's* payment is based on the *maximum allowed amount*. *Non-participating providers* (both inside and outside of California) may also bill you for any charges over the *plan's reasonable and customary value* or *maximum allowed amount*, respectively.

- **Cancer Clinical Trials.** The *maximum allowed amount* for services and supplies provided in connection with Cancer Clinical Trials will be the lesser of the billed charge or the amount that ordinarily applies when services are provided by a *participating provider*.

- **If Medicare is the primary payor, the *maximum allowed amount* does not include any charge:**

  1. By a *hospital,* in excess of the approved amount as determined by Medicare; or

  2. By a *physician* who is a *participating provider* who accepts Medicare assignment, in excess of the approved amount as determined by Medicare; or

  3. By a *physician* who is a *non-participating provider* or *other health care provider* who accepts Medicare assignment, in excess of the lesser of *maximum allowed amount* stated above, or the approved amount as determined by Medicare; or

  4. By a *physician* or *other health care provider* who does not accept Medicare assignment, in excess of the lesser of the *maximum allowed amount* stated above, or the limiting charge as determined by Medicare.

Member Cost Share

For certain covered services, and depending on your plan design, you may be required to pay all or a part of the *maximum allowed amount* as your cost share amount (Deductibles or Co-Payments). Your cost share

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

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

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

Authorized Referrals

In some circumstances we may authorize *participating provider* cost share amounts (Deductibles or Co-Payments) to apply to a claim for a covered service you receive from a *non-participating provider*. In such circumstance, you or your *physician* must contact us in advance of obtaining the covered service. It is your responsibility to ensure that we have been contacted. If we authorize a *participating provider* cost share amount to apply to a covered service received from a *non-participating provider*, you also may still be liable for the difference between the *maximum allowed amount* and the *non-participating provider's* charge. If you receive prior authorization for a *non-participating provider* due to network adequacy issues, you will not be responsible for the difference between the *non-participating provider's* charge and the *maximum allowed amount*. Please call the customer service telephone number on your ID card for *authorized referral* information or to request authorization.

WARNING! Reduction of *Maximum Allowed Amount* for *Non-Contracting Hospitals*. A small percentage of *hospitals* which are *non-participating providers* are also *non-contracting hospitals*. Except for *emergency* care, the *maximum allowed amount* **is reduced by 25%** for all services and supplies provided by a *non-contracting hospital*. You will be responsible for paying this amount. You are strongly encouraged to avoid this additional expense by seeking care from a *contracting hospital*. **You can call the customer service number on your identification card to locate a *contracting hospital*.**

DEDUCTIBLES, CO-PAYMENTS, OUT-OF-POCKET AMOUNTS AND MEDICAL BENEFIT MAXIMUMS

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

DEDUCTIBLES

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

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

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

Additional Deductibles

1. Each time you visit an emergency room for treatment you will be responsible for paying the Emergency Room Deductible. But this deductible will not apply if you are admitted as a *hospital* inpatient from the emergency room immediately following emergency room treatment.

2. Each time you are admitted to a *hospital* or *residential treatment center,* you are responsible for paying the applicable Inpatient Deductible. This deductible will not apply to an *emergency* admission.

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

Note: You will no longer be responsible for paying any Additional Deductibles for the remainder of the *year* once your Out-of-Pocket Amount is reached (see the SUMMARY OF BENEFITS section for details).

CO-PAYMENTS

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

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

OUT-OF-POCKET AMOUNTS

Satisfaction of the Out-of-Pocket Amount. If, after you have met your Calendar Year Deductible, you pay Co-Payments equal to your Out-of-Pocket Amount per *member* during a *calendar year*, you will no longer be required to make Co-Payments for any additional covered services or supplies you incur during the remainder of that *year*.

Participating Providers, Participating Pharmacies, Home Delivery Pharmacy and Other Health Care Providers. Amounts applied to a Deductible and covered charges up to the *maximum allowed amount* or *prescription drug maximum allowed amount* for the services of *participating providers*, *participating pharmacies*, home delivery pharmacy and *other health care providers* will be applied to the *Participating Providers*, *Participating Pharmacies*, Home Delivery Pharmacy and *Other Health Care Providers* Out-of-Pocket Amount.

After this Out-of-Pocket Amount per *member* or family has been satisfied during a *calendar year*, you will no longer be required to make any Co-Payment for the covered services provided by a *participating provider*, *participating pharmacy*, home delivery pharmacy or *other health care*

provider for the remainder of that *year*. You will continue to be required to make Co-Payments for the covered services of a *non-participating provider* and *non-participating pharmacy* until the *Non-Participating Providers* and *Non-Participating Pharmacies* Out-of-Pocket Amount has been met.

Non-Participating Providers and Non-Participating Pharmacies. Amounts applied to a Deductible and covered charges up to the *maximum allowed amount* or *prescription drug maximum allowed amount* for the services of *non-participating providers* and *non-participating pharmacies* will be applied to the *Non-Participating Providers* and *Non-Participating Pharmacies* Out-of-Pocket Amount.

After this Out-of-Pocket Amount has been satisfied during a *calendar year*, you will no longer be required to make any Co-Payment for the covered services provided by a *non-participating provider* or *non-participating pharmacy* for the remainder of that *year*.

Charges Which Do Not Apply Toward the Out-Of-Pocket Amount. The following charges will not be applied toward satisfaction of an Out-Of-Pocket Amount:

- Charges for services or supplies not covered under this plan;
- Charges which exceed the *maximum allowed amount*; and
- Charges which exceed the *prescription drug maximum allowed amount.*

MEDICAL BENEFIT MAXIMUMS

We do not make benefit payments for any *member* in excess of any of the Medical Benefit Maximums.

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

CREDITING PRIOR PLAN COVERAGE

If you were covered by the *group's prior plan* immediately before the *group* signs up with us, with no lapse in coverage, then you will get credit for any accrued Calendar Year Deductible and, if applicable and approved by us, Out of Pocket Amounts under the *prior plan*. This does not apply to individuals who were not covered by the *prior plan* on the day before the *group's* coverage with us began, or who join the *group* later.

If your *group* 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 Calendar Year Deductible and Out of Pocket Amounts, if applicable and approved by us. Any maximums, when applicable, will be carried over and charged against the Medical Benefit Maximums under this *plan*.

If your *group* 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 Calendar Year Deductible and, if applicable, Out of Pocket Amounts and any maximums will be carried over and charged against Medical Benefit Maximums under this *plan*.

If your *group* 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 Calendar Year Deductible, Out of Pocket Amount, and any Medical Benefit Maximums under this *plan*.

This Section Does Not Apply To You If:

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

CONDITIONS OF COVERAGE

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

1. You must incur this expense while you are covered under this *plan*. Expense is incurred on the date you receive the service or supply for which the charge is made.
2. The expense must be for a medical service or supply furnished to you as a result of illness or injury or pregnancy, unless a specific exception is made.
3. The expense must be for a medical service or supply included in MEDICAL CARE THAT IS COVERED. Additional limits on covered charges are included under specific benefits and in the SUMMARY OF BENEFITS.
4. The expense must not be for a medical service or supply listed in MEDICAL CARE THAT IS NOT COVERED. If the service or supply is partially excluded, then only that portion which is not excluded will be covered under this plan.

5. The expense must not exceed any of the maximum benefits or limitations of this *plan*.

6. Any services received must be those which are regularly provided and billed by the provider. In addition, those services must be consistent with the illness, injury, degree of disability and your medical needs. Benefits are provided only for the number of days required to treat your illness or injury.

7. All services and supplies must be ordered by a *physician*.

MEDICAL CARE THAT IS COVERED

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

Hospital

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

2. Services in *special care units*.

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

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

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

If we apply covered charges toward the Calendar Year Deductible and do not provide payment, those days will be included in the 100 days for that *year*.

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

1. Services of a registered nurse or licensed vocational nurse under the supervision of a registered nurse or a *physician*.

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

In no event will benefits exceed 100 visits during a *calendar year*. A visit of four hours or less by a home health aide shall be considered as one home health visit.

If we apply covered charges toward the Calendar Year Deductible and do not provide payment, those visits will be included in the 100 visits for that *year*.

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

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

Hospice Care. The services and supplies listed below are covered when provided by a *hospice* for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care is care that controls pain and relieves symptoms but is not intended to cure the illness. You must be suffering from a terminal illness for which the prognosis of life expectancy is one year or less, as certified by your *physician* and submitted to us. Covered services are available on a 24-hour basis for the management of your condition.

1. Interdisciplinary team care with the development and maintenance of an appropriate plan of care.
2. Short-term inpatient *hospital* care when required in periods of crisis or as respite care. Coverage of inpatient respite care is provided on an occasional basis and is limited to a maximum of five consecutive days per admission.

3. Skilled nursing services provided by or under the supervision of a registered nurse. Certified home health aide services and homemaker services provided under the supervision of a registered nurse.

4. Social services and counseling services provided by a qualified social worker.

5. Dietary and nutritional guidance. Nutritional support such as intravenous feeding or hyperalimentation.

6. Physical therapy, occupational therapy, speech therapy, and respiratory therapy provided by a licensed therapist.

7. Volunteer services provided by trained *hospice* volunteers under the direction of a *hospice* staff member.

8. Pharmaceuticals, medical equipment, and supplies necessary for the management of your condition. Oxygen and related respiratory therapy supplies.

9. Bereavement services, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following the *subscriber's* or the *family member's* death. Bereavement services are available to surviving members of the immediate family for a period of one year after the death. Your immediate family means your spouse, children, step-children, parents, and siblings.

10. Palliative care (care which controls pain and relieves symptoms, but does not cure) which is appropriate for the illness.

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

Infusion Therapy. The following services and supplies when provided by a *home infusion therapy provider* in your home or in any other outpatient setting by a qualified health care provider, for the intravenous administration of your total daily nutritional intake or fluid requirements, including but not limited to Parenteral Therapy and Total Parenteral Nutrition (TPN), medication related to illness or injury, chemotherapy, antibiotic therapy, aerosol therapy, tocolytic therapy, special therapy, intravenous hydration, or pain management:

1. Medication, ancillary medical supplies and supply delivery, (not to exceed a 14-day supply); however, medication which is delivered but not administered is not covered;

2. Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications (if outpatient prescription drug benefits are provided under this *plan*, *compound medications* must be obtained from a *participating pharmacy*);

3. *Hospital* and home clinical visits related to the administration of infusion therapy, including skilled nursing services including those provided for: (a) patient or alternative caregiver training; and (b) visits to monitor the therapy;

4. Rental and purchase charges for durable medical equipment; maintenance and repair charges for such equipment;

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

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

Please note: only specified *participating providers* have been approved by us to provide medications to treat hemophilia. To find an approved *participating provider* who can provide medications to treat hemophilia, please call the toll-free number printed on your identification card if you have any questions about making this determination. *Drugs* to treat hemophilia that you receive from a provider other than a *participating provider* approved by us will be considered *non-participating provider* charges subject to the cost shares and any limitations associated with those services.

Our maximum payment will not exceed **$600** per day for services or supplies provided by a *non-participating provider*.

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

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

For the services of a *non-participating provider* facility only, our maximum payment is limited to **$350** each time you have outpatient surgery at an *ambulatory surgical center*.

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

Professional Services

1. Services of a *physician*.

2. Services of an anesthetist (M.D. or C.R.N.A.).

Reconstructive Surgery. Reconstructive surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or creating a normal appearance. This includes *medically necessary* dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. "Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

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

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

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

Ambulance services are subject to medical necessity reviews. Pre-service review is required for air ambulance in a non-medical *emergency*. When using an air ambulance in a non-emergency situation, we reserve the right to select the air ambulance provider. If

you do not use the air ambulance we select in a non-emergency situation, no coverage will be provided.

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

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

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

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

Important information about air ambulance coverage. Coverage is only provided for air ambulance services when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a *hospital* than the ground ambulance can provide, this plan will cover the air ambulance. Air ambulance will also be covered if you are in a location that a ground or water ambulance cannot reach.

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

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

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

Diagnostic Services. Outpatient diagnostic imaging and laboratory services. Certain imaging procedures, including, but not limited to, Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and nuclear cardiac imaging are subject to pre-service review to determine medical necessity. You may call the toll-free customer service telephone number on your identification card to find out if an imaging procedure requires pre-service review. See UTILIZATION REVIEW PROGRAM for details.

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

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

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

The following renal dialysis services are covered:

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

Treatment provided by a freestanding outpatient hemodialysis center which is a *non-participating provider* is limited to **$350** per visit.

Prosthetic Devices

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

3. We will pay for other *medically necessary prosthetic devices*, including:

    a. Surgical implants;

    b. Artificial limbs or eyes;

    c. The first pair of contact lenses or eye glasses when required as a result of a covered *medically necessary* eye surgery;

    d. Therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications; and

    e. Orthopedic footwear used as an integral part of a brace; shoe inserts that are custom molded to the patient.

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

1. Of no further use when medical needs end (but not disposable);

2. For the exclusive use of the patient;

3. Not primarily for comfort or hygiene;

4. Not for environmental control or for exercise; and

5. Manufactured specifically for medical use.

We will determine whether the item satisfies the conditions above.

Specific durable medical equipment is subject to pre-service review to determine medical necessity. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

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

1. Nebulizers, including face masks and tubing. These items are covered under the *plan's* medical benefits and are not subject to any limitations or maximums that apply to coverage for durable medical equipment (see "Durable Medical Equipment").

2. Inhaler spacers and peak flow meters. These items are covered under your *prescription drug* benefits and are subject to the copayment for *brand name drugs* (see YOUR PRESCRIPTION DRUG BENEFITS).

3. Education for pediatric asthma, including education to enable the *child* to properly use the items listed above. This education will be covered under the *plan's* benefits for office visits to a *physician*.

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

Dental Care

1. **Admissions for Dental Care.** Listed inpatient *hospital* services for up to three days during a *hospital stay,* when such *stay* is required for dental treatment and has been ordered by a *physician* (M.D.) and a dentist (D.D.S. or D.M.D.). We will make the final determination as to whether the dental treatment could have been safely rendered in another setting due to the nature of the procedure or your medical condition. *Hospital stays* for the purpose of administering general anesthesia are not considered necessary and are not covered except as specified in #2, below.

2. **General Anesthesia.** General anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a *hospital* or a*mbulatory surgical center*. This applies only if (a) the *member* is less than seven years old, (b) the *member* is developmentally disabled, or (c) the *member's* health is compromised and general anesthesia is *medically necessary*. Charges for the dental procedure itself, including professional fees of a dentist, are not covered.

3. **Dental Injury.** Services of a *physician* (M.D.) or dentist (D.D.S. or D.M.D.) solely to treat an *accidental injury* to natural teeth. Coverage shall be limited to only such services that are *medically necessary* to repair the damage done by the *accidental injury* and/or restore function lost as a direct result of the *accidental injury*. Damage to natural teeth due to chewing or biting is not *accidental injury* unless the chewing or biting results from a medical or mental condition.

4. **Cleft Palate.** *Medically necessary* dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. "Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

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

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

Pregnancy and Maternity Care

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

   a. Prenatal, postnatal and postpartum care;

   b. Ambulatory care services (including ultrasounds, fetal non-stress tests, *physician* office visits, and other *medically necessary* maternity services performed outside of a *hospital*);

   c. Involuntary complications of pregnancy;

   d. Diagnosis of genetic disorders in cases of high-risk pregnancy; and

   e. Inpatient *hospital* care including labor and delivery.

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

2. Medical *hospital* benefits for routine nursery care of a newborn *child,* if the *child's* natural mother is an enrolled *member*. Routine nursery care of a newborn child includes screening of a newborn for genetic diseases, congenital conditions, and other health conditions provided through a program established by law or regulation.

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

Transplant Services. Services and supplies provided in connection with a non-*investigative* organ or tissue transplant, if you are:

1. The recipient; or

2. The donor.

Benefits for an organ donor are as follows:

- When both the person donating the organ and the person getting the organ are *members*, each will get benefits under their plans.

- When the person getting the organ is a *member*, but the person donating the organ is not, benefits under this *plan* are limited to benefits not available to the donor from any other source. This includes, but is not limited to, other insurance, grants, foundations, and government programs.

- If our covered *member* is donating the organ to someone who is **not** a *member*, benefits are not available under this *plan*.

The *maximum allowed amount* for a donor, including donor testing and donor search, is limited to expense incurred for *medically necessary* medical services only. The *maximum allowed amount* for services incident to obtaining the transplanted material from a living donor or a human organ transplant bank will be covered. Such charges, including complications from the donor procedure for up to six weeks from the date of procurement, are covered. Services for treatment of a condition that is not directly related to, or a direct result of, the transplant are not covered.

An unrelated donor search may be required when the patient has a disease for which a transplant is needed and a suitable donor within the family is not available. Our payment for unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants will not exceed **$30,000** per transplant.

Covered services are subject to any applicable deductibles, co-payments and medical benefit maximums set forth in the SUMMARY OF BENEFITS. The *maximum allowed amount* does not include charges for services received without first obtaining our prior authorization or which are provided at a facility other than a transplant center approved by us. See UTILIZATION REVIEW PROGRAM for details.

To maximize your benefits, you should call our Transplant Department as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation or work-up for a transplant. We will help you maximize your benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, *Centers of Medical Excellence (CME)* or *Blue Distinction Centers for Specialty Care*

(BDCSC) rules, or exclusions apply. Call the customer service phone number on the back of your ID card and ask for the transplant coordinator.

You or your *physician* must call our Transplant Department for pre-service review prior to the transplant, whether it is performed in an inpatient or outpatient setting. Prior authorization is required before we will provide benefits for a transplant. Your *physician* must certify, and we must agree, that the transplant is *medically necessary*. Your *physician* should send a written request for prior authorization to us as soon as possible to start this process. Not getting prior authorization will result in a denial of benefits.

Please note that your *physician* may ask for approval for HLA (human leukocyte antigen) testing, donor searches, or collection and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges will be covered as routine diagnostic tests. The collection and storage request will be reviewed for medical necessity and may be approved. However, such an approval for HLA testing, donor search, or collection and storage is NOT an approval for the later transplant. A separate medical necessity decision will be needed for the transplant itself.

Specified Transplants

You must obtain our prior authorization for all services including, but not limited to, preoperative tests and postoperative care related to the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. Specified transplants must be performed at *Centers of Medical Excellence (CME)* or *Blue Distinction Centers for Specialty Care (BDCSC)*. **Charges for services provided for or in connection with a specified transplant performed at a facility other than a *CME* or *BDCSC* will not be considered covered under this plan.** Call the toll-free telephone number for pre-service review on your identification card if your *physician* recommends a specified transplant for your medical care. A case manager transplant coordinator will assist in facilitating your access to a *CME* or *BDCSC*. See UTILIZATION REVIEW PROGRAM for details.

Transplant Travel Expense

Certain travel expenses incurred in connection with an approved, specified transplant (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures) performed at a designated *CME* or *BDCSC* that is 75 miles or more from the recipient's or donor's place of residence are covered, provided the expenses are authorized by us in advance. Our

maximum payment will not exceed **$10,000** per transplant for the following travel expenses incurred by the recipient and one companion* or the donor:

- Ground transportation to and from the *CME* or *BDCSC* when the designated *CME* or *BDCSC* is 75 miles or more from the recipient's or donor's place of residence.
- Coach airfare to and from the *CME* or *BDCSC* when the designated *CME* or *BDCSC* is 300 miles or more from the recipient's or donor's residence
- Lodging, limited to one room, double occupancy
- Other reasonable expenses. Tobacco, alcohol, drug expenses, and meals are excluded.

*Note: When the *member* recipient is under 18 years of age, this benefit will apply to the recipient and two companions or caregivers.

The Calendar Year Deductible will not apply and no co-payments will be required for transplant travel expenses authorized in advance by us. We will provide benefits for lodging and ground transportation, up to the current limits set forth in the Internal Revenue Code.

Expense incurred for the following is not covered: interim visits to a medical care facility while waiting for the actual transplant procedure; travel expenses for a companion and/or caregiver for a transplant donor; return visits for a transplant donor for treatment of a condition found during the evaluation; rental cars, buses, taxis or shuttle services; and mileage within the city in which the medical transplant facility is located.

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

Bariatric Surgery. Services and supplies in connection with *medically necessary* surgery for weight loss, only for morbid obesity and only when performed at a designated *BDCSC* facility. See UTILIZATION REVIEW PROGRAM for details.

You must obtain pre-service review for all bariatric surgical procedures. **Charges for services provided for or in connection with a bariatric surgical procedure performed at a facility other than a *BDCSC* will not be covered.**

Bariatric Travel Expense. The following travel expense benefits will be provided in connection with an approved bariatric surgical procedure only when the *member's* place of residence is fifty (50) miles or more from the

nearest bariatric *CME.* All travel expenses must be approved by us in advance. The fifty (50) mile radius around the *CME* will be determined by the *bariatric CME coverage area* (See DEFINITIONS).

- Transportation for the *member* to and from the *CME* up to **$130** per trip for a maximum of three (3) trips (one pre-surgical visit, the initial surgery and one follow-up visit).
- Transportation for one companion to and from the *CME* up to **$130** per trip for a maximum of two (2) trips (the initial surgery and one follow-up visit).
- Hotel accommodations for the *member* and one companion not to exceed **$100** per day for the pre-surgical visit and the follow-up visit, up to two (2) days per trip or as *medically necessary*. Limited to one room, double occupancy.
- Hotel accommodations for one companion not to exceed **$100** per day for the duration of the *member's* initial surgery stay, up to four (4) days. Limited to one room, double occupancy.
- Other reasonable expenses not to exceed **$25** per day, up to four (4) days per trip. Tobacco, alcohol, drug and meal expenses are excluded from coverage.

Customer service will confirm if the "Bariatric Travel Expense" benefit is available in connection with access to the selected bariatric *CME.* Details regarding reimbursement can be obtained by calling the customer service number on your I.D. card. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

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

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

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. Transgender services are subject to prior authorization in order for coverage to be provided. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

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

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

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

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

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

1. Inpatient *hospital* services and services from a *residential treatment center* as stated in the "Hospital" provision of this section, for inpatient services and supplies.
2. Partial hospitalization, including intensive outpatient programs and visits to a *day treatment center*. Partial hospitalization is covered as

stated in the “Hospital” provision of this section, for outpatient services and supplies.

3. *Physician* visits during a covered inpatient *stay*.

4. *Physician* visits for outpatient psychotherapy or psychological testing for the treatment of *mental or nervous disorders* or substance abuse. This includes nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa.

5. Behavioral health treatment for pervasive developmental disorder or autism. See the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM for a description of the services that are covered. **Note:** You must obtain pre-service review for all behavioral health treatment services for the treatment of pervasive developmental disorder or autism in order for these services to be covered by this *plan* (see UTILIZATION REVIEW PROGRAM for details).

6. Diagnosis and all *medically necessary* treatment of severe mental illness or a person of any age and serious emotional disturbances of a child.

Treatment for substance abuse does not include smoking cessation programs, nor treatment for nicotine dependency or tobacco use. Certain services are covered under the “Preventive Care Services” benefit or as specified in the “Preventive Prescription Drugs and Other Items” covered under YOUR PRESCRIPTION DRUG BENEFITS. Please see those provisions for further details.

Preventive Care Services. Screening services and supplies provided in connection with *preventive care services* as shown below. The *calendar year* deductible will not apply to these services or supplies when they are provided by a *participating provider.* No co-payment will apply to these services or supplies when they are provided by a *participating provider.*

1. A *physician's* services for routine physical examinations.

2. Immunizations prescribed by the examining *physician.*

3. Radiology and laboratory services and tests ordered by the examining *physician* in connection with a routine physical examination, excluding any such tests related to an illness or injury. Those radiology and laboratory services and tests related to an illness or injury will be covered as any other medical service available under the terms and conditions of the provision “Diagnostic Services”.

4. Health screenings as ordered by the examining *physician* for the following: breast cancer, including BRCA testing if appropriate (in conjunction with genetic counseling and evaluation), cervical cancer,

including human papillomavirus (HPV), prostate cancer, colorectal cancer, and other medically accepted cancer screening tests, blood lead levels, high blood pressure, type 2 diabetes mellitus, cholesterol, obesity, and screening for iron deficiency anemia in pregnant women.

5. Human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.

6. Counseling and risk factor reduction intervention services for sexually transmitted infections, human immunodeficiency virus (HIV), contraception, tobacco use, and tobacco use-related diseases.

7. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:

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

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

   In order to be covered as preventive care, contraceptive prescription 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 your prescription drug benefits).

   b. Breast feeding support, supplies, and counseling.

   c. Gestational diabetes screening.

   d. Preventive prenatal care.

8. Preventive services for certain high-risk populations as determined by your *physician*, based on clinical expertise.

This list of *preventive care services* 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 with no copayment and will not apply to the *calendar year* deductible.

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

Hearing Aid Services. The following hearing aid services are covered when provided by or purchased as a result of a written recommendation from an otolaryngologist or a state-certified audiologist.

1. 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 *plan* benefits for office visits to *physicians.*

2. Hearing aids (monaural or binaural) including ear mold(s), the hearing aid instrument, batteries, cords and other ancillary equipment.

3. Visits for fitting, counseling, adjustments and repairs for a one year period after receiving the covered hearing aid.

Benefits are provided for one hearing aid per ear every three years.

No benefits will be provided for the following:

1. Charges for a hearing aid which exceeds specifications prescribed for the correction of hearing loss.

2. 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").

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

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

2. Breast cancer (BRCA) testing, if appropriate, in conjunction with genetic counseling and evaluation. When done as a *preventive care service*, BRCA testing will be covered under the Preventive Care Services benefit.

3. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.

4. Reconstructive surgery of both breasts performed to restore and achieve symmetry following a *medically necessary* mastectomy.

5. Breast prostheses following a mastectomy (see "Prosthetic Devices").

This coverage is provided according to the terms and conditions of this *plan* that apply to all other medical conditions.

Clinical Trials. Coverage is provided for routine patient 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:

1. Federally funded trials approved or funded by one or more of the following:

    a. The National Institutes of Health,

    b. The Centers for Disease Control and Prevention,

    c. The Agency for Health Care Research and Quality,

    d. The Centers for Medicare and Medicaid Services,

    e. A cooperative group or center of any of the four entities listed above or the Department of Defense or the Department of Veterans Affairs,

    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants, or

g. 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:

   i. The Department of Veterans Affairs,

   ii. The Department of Defense, or

   iii. The Department of Energy.

2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration.

3. 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 *physician* after determining participation has a meaningful potential to benefit you. 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 the costs associated with any of the following:

1. The investigational item, device, or service.

2. 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.

3. Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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

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

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

Physical Therapy, Physical Medicine and Occupational Therapy including Chiropractic Services. The following services provided by a *physician* under a treatment plan:

1. Physical therapy and physical medicine provided on an outpatient basis for the treatment of illness or injury including the therapeutic use of heat, cold, exercise, electricity, ultra violet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care which are customarily provided by chiropractors, physical therapists and osteopaths. It does not include massage therapy services at spas or health clubs.)

2. Occupational therapy provided on an outpatient basis when the ability to perform daily life tasks has been lost or reduced by illness or injury including programs which are designed to rehabilitate mentally, physically or emotionally handicapped persons. Occupational therapy programs are designed to maximize or improve a patient's upper extremity function, perceptual motor skills and ability to function in daily living activities.

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

Up to 24 visits in a *year* for all covered services are payable. But, if it is determined that an additional period of physical therapy, physical medicine or occupational therapy is *medically necessary*, we will specify a specific number of additional visits.

Such additional visits are not payable if pre-service review is not obtained. (See UTILIZATION REVIEW PROGRAM.)

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

American Specialty Health
P.O. Box 509001
San Diego, CA 92150-9002

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

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

If your *physician* determines that none of these contraceptive methods are appropriate for you based on your medical or personal history, coverage will be provided for another prescription contraceptive method that is approved by the Food and Drug Administration (FDA) and prescribed by your *physician*.

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

Sterilization Services. 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. Please see that provision for further details.

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

Acupuncture. The services of a *physician* for acupuncture treatment to treat a disease, illness or injury, including a patient history visit, physical examination, treatment planning and treatment evaluation, electroacupuncture, cupping and moxibustion. We will pay for up to 12 visits during a *calendar year*.

If we apply *maximum allowed amounts* toward the Calendar Year Deductible and do not provide payment, that visit is included in the visit maximum 12 visits for that *year*.

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

1. The following equipment and supplies:
    a. Blood glucose monitors, including monitors designed to assist the visually impaired, and blood glucose testing strips.

b. Insulin pumps.

c. Pen delivery systems for insulin administration (non-disposable).

d. Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin.

e. Podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes-related complications.

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

2. Diabetes education program which:

   a. Is designed to teach a *member* who is a patient and covered members of the patient's family about the disease process and the daily management of diabetic therapy;

   b. Includes self-management training, education, and medical nutrition therapy to enable the *member* to properly use the equipment, supplies, and medications necessary to manage the disease; and

   c. Is supervised by a *physician*.

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

3. The following items are covered under your *prescription drug* benefits:

   a. Insulin, glucagon, and other *prescription drugs* for the treatment of diabetes.

   b. Insulin syringes, disposable pen delivery systems for insulin administration.

   c. Testing strips, lancets, and alcohol swabs.

   These items must be obtained either from a retail *pharmacy* or through the home delivery program (see YOUR PRESCRIPTION DRUG BENEFITS).

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

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

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

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

Prescription Drugs Obtained From Or Administered By a Medical Provider. Your *plan* includes benefits for *prescription drugs* when they are administered to you as part of a *physician* visit, services from a *home health agency*, or at an outpatient *hospital*. This includes *drugs* for home infusion therapy, chemotherapy, *specialty pharmacy drugs*, blood products and any drug that must be administered by a *physician*. This section describes your benefits when your *physician* orders the medication and administers it to you.

If you receive medications to treat hemophilia, please see the note for your benefits under the "Infusion Therapy or Home Infusion Therapy" provision of this section.

Benefits for *drugs* that you inject or get at a *retail pharmacy* (i.e., self-administered *drugs*) are not covered under this section. Benefits for those and other covered *drugs* are described under YOUR PRESCRIPTION DRUG BENEFITS, if included.

Non-duplication of benefits applies to *pharmacy drugs* under this *plan*. When benefits are provided for *pharmacy drugs* under the *plan's* medical benefits, they will not be provided under your prescription drug benefits, if included. Conversely, if benefits are provided for *pharmacy drugs* under your prescription drug benefits, if included, they will not be provided under the *plan's* medical benefits.

Prior Authorization. Certain *specialty pharmacy drugs* require written prior authorization of benefits in order for you to receive them. Prior authorization criteria will be based on medical policy and the *pharmacy and therapeutics process*. You may need to try a *drug* other than the one originally prescribed if we determine that it should be clinically effective for you. However, if we determine through prior authorization that the *drug* originally prescribed is *medically necessary* and is cost effective, you will be provided the *drug* originally requested. 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, we will not require you to try a *drug* other than the one you are currently taking.

In order for you to get a *specialty pharmacy drug* that requires prior authorization, your *physician* must make a request to us using the required uniform prior authorization request form. The request may be made by mail, telephone, facsimile, or it may be made electronically. At the time the request is initiated, specific clinical information will be requested from your *physician* based on medical policy and/or clinical guidelines, based specifically on your diagnosis and/or the *physician's* statement in the request or clinical rationale for the *specialty pharmacy drug*.

After we get the request from your *physician,* we will review the request and respond within the following time periods:

- 72 hours for non-urgent 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*.

If you have any questions regarding whether a *specialty pharmacy drug* requires prior authorization, please call us at 1-800-700-2541 (or TTY/TDD 1-800-905-9821).

If we deny a request for prior authorization of a *specialty pharmacy drug*, you or your prescribing *physician* may appeal our decision by calling us at 1-800-700-2541 (or TTY/TDD 1-800-905-9821). If you are not satisfied with the resolution based on your inquiry, you may file a grievance with us by following the procedures described in the section entitled GRIEVANCE PROCEDURES.

MEDICAL CARE THAT IS NOT COVERED

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

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

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

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

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

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

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

Excess Amounts. Any amounts in excess of *maximum allowed amounts* or any Medical Benefit Maximum.

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

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

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

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

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

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

1. It must be internationally known as being devoted mainly to medical research;
2. At least **10%** of its yearly budget must be spent on research not directly related to patient care;
3. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. It must accept patients who are unable to pay; and
5. Two-thirds of its patients must have conditions directly related to the *hospital's* research.

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

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

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

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

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

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

This exclusion does not apply to the following:

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

Hearing Aids or Tests. Hearing aids. Routine hearing tests, except as specifically provided under the "Preventive Care Services" provisions of MEDICAL CARE THAT IS COVERED.

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

Outpatient Occupational Therapy. Outpatient occupational therapy, except as specifically stated in the "Infusion Therapy" provision of MEDICAL CARE THAT IS COVERED, or when provided by a *home health agency* or *hospice,* as specifically stated in the "Home Health Care", "Hospice Care" or "Physical Therapy, Physical Medicine and Occupational Therapy" provisions of that section. This exclusion also does not apply to the *medically necessary* treatment of *severe mental disorders*, or to the *medically necessary* treatment of pervasive

developmental disorder or autism, to the extent stated in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.

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

Scalp hair prostheses. Scalp hair prostheses, including wigs or any form of hair replacement.

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

Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or *physician* 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 dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as stated in the “Bariatric Surgery” provision of MEDICAL CARE THAT IS COVERED.

Transgender Services. Services and supplies in connection with transgender services, except as specifically stated in the “Transgender Services” provision under the section MEDICAL CARE THAT IS COVERED.

Sterilization Reversal. Reversal of an elective sterilization.

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

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).

Orthopedic Supplies. 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 the “Prosthetic Devices” provision of MEDICAL CARE THAT IS COVERED.

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

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

Health Club Memberships. 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 *physician*. This exclusion also applies to health spas.

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

Educational or Academic Services. This plan does not cover:

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

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

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

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

Telephone, Facsimile Machine, and Electronic Mail Consultations. Consultations provided using telephone, facsimile machine, or electronic mail.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specifically stated in the "Preventive Care Services" provision of MEDICAL CARE THAT IS COVERED.

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

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

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

Outpatient Prescription Drugs and Medications. Outpatient *prescription drugs* or medications and insulin, except as specifically

stated in the "Infusion Therapy" or "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED or under YOUR PRESCRIPTION DRUG BENEFITS section of this booklet. Non-prescription, over-the-counter patent or proprietary drugs or medicines, except as specified in "Preventive Prescription Drugs and Other Items" covered under YOUR PRESCRIPTION DRUG BENEFITS. Cosmetics, health or beauty aids. However, health aids that are *medically necessary* and meet the requirements for durable medical equipment as specified under the "Durable Medical Equipment" provision of MEDICAL CARE THAT IS COVERED, are covered, subject to all terms of this *plan* that apply to that benefit.

Specialty drugs. *Specialty drugs* that must be obtained from the specialty drug program, but, which are obtained from a retail *pharmacy* are not covered by this *plan*. **You will have to pay the full cost of the *specialty drugs* you get from a retail *pharmacy* that you should have obtained from the specialty drug program**.

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

Diabetic Supplies. Prescription and non-prescription diabetic supplies, except as specifically stated in "YOUR PRESCRIPTION DRUG BENEFITS" section of this booklet.

Private Duty Nursing. Private duty nursing services.

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.

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

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

BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM

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

Behavioral health treatment services covered under this *plan* are subject to the same deductibles, coinsurance, and copayments 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 *physicians*, 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 pre-service review for all behavioral health treatment services for the treatment of Pervasive Developmental Disorder or autism in order for these services to be covered by this *plan* (see UTILIZATION REVIEW PROGRAM for details).

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.

The network of *participating providers* may be limited to licensed Qualified Autism Service Providers who contract with a Blue Cross and/or Blue Shield Plan and who may supervise and employ Qualified Autism Service Professionals or Qualified Autism Service Paraprofessionals who provide and administer Behavioral Health Treatment.

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

- Provides behavioral health treatment,
- 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 or who meets equivalent criteria in the state in which he or she practices if not providing services in California, 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.

REIMBURSEMENT FOR ACTS OF THIRD PARTIES

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

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

   - If we paid the provider other than on a capitated basis, our lien will not be more than amount we paid for those services.

   - If we paid the provider on a capitated basis, our lien will not be more than 80% of the usual and customary charges for those services in the geographic area in which they were given.

   - If you hired an attorney to gain your recovery from the third party, our lien will not be for more than one-third of the money due you under any final judgment, compromise, or settlement agreement.

   - If you did not hire an attorney, our lien will not be for more than one-half of the money due you under any final judgment, compromise or settlement agreement.

   - If a final judgment includes a special finding by a judge, jury, or arbitrator that you were partially at fault, our lien will be reduced by the same comparative fault percentage by which your recovery was reduced.

   - Our lien is subject to a pro rata reduction equal to your reasonable attorney’s fees and costs in line with the common fund doctrine.

2. You must advise us in writing, within 60 days of filing a claim against the third party and take necessary action, furnish such information and assistance, and execute such papers as we may require to facilitate enforcement of our rights. You must not take action which may prejudice our rights or interests under your *plan*. Failure to give us such notice or to cooperate with us, or actions that prejudice our rights or interests will be a material breach of this *plan* and will result in your being personally responsible for reimbursing us.

3. We will be entitled to collect on our lien even if the amount you or anyone recovered for you (or your estate, parent or legal guardian) from or for the account of such third party as compensation for the injury, illness or condition is less than the actual loss you suffered.

YOUR PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG COVERED EXPENSE

Prescription drug covered expense is the maximum charge for each covered service or supply that will be accepted by us for each different type of *pharmacy*. It is not necessarily the amount a *pharmacy* bills for the service.

You may avoid higher out-of-pocket expenses by choosing a *participating pharmacy*, or by utilizing the home delivery program whenever possible. In addition, you may also reduce your costs by asking your *physician*, and your pharmacist, for the more cost-effective *generic* form of *prescription drugs*.

Prescription drug covered expense will always be the lesser of the billed charge or the *prescription drug maximum allowed amount*. Expense is incurred on the date you receive the *drug* for which the charge is made.

When you choose a *participating pharmacy*, the *pharmacy benefits manager* will subtract any expense which is not covered under your *prescription drug* benefits. The remainder is the amount of *prescription drug covered expense* for that claim. You will not be responsible for any amount in excess of the *prescription maximum allowed amount* for the covered services of a *participating pharmacy*.

When the *pharmacy benefits manager* receives a claim for *drugs* supplied by a *non-participating pharmacy*, they first subtract any expense which is not covered under your *prescription drug* benefits, and then any expense exceeding the *prescription maximum allowed amount*. The remainder is the amount of *prescription drug covered expense* for that claim.

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

PRESCRIPTION DRUG CO-PAYMENTS

CO-PAYMENTS

After the *pharmacy benefits manager* determines *prescription drug covered expense*, it will subtract your Prescription Drug Co-Payment for each *prescription*.

If your Prescription Drug Co-Payment includes a percentage of *prescription drug covered expense*, then the *pharmacy benefits manager* will apply that percentage to such expense. This will determine the dollar amount of your Prescription Drug Co-Payment.

The Prescription Co-Payments are set forth in the SUMMARY OF BENEFITS.

HOW TO USE YOUR PRESCRIPTION DRUG BENEFITS

When You Go to a Participating Pharmacy. To identify you as a *member* covered for *prescription drug* benefits, you will be issued an identification card. You must present this card to *participating pharmacies* when you have a *prescription* filled. Provided you have properly identified yourself as a *member*, a *participating pharmacy* will only charge your Co-Payment.

Generic drugs will be dispensed by *participating pharmacies* when the *prescription* indicates a *generic drug*. When a *brand name drug* is specified, but a *generic drug* equivalent exists, the *generic drug* will be substituted. *Brand name drugs* will be dispensed by *participating pharmacies* when the *prescription* specifies a *brand name* and states “dispense as written” or no *generic drug* equivalent exists.

Many *participating pharmacies* display an "Rx" decal with our logo in their window. For information on how to locate a *participating pharmacy* in your area, call 1-800-700-2541 (or TTY/TDD 1-800-905-9821).

Please note that presentation of a prescription to a pharmacy or pharmacist does not constitute a claim for benefit coverage. If you present a *prescription* to a *participating pharmacy*, and the *participating pharmacy* indicates your *prescription* cannot be filled, or requires an additional Co-Payment, this is not considered an adverse claim decision. If you want the *prescription* filled, you will have to pay either the full cost, or the additional Co-Payment, for the *prescription drug.* If you believe you are entitled to some *plan* benefits in connection with the *prescription drug*, submit a claim for reimbursement to the *pharmacy benefits manager* at the address shown below:

Prescription Drug Program
ATTN: Commercial Claims

P.O. Box 2872
Clinton, IA 52733-2872

Participating pharmacies usually have claims forms, but, if the *participating pharmacy* does not have claim forms, claim forms and customer service are available by calling 1-800-700-2541 (or TTY/TDD 1-800-905-9821). Mail your claim, with the appropriate portion completed by the pharmacist, to the *pharmacy benefits manager* within 90 days of the date of purchase. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed.

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 *participating pharmacies* may be limited. If this happens, we may require you to select a single *participating pharmacy* that will provide and coordinate all future pharmacy services. Benefits will only be paid if you use the single *participating pharmacy*. We will contact you if we determine that use of a single *participating pharmacy* is needed and give you options as to which *participating pharmacy* you may use. If you do not select one of the *participating pharmacies* we offer within 31 days, we will select a single *participating pharmacy* for you. If you disagree with our decision, you may ask us to reconsider it as outlined in the "GRIEVANCE PROCEDURES" section.

When You Go to a Non-Participating Pharmacy. If you purchase a *prescription drug* from a *non-participating pharmacy*, you will have to pay the full cost of the *drug* and submit a claim to us, at the address below:

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

Non-participating pharmacies do not have our prescription drug claim forms. You must take a claim form with you to a *non-participating pharmacy*. The pharmacist must complete the *pharmacy's* portion of the form and sign it.

Claim forms and customer service are available by calling 1-800-700-2541 (or TTY/TDD 1-800-905-9821). Mail your claim with the appropriate portion completed by the pharmacist to us within 90 days of the date of purchase. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed.

When You are Out of State. If you need to purchase a *prescription drug* out of the state of California, you may locate a *participating pharmacy* by calling 1-800-700-2541 (or TTY/TDD 1-800-905-9821). If you cannot locate a *participating pharmacy*, you must pay for the *drug* and submit a claim to us. (See "When You Go to a Non-Participating Pharmacy" above.)

When You Order Your Prescription Through the Home Delivery Program. You can order your *prescription* through the home delivery *prescription drug* program. Not all medications are available through the home delivery pharmacy.

The *prescription* must state the drug name, dosage, directions for use, quantity, the *physician's* name and phone number, the patient's name and address, and be signed by a *physician*. You must submit it with the appropriate payment for the amount of the purchase, and a properly completed order form. You need only pay the cost of your Co-Payment.

Your first home delivery *prescription* must also include a completed Patient Profile questionnaire. The Patient Profile questionnaire can be obtained by calling the toll-free number on your ID card. You need only enclose the *prescription* or refill notice, and the appropriate payment for any subsequent home delivery prescriptions, or call the toll-free number. Co-payments can be paid by check, money order or credit card.

Order forms can be obtained by contacting us at 1-800-700-2541 (or TTY/TDD 1-800-905-9821) to request one. The form is also available on-line at www.anthem.com/ca.

When You Order Your Prescription Through Specialty Drug Program. Certain specified *specialty drugs* must be obtained through the specialty pharmacy program unless you are given an exception from the specialty drug program (see PRESCRIPTION DRUG CONDITIONS OF SERVICE). These specified *specialty drugs* that must be obtained through the Specialty Drug Program are limited to up to a 30-day supply. The Specialty Drug Program will deliver your medication to you by mail or common carrier (you cannot pick up your medication at Anthem Blue Cross).

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

You or your *physician* may order your *specialty drug* by calling 1-800-700-2541. When you call the Specialty Drug 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 Specialty Drug Program. Once you have met your deductible, if any, you will only have to pay the cost of your Co-Payment.

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 in the SUMMARY OF BENEFITS or $200 for a 30-day supply for medications obtained at a retail *pharmacy* 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. Co-payments 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.

PRESCRIPTION DRUG UTILIZATION REVIEW

Your *prescription drug* benefits include utilization review of *prescription drug* usage for your health and safety. Certain *drugs* may require prior authorization. If there are patterns of over-utilization or misuse of *drugs*, our medical consultant will notify your personal *physician* and your pharmacist. We reserve the right to limit benefits to prevent over-utilization of *drugs*.

PRESCRIPTION DRUG FORMULARY

We use a *prescription drug formulary* to help your *physician* make prescribing decisions. The presence of a *drug* on the *plan's prescription drug formulary* list does not guarantee that you will be prescribed that *drug* by your *physician*. These medications, which include both generic and *brand name drugs*, are listed in the *prescription drug formulary*. The *formulary* is updated quarterly to ensure that the list includes *drugs* that

are safe and effective. Note: The *formulary drugs* may change from time to time.

Some *drugs* may require prior authorization. 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 exceptions).

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 *physician* 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 *physician* must complete a non-formulary exception form and return it to us. You or your *physician* can get the form online at www.anthem.com 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 "GRIEVANCE PROCEDURES" 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*.

Prior Authorization. Certain *drugs* require written prior authorization of benefits in order for you to receive benefits. Prior authorization criteria will be based on medical policy and the *Pharmacy and Therapeutics Process* established guidelines. You may need to try a *drug* other than the one originally prescribed if we determine that it should be clinically effective for you. However, 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 co-payment. (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 approved, *drugs* requiring prior authorization for benefits will be provided to you after you make the required co-payment.

In order for you to get a *drug* that requires prior authorization, your *physician* must send a written request to us for the *drug* using the required uniform prior authorization request form. The request can be sent to us by mail, facsimile, or it may be submitted electronically. If your *physician* 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. The form is also available 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 non-urgent 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 *physician* or pharmacist determines that it is appropriate and *medically necessary*. You may have to pay the applicable co-payment shown in SUMMARY OF BENEFITS: PRESCRIPTION DRUG BENEFITS: PRESCRIPTION DRUG CO-PAYMENTS 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 copayment.

If you have any questions regarding whether a *drug* is on our *prescription drug formulary*, 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.

If we deny a request for prior authorization of a *drug*, you or your prescribing *physician* may appeal our decision by calling us at 1-800-700-2541 (or TTY/TDD 1-800-905-9821). If you are not satisfied with the resolution based on your inquiry, you may file a grievance with us by following the procedures described in the section entitled GRIEVANCE PROCEDURES.

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* included on the list of *formulary drugs* covered by the *plan* is decided by the *Pharmacy and Therapeutics Process*, which is comprised of independent nurses, *physicians* and pharmacists. The *Pharmacy and Therapeutics Process* meets quarterly and decides on changes to make in the *formulary drug* list based on recommendations from us and a review of relevant information, including current medical literature.

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 *physician* and obtained from a *participating pharmacy* or through the home delivery program. This includes items that can be obtained over the counter for which a *physician's* 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 *participating pharmacy*.
- 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 *physician's* prescription.

  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 CONDITIONS OF SERVICE

To be covered, the *drug* or medication must satisfy all of the following requirements:

1. It must be prescribed by a licensed prescriber and be dispensed within one year of being prescribed, subject to federal and state laws. This requirement will not apply to covered vaccinations provided at a *participating pharmacy*.
2. It must be approved for general use by the Food and Drug Administration (FDA).
3. It must be for the direct care and treatment of your illness, injury or condition. Dietary supplements, health aids or drugs for cosmetic purposes are not included. However the following items are covered:
   a. Formulas prescribed by a *physician* for the treatment of phenylketonuria.
   b. Vaccinations provided at a *participating pharmacy* as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS, subject to all terms of this *plan* that apply to those benefits.
   c. Vitamins, supplements, and health aids as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS, subject to all terms of this *plan* that apply to those benefits.
4. It must be dispensed from a licensed retail *pharmacy*, through our home delivery program or through our specialty drug program.
5. **If it is an approved *compound medication*, be dispensed by a participating *pharmacy*.** 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 participating

pharmacy at www.anthem.com/ca.) **Some compound medications must be approved before you can get them (See PRESCRIPTION DRUG FORMULARY: PRIOR AUTHORIZATION). You will have to pay the full cost of the *compound medications* you get from a *pharmacy* that is not a *participating pharmacy*.**

6. **If it is a specified *specialty drug*, be obtained by using the specialty drug program.** See the section HOW TO USE YOUR PRESCRIPTION DRUG BENEFITS: WHEN YOU ORDER YOUR PRESCRIPTION THROUGH SPECIALTY DRUG PROGRAM for how to get your *drugs* by using the specialty drug program. **You will have to pay the full cost of any *specialty drugs* you get from a retail *pharmacy* that you should have obtained from the specialty drug 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 drug program for processing and will be processed according to specialty drug program rules.**

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

   a. The first one month supply of a specified *specialty drug* which is available through a participating retail *pharmacy*; or

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

   c. A *member* who is unable to pay for delivery of their medication (i.e., no credit card); or

   d. 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 drug program. If you believe that you should not be required to get your medication through the specialty drug program, for any of the reasons listed above, except for d., 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 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 drug 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 drug program. If you are out of a *specialty drug* which must be obtained through the specialty drug program, we will authorize an override of the specialty drug 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 co-payment shown SUMMARY OF BENEFITS: PRESCRIPTION DRUG BENEFITS: PRESCRIPTION DRUG CO-PAYMENTS for the 72-hour supply of your *drug*.

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

7. It must not be used while you are confined in a *hospital*, *skilled nursing facility,* rest home, sanitarium, convalescent hospital, or similar facility. Also, it must not be dispensed in or administered by a *hospital*, *skilled nursing facility,* rest home, sanitarium, convalescent hospital, or similar facility. Other *drugs* that may be prescribed by your *physician* while you are confined in a rest home, sanitarium, convalescent hospital or similar facility, may be purchased at a *pharmacy* by the member, or a friend, relative or care giver on your behalf, and are covered under this *prescription drug* benefit.

8. For a retail *pharmacy* or for drugs you get through the specialty pharmacy program, the *prescription* typically does not exceed a 30-day supply. However, a *physician* can prescribe an additional supply of your medication for you to receive at a retail *pharmacy* or specialty pharmacy. If you receive more than 30-day supply of medication, you will have to pay the applicable copay for each additional 30-day supply of medication you receive.

   Prescription drugs federally-classified as Schedule II which are FDA-approved for the treatment of attention deficit disorder must not exceed a 60-day supply. If the *physician* prescribes a 60-day supply for *drugs* classified as Schedule II for the treatment of attention deficit disorders, the *member* has to pay double the amount of co-payment for retail *pharmacies.* If the *drugs* are obtained through the home delivery program, the co-payment will remain the same as for any other *prescription drug.*

FDA-approved smoking cessation products and over-the-counter nicotine replacement products are limited as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS.

9. Certain *drugs* have specific quantity supply limits based on our analysis of prescription dispensing trends and the Food and Drug Administration dosing recommendations.

10. For the home delivery program, the *prescription* must not exceed a 90-day supply.

11. The *drug* will be covered under YOUR PRESCRIPTION DRUG BENEFITS only if it is not covered under another benefit of your *plan*.

12. *Drugs* for the treatment of impotence and/or sexual dysfunction are limited to six tablets/units for a 30-day period and are available at retail *pharmacies* only. Documented evidence of contributing medical condition must be submitted to us for review.

PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED

1. Outpatient *drugs* and medications which the law restricts to sale by *prescription*, except as specifically stated in this section. Formulas prescribed by a *physician* for the treatment of phenylketonuria. These formulas are subject to the copayment for *brand name drugs*.

2. Insulin.

3. Syringes when dispensed for use with insulin and other self-injectable *drugs* or medications.

4. *Drugs* with Food and Drug Administration (FDA) labeling for self-administration.

5. AIDS vaccine (when approved by the federal Food and Drug Administration and that is recommended by the US Public Health Service).

6. All compound *prescription drugs* when a commercially available dosage form of a *medically necessary* medication is not available, all the ingredients of the compound *drug* are FDA approved, a prescription to dispense is required, and the compound *drug* is not essentially the same as an FDA approved product from a *drug* manufacturer. Non-FDA approved non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.

7. Diabetic supplies (i.e. test strips and lancets).

8. Inhaler spacers and peak flow meters for the treatment of pediatric asthma. These items are subject to the copayment for *brand name drugs*.

9. *Prescription drugs*, vaccinations, vitamins, supplements, and certain over-the-counter items as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS, subject to all terms of this *plan* that apply to those benefits.

10. *Prescription drugs* for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.

PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED

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

1. Hypodermic syringes and/or needles except when dispensed for use with insulin and other self-injectable *drugs* or medications. While not covered under this *prescription drug* benefit, these items are covered under the "Home Health Care," "Hospice Care," "Infusion Therapy or Home Infusion Therapy," and "Diabetes" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

2. *Drugs* and medications 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 *physician*, such as *drugs* and medications used to induce non-spontaneous abortions, are covered as specifically stated in the "Prescription Drug for Abortion" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to the benefit.

3. *Drugs* and medications dispensed or administered in an outpatient setting; including, but not limited to, outpatient *hospital* facilities and *physicians'* offices. While not covered under this *prescription drug* benefit, these services are covered as specified under the "Hospital," "Home Health Care," "Hospice Care," and "Infusion Therapy or Home Infusion Therapy" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

4. Professional charges in connection with administering, injecting or dispensing of *drugs*. While not covered under this *prescription drug* benefit, these services are covered as specified under the "Professional Services" and "Infusion Therapy or Home Infusion Therapy" provisions (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

5. *Drugs* and medications which may be obtained without a *physician's* written *prescription*, except insulin or niacin for cholesterol reduction.

   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 *physician's prescription*, subject to all terms of this *plan* that apply to those benefits.

6. *Drugs* and medications 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, such *drugs* are covered as specified under the "Hospital", "Skilled Nursing Facility", and "Hospice Care", provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits. While you are confined in a rest home, sanitarium, convalescent hospital or similar facility, *drugs* and medications supplied and administered by your *physician* are covered as specified under the "Professional Services" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to the benefit. Other *drugs* that may be prescribed by your *physician* while you are confined in a rest home, sanitarium, convalescent hospital or similar facility, may be purchased at a *pharmacy* by the *member*, or a friend, relative or care giver on your behalf, and are covered under this *prescription drug* benefit.

7. Durable medical equipment, devices, appliances and supplies, even if prescribed by a *physician*, except *prescription* contraceptives as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS. While not covered under this *prescription drug* benefit, these items are covered as specified under the "Durable Medical Equipment", "Hearing Aid Services", and "Diabetes" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

8. Services or supplies for which you are not charged.

9. Oxygen. While not covered under this *prescription drug* benefit, oxygen is covered as specified under the “Hospital”, “Skilled Nursing Facility”, “Home Health Care” and “Hospice Care” provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

10. Cosmetics and health or beauty aids. However, health aids that are *medically necessary* and meet the requirements for durable medical equipment as specified under the “Durable Medical Equipment” provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), are covered, subject to all terms of this *plan* that apply to that benefit.

11. *Drugs* labeled "Caution, Limited by Federal Law to Investigational Use" or Non-FDA approved investigational *drugs*. Any *drugs* or medications 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” (see Table of Contents) for how to ask for a review of your *drug* denial.)

12. Any expense incurred for a *drug* or medication in excess of: *prescription drug maximum allowed amount*.

13. *Drugs* which have not been approved for general use by the Food and Drug Administration. This does not apply to *drugs* that are *medically necessary* for a covered condition.

14. *Drugs* used primarily for cosmetic purposes (e.g., Retin-A for wrinkles). However, 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.

15. *Drugs* used primarily for the purpose of treating *infertility* (including but not limited to Clomid, Pergonal, and Metrodin) unless *medically necessary* for another covered condition.

16. Anorexiants and *drugs* used for weight loss except when used to treat morbid obesity (e.g., diet pills and appetite suppressants).This exclusion does not apply to *drugs* used for weight loss which are listed as covered under the PreventiveRx program, if included.

17. *Drugs* obtained outside of the United States unless they are furnished in connection with *urgent care* or an *emergency*.

18. Allergy desensitization products or allergy serum. While not covered under this *prescription drug* benefit, such *drugs* are covered as specified under the "Hospital", "Skilled Nursing Facility", and "Professional Services" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

19. Infusion *drugs*, except *drugs* that are self-administered subcutaneously. While not covered under this *prescription drug* benefit, infusion *drugs* are covered as specified under the "Professional Services" and "Infusion Therapy or Home Infusion Therapy" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

20. Herbal supplements, nutritional and dietary supplements. However, formulas prescribed by a *physician* for the treatment of phenylketonuria that are obtained from a *pharmacy* are covered as specified under PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED. Special food products that are not available from a *pharmacy* are covered as specified under the "Special Food Products" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to the benefit. Also, 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 *physician's prescription*, subject to all terms of this *plan* that apply to those benefits.

21. *Prescription drugs* with a non-prescription (over-the-counter) chemical and dose equivalent except insulin. This does not apply if an over-the-counter equivalent was tried and was ineffective.

22. Onychomycosis (toenail fungus) *drugs* except to treat patients who are immuno-compromised or diabetic.

23. *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 *participating pharmacy*. **You will have to pay the full cost of the *compound medications* you get from a *non-participating pharmacy*.** If you are denied a *compound medication* because you obtained it from a *non-participating pharmacy*, you may file a grievance with us by following the procedures described in the section entitled GRIEVANCE PROCEDURES.

24. *Specialty drugs* that must be obtained from the specialty pharmacy program, but, which are obtained from a retail *pharmacy* or through the home delivery program. Unless you qualify for an exception, these *drugs* are not covered by this *plan* (please see YOUR PRESCRIPTION DRUG BENEFITS: PRESCRIPTION DRUG CONDITIONS OF SERVICE). **You will have to pay the full cost of the *specialty drugs* you get from a retail *pharmacy* 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.

COORDINATION OF BENEFITS

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

DEFINITIONS

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

Allowable Expense is any necessary, reasonable and customary item of expense which is at least partially covered by any plan covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid. An expense that is not covered by any plan covering the person for whom claim is made is not an Allowable Expense.

The following are not Allowable Expense:

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

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

reimbursement method, any amount in excess of the higher of the reasonable and customary amounts.

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

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

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

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

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage;

2. Group service plan contract, group practice, group individual practice and other group prepayment coverages;

3. Group coverage under labor-management trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.

4. Medicare. This does not include Medicare when, by law, its benefits are secondary to those of any private insurance program or other non-governmental program.

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

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

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

EFFECT ON BENEFITS

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

1. If This Plan is the Principal Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan.

2. If This Plan is not the Principal Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed Allowable Expense.

3. The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if you were covered under This Plan only.

ORDER OF BENEFITS DETERMINATION

The first of the following rules which applies will determine the order in which benefits are payable:

1. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision. This would include Medicare in all cases, except when the law requires that This Plan pays before Medicare.

2. A plan which covers you as a *subscriber* pays before a plan which covers you as a dependent. But, if you are retired and eligible for Medicare, Medicare pays (a) after the plan which covers you as a dependent of an active employee, but (b) before the plan which covers you as a retired *subscriber.*

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

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

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

a. If the parent with custody of that *child* for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that *child* as a dependent pays first.

b. If the parent with custody of that *child* for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:

   i. The plan which covers that *child* as a dependent of the parent with custody.

   ii. The plan which covers that *child* as a dependent of the stepparent (married to the parent with custody).

   iii. The plan which covers that *child* as a dependent of the parent without custody.

   iv. The plan which covers that *child* as a dependent of the stepparent (married to the parent without custody).

c. Regardless of a and b above, if there is a court decree which establishes a parent's financial responsibility for that *child's* health care coverage, a plan which covers that *child* as a dependent of that parent pays first.

4. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But if either plan does not have a provision regarding laid-off or retired employees, provision 6 applies.

5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan do not agree under these circumstances with the Order of Benefit Determination provisions of This Plan, this rule will not apply.

6. When the above rules do not establish the order of payment, the plan on which you have been enrolled the longest pays first unless two of the plans have the same effective date. In this case, Allowable Expense is split equally between the two plans.

OUR RIGHTS UNDER THIS PROVISION

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

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

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

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

BENEFITS FOR MEDICARE ELIGIBLE MEMBERS

If you are entitled to Medicare, you will receive the full benefits of this *plan*, except as listed below:

1. You are receiving treatment for end-stage renal disease following the first 30 months you are entitled to end-stage renal disease benefits under Medicare; or

2. You are entitled to Medicare benefits as a disabled person, unless you have a current employment status as determined by Medicare rules through a *group* of 100 or more employees (according to federal OBRA legislation).

In cases where exceptions 1 or 2 apply, our payment will be determined according to the provisions in the section entitled COORDINATION OF BENEFITS and the provision "Coordinating Benefits With Medicare", below.

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

pay additional premium for any part of Medicare, this exclusion will apply to that part of Medicare only if you are enrolled in that part.

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

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

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

UTILIZATION REVIEW PROGRAM

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

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

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

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

This *plan* includes the processes of pre-service, care coordination, and retrospective reviews to determine when services should be covered. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where

appropriate, the setting or place of service where care is provided. This *plan* requires that covered services be *medically necessary* for benefits to be provided.

Certain services require pre-service review of benefits in order for benefits to be provided. *Participating providers* will initiate the review on your behalf. A *non-participating provider* may or may not initiate the review for you. In both cases, it is your responsibility to initiate the process and ask your *physician* 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.

It is your responsibility to determine whether a particular service requires pre-service authorization. Please read the following information that follows to assist you in this determination and please feel free to visit www.anthem.com or call the toll-free number for pre-service printed on your identification card if you have any questions about making this determination.

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

UTILIZATION REVIEW REQUIREMENTS AND EFFECT ON BENEFITS

The stages of utilization review are pre-service review, care coordination review, and retrospective review.

Pre-service review determines in advance the medical necessity and appropriateness of certain procedures or admissions and the appropriate length of stay, if applicable. Pre-service review is required for the services listed below.

1. The appropriate utilization reviews must be performed in accordance with this *plan*. When pre-service review is not performed as required for the services listed below, the benefits to which you would have been otherwise entitled will be subject to the Co-payment when you are admitted to a *hospital* without properly obtaining certification shown in the SUMMARY OF BENEFITS.

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

Exceptions: Pre-service review is not required for inpatient *hospital stays* for the following services:

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

- Specific non-emergency outpatient services, including diagnostic treatment and other services.
- Specific outpatient surgeries performed in an outpatient facility or a doctor's office.

2. When pre-service review is performed and the admission, procedure or service is determined to be *medically necessary* and appropriate, benefits will be provided for the services listed below.

- Transplant services, including transplant travel expense. The following criteria must be met for certain transplants, as follows:
  - ♦ For bone, skin or cornea transplants, the *physicians* on the surgical team and the facility in which the transplant is to take place must be approved for the transplant requested.
  - ♦ For transplantation of heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney or bone marrow/stem cell and similar procedures, the providers of the related preoperative and postoperative services must be approved and the transplant must be performed at a *Centers of Medical Excellence (CME)* or a *Blue Distinction Centers for Specialty Care* (*BDCSC*) facility.
- Air ambulance in a non-medical *emergency*.
- Visits for physical therapy, physical medicine and occupational therapy beyond those described under the "Physical Therapy, Physical Medicine and Occupational Therapy" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED. A specified number of additional visits may be authorized after your initial visit. While there is no limit on the number of covered visits for *medically necessary* physical therapy, physical medicine, and occupational therapy, visits must be authorized in advance.
- Visits for *chiropractic services* beyond those described under the "Physical Therapy, Physical Medicine and Occupational Therapy" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED. A specified number of additional visits may be authorized. While there is no limit on the number of covered visits for *medically necessary chiropractic services*, additional

visits in excess of the stated number of visits must be authorized in advance.

- Specific durable medical equipment.
- Infusion therapy or home infusion therapy, if the attending physician has submitted both a prescription and a plan of treatment before services are rendered.
- Home health care. The following criteria must be met:
  - The services can be safely provided in your home, as certified by your attending *physician*;
  - Your attending *physician* manages and directs your medical care at home; and
  - Your attending *physician* has established a definitive treatment plan which must be consistent with your medical needs and lists the services to be provided by the *home health agency*.
- Admissions to a *skilled nursing facility*, if you require daily skilled nursing or rehabilitation, as certified by your attending *physician*.
- Bariatric surgical services, such as gastric bypass and other surgical procedures for weight loss, including bariatric travel expense, if:
  - The services are to be performed for the treatment of morbid obesity;
  - The *physicians* on the surgical team and the facility in which the surgical procedure is to take place are approved for the surgical procedure requested; and
  - The bariatric surgical procedure will be performed at a *BDCSC* facility.
- Select imaging procedures, including but not limited to: Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scan), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and Nuclear Cardiac Imaging. You may call the toll-free customer service telephone number on your identification card to find out if an imaging procedure requires pre-service review.

- Behavioral health treatment for pervasive developmental disorder or autism, as specified in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.

- Transgender services, including transgender travel expense, as specified under the "Transgender Services" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED. You must be diagnosed with gender identity disorder or gender dysphoria by a *physician*.

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

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

Retrospective review for medical necessity is 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.

HOW TO OBTAIN UTILIZATION REVIEWS

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

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

1. For all scheduled services that are subject to utilization review, you or your *physician* must initiate the pre-service review at least five working days prior to when you are scheduled to receive services.

2. You must tell your *physician* that this *plan* requires pre-service review. *Physicians* who are *participating providers* will initiate the review on your behalf. A *non-participating provider* may initiate the

review for you, or you may call us directly. The toll-free number for pre-service review is printed on your identification card.

3. If you do not receive the reviewed service within 60 days of the certification, or if the nature of the service changes, a new pre-service review must be obtained.

4. We will determine if services are *medically necessary* and appropriate. For inpatient *hospital* and *residential treatment center* stays, we will, if appropriate, specify a specific length of *stay* for services. You, your *physician* and the provider of the service will receive a written confirmation showing this information.

Care Coordination Reviews

1. If pre-service review was not performed, you, your *physician* or the provider of the service must contact us for care coordination review. For an *emergency* admission or procedure, we must be notified within one working day of the admission or procedure, unless extraordinary circumstances* prevent such notification within that time period.

2. When *participating providers* have been informed of your need for utilization review, they will initiate the review on your behalf. You may ask a *non-participating provider* to call the toll free number printed on your identification card or you may call directly.

3. When we determine that the service is *medically necessary* and appropriate, we will, depending upon the type of treatment or procedure, specify the period of time for which the service is medically appropriate. We will also determine the medically appropriate setting.

4. If we determine that the service is not *medically necessary* and appropriate, your *physician* will be notified by telephone no later than 24 hours following our decision. We will send written notice to you and your *physician* within two business days following our decision. However, care will not be discontinued until your *physician* has been notified and a plan of care that is appropriate for your needs has been agreed upon.

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

Retrospective Reviews

- If a pre-service review or a care coordination review was not performed, a retrospective review will be done to review services that have already been provided to determine if they are *medically necessary*.
- Retrospective review is performed when we are not notified of the service you received, and are therefore unable to perform the appropriate review. It is also performed when pre-service or care coordination review has been done, but services continue longer than originally certified.

  It may also be performed for the evaluation and audit of medical documentation after services have been provided, whether or not pre-service or care coordination review was performed.
- Such services which have been retroactively determined to not be *medically necessary* and appropriate will be retrospectively denied certification.

DECISION AND NOTICE REQUIREMENTS

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

Request Category	**Timeframe Requirement for Decision**
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 our decision, we will follow state and federal law and tell the requesting *physician* and send written notice to you or your authorized representative of the specific information needed to finish the review. If we do not get the specific information we need or if the information is not complete by the timeframe identified in the written notice, we will make a decision based upon the information we have.

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

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

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

- The information submitted with the claim differs from that given by phone;
- The service is excluded from coverage;
- You must not have exceeded any applicable limits under this *plan*; or
- You are not eligible for coverage when the service is actually provided.

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

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

For a copy of the medical necessity review process, please contact customer service at the telephone number on the back of your identification card.

HEALTH PLAN INDIVIDUAL CASE MANAGEMENT

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

HOW HEALTH PLAN INDIVIDUAL CASE MANAGEMENT WORKS

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

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

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

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

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

EXCEPTIONS TO THE UTILIZATION REVIEW PROGRAM

From time to time, we may waive, enhance, modify, or discontinue certain medical management processes (including utilization management, case management, and disease management) 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.anthem.com/ca** or by calling us at the customer service telephone number listed on your ID card.

QUALITY ASSURANCE

Utilization review programs are monitored, evaluated, and improved on an ongoing basis to ensure consistency of application of screening criteria and medical policy, consistency and reliability of decisions by reviewers, and compliance with policy and procedure including but not

limited to timeframes for decision making, notification and written confirmation. Our Board of Directors is responsible for medical necessity review processes through its oversight committees including the Strategic Planning Committee, Quality Management Committee, and Physician Relations Committee. Oversight includes approval of policies and procedures, review and approval of self-audit tools, procedures, and results. Monthly process audits measure the performance of reviewers and Peer Clinical Reviewers against approved written policies, procedures, and timeframes. Quarterly reports of audit results and, when needed, corrective action plans are reviewed and approved through the committee structure.

HOW COVERAGE BEGINS AND ENDS

HOW COVERAGE BEGINS

ELIGIBLE STATUS

1. **Subscribers.** Permanent *full-time employees* are eligible to enroll as *subscribers*. A *full-time employee* is one who works at least 20 hours a week in the conduct of the business of the *group*.

2. **Family Members.** The following are eligible to enroll as *family members*: (a) Either the *subscriber's spouse* or *domestic partner;* and (b) A *child*.

Definition of Family Member

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

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

3. **Child** is the *subscriber's*, *spouse's* or *domestic partner's* natural child, stepchild, legally adopted child, or a child for whom the *subscriber*, *spouse*, or *domestic partner* has been appointed legal guardian by a court of law, subject to the following:

    a. The child is under 26 years of age.

    b. The unmarried child is 26 years of age or older and: (i) was covered under the *prior plan*, was covered as a *family member* of the *subscriber* under another plan or health insurer, or has six or more months of other *creditable coverage*, (ii) is chiefly

dependent on the *subscriber, spouse or domestic partner* for support and maintenance, and (iii) is incapable of self-sustaining employment due to a physical or mental condition. A *physician* must certify in writing that the child is incapable of self-sustaining employment due to a physical or mental condition. We must receive the certification, at no expense to us, within 60-days of the date the *subscriber* receives our request. We may request proof of continuing dependency and that a physical or mental condition still exists, but not more often than once each year after the initial certification. This exception will last until the child is no longer chiefly dependent on the *subscriber, spouse* or *domestic partner* for support and maintenance due to a continuing physical or mental condition. A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

c. A child who is in the process of being adopted is considered a legally adopted child if we receive legal evidence of both: (i) the intent to adopt; and (ii) that the *subscriber*, *spouse* or *domestic partner* have either: (a) the right to control the health care of the child; or (b) assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption.

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

d. A child for whom the *subscriber, spouse* or *domestic partner* is a legal guardian is considered eligible on the date of the court decree (the "eligibility date"). We must receive legal evidence of the decree.

ELIGIBILITY DATE

1. **For Subscribers:** You become eligible for coverage 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.

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

If, after you become covered under this *plan*, you cease to be eligible due to termination of employment, and you return to an eligible status within six months after the date your employment terminated, you will become eligible to re-enroll for coverage on the first day of the month following the date you return.

ENROLLMENT

To enroll as a *subscriber,* or to enroll *family members,* the *subscriber* must properly file an application. An application is considered properly filed, only if it is personally signed, dated, and given to the *group* within 60 days from your eligibility date.

EFFECTIVE DATE

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

1. **Timely Enrollment:** If you enroll for coverage before, on, or within 60 days after your eligibility date, then your coverage will begin as follows: (a) for *subscribers,* on your eligibility date; and (b) for *family members,* on the later of (i) the date the *subscriber's* coverage begins, or (ii) the first day of the month after the *family member* becomes eligible. If you become eligible before the *agreement* takes effect, coverage begins on the effective date of the *agreement,* provided the enrollment application is on time and in order.

2. **Late Enrollment.** If you fail to enroll within 60 days after your eligibility date, you must wait until the *group's* next Open Enrollment Period to enroll.

3. **Disenrollment:** If you voluntarily choose to disenroll from coverage under this *plan*, you will be eligible to reapply for coverage as set forth in the "Enrollment" provision above, during the *group's* next Open Enrollment period (see OPEN ENROLLMENT PERIOD).

For late enrollees and disenrollees: You may enroll earlier than the *group's* next Open Enrollment Period if you meet any of the conditions listed under SPECIAL ENROLLMENT PERIODS.

Important Note for Newborn and Newly-Adopted Children. If the *subscriber* (or *spouse* or *domestic partner,* if the *spouse* or *domestic partner* is enrolled) is already covered:(1) any *child* born to the *subscriber, spouse* or *domestic partner* will be enrolled from the moment of birth; and (2) any *child* being adopted by the *subscriber, spouse* or *domestic partner* will be enrolled from the date on which either: (a) the adoptive *child's* birth parent, or other appropriate legal authority, signs a written document granting the *subscriber, spouse* or *domestic partner*

the right to control the health care of the *child* (in the absence of a written document, other evidence of the *subscriber's, spouse's* or *domestic partner's* right to control the health care of the *child* may be used)*;* or (b) the *subscriber, spouse* or *domestic partner* assumed a legal obligation for full or partial financial responsibility for the *child* in anticipation of the *child's* adoption. The written document referred to above includes, but is not limited to, a health facility minor release report, a medical authorization form, or relinquishment form.

In both cases, coverage will be in effect for 31 days. For coverage to continue beyond this 31-day period, the *subscriber* must enroll the *child* within the 60-day period by submitting a membership change form to the *group*.

Special Enrollment Periods

You may enroll without waiting for the *group's* next open enrollment period if you are otherwise eligible under any one of the circumstances set forth below:

1. You have met all of the following requirements:

    a. You were covered as an individual or dependent under either:

        i. Another employer group health plan or health insurance coverage, including coverage under a COBRA or CalCOBRA continuation; or

        ii. A state Medicaid plan or under a state child health insurance program (SCHIP), including the Healthy Families Program or the Access for Infants and Mothers (AIM) Program.

    b. You certified in writing at the time you became eligible for coverage under this *plan* that you were declining coverage under this *plan* or disenrolling because you were covered under another health plan as stated above and you were given written notice that if you choose to enroll later, you may be required to wait until the *group's* next open enrollment period to do so.

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

i. If the other health plan was another employer group health plan or health insurance coverage, including coverage under a COBRA or CalCOBRA continuation, coverage ended because you lost eligibility under the other plan, your coverage under a COBRA or CalCOBRA continuation was exhausted, or employer contributions toward coverage under the other plan terminated. You must properly file an application with the *group* within 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, and any loss of eligibility for coverage after a period of time that is measured by reference to any of the foregoing.

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

2. A court has ordered coverage be provided for a *spouse, domestic partner* or dependent *child* under your employee health plan and an application is filed within 60 days from the date the court order is issued.

3. We do not have a written statement from the *group* stating that prior to declining coverage or disenrolling, you received and signed acknowledgment of a written notice specifying that if you do not enroll for coverage within 60 days after your eligibility date, or if you disenroll, and later file an enrollment application, your coverage may not begin until the first day of the month following the end of the *group's* next open enrollment period.

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

   a. If you are enrolling following marriage or domestic partnership, you and your new *spouse* or *domestic partner* must enroll within 60 days of the date of marriage or domestic partnership. Your

new *spouse* or *domestic partner's* children may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above.

b. If you are enrolling following the birth, adoption, or placement for adoption of a *child*, your *spouse* (if you are already married) or *domestic partner*, who is eligible but not enrolled, may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above. Application must be made within 60 days of the birth or date of adoption or placement for adoption.

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

6. You become eligible for assistance, with respect to the cost of coverage under the employer's group *plan*, under a state Medicaid or SCHIP health plan, including any waiver or demonstration project conducted under or in relation to these plans. You must properly file an application with the *group* within 60 days after the date you are determined to be eligible for this assistance.

7. 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.

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

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

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

3. 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.

OPEN ENROLLMENT PERIOD

The *group* has an open enrollment period once each *year*. During that time, an individual who meets the eligibility requirements as a *subscriber* under this *plan* may enroll. A *subscriber* may also enroll any eligible *family members* at that time. Persons eligible to enroll as *family members* may enroll only under the *subscriber's plan*.

For anyone so enrolling, coverage under this *plan* will begin on January 1 following the end of the Open Enrollment Period. Coverage under the former plan ends when coverage under this *plan* begins.

HOW COVERAGE ENDS

Your coverage ends without notice from us as provided below:

1. If the *agreement* terminates, your coverage ends at the same time. This *agreement* may be canceled or changed without notice to you.

2. If the *group* no longer provides coverage for the class of *members* to which you belong, your coverage ends on the effective date of that change. If this *agreement* is amended to delete coverage for *family members,* a *family member*'s coverage ends on the effective date of that change.

3. Coverage for *family members* ends when *subscriber's* coverage ends.

4. Coverage ends at the end of the period for which subscription charges have been paid to us on your behalf when the required subscription charges for the next period are not paid.

5. If you voluntarily cancel coverage at any time, coverage ends on the subscription charge due date coinciding with or following the date of voluntary cancellation, as provided by written notice to us.

6. If you no longer meet the requirements set forth in the "Eligible Status" provision of HOW COVERAGE BEGINS, your coverage ends as of the subscription charge due date coinciding with or following the date you cease to meet such requirements.

   Exceptions to Item 6:

a. **Leave of Absence.** If you are a *subscriber* and the *group* pays subscription charges to us on your behalf, your coverage may continue during a temporary leave of absence approved by the *group*.

b. **Handicapped Children:** If a *child* reaches the age limit shown in the "Eligible Status" provision of this section, the *child* will continue to qualify as a *family member* if he or she is (i) covered under this *plan,* (ii) chiefly dependent on the *subscriber*, *spouse* or *domestic partner* for support and maintenance, and (iii) incapable of self-sustaining employment due to a physical or mental condition. A *physician* must certify in writing that the *child* has a physical or mental condition that makes the *child* incapable of obtaining self-sustaining employment. We will notify the *subscriber* that the *child's* coverage will end when the *child* reaches the *plan's* upper age limit at least 90-days prior to the date the *child* reaches that age. The *subscriber* must send proof of the *child's* physical or mental condition within 60-days of the date the *subscriber* receives our request. If we do not complete our determination of the *child's* continuing eligibility by the date the *child* reaches the *plan's* upper age limit, the *child* will remain covered pending our determination. When a period of two years has passed, we may request proof of continuing dependency due to a continuing physical or mental condition, but not more often than once each year. This exception will last until the *child* is no longer chiefly dependent on the *subscriber*, *spouse* or *domestic partner* for support and maintenance or a physical or mental condition no longer exists. A *child* is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

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

You may be entitled to continued benefits under terms which are specified elsewhere under CONTINUATION OF COVERAGE, CALCOBRA CONTINUATION OF COVERAGE, and EXTENSION OF BENEFITS.

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

CONTINUATION OF COVERAGE

Most employers who employ 20 or more people on a typical business day are subject to The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If the employer who provides coverage under the *agreement* is subject to the federal law which governs this provision (Title X of P. L. 99-272), you may be entitled to continuation of coverage. Check with your employer for details.

DEFINITIONS

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

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

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

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

1. **For Subscribers and Family Members:**

   a. The *subscriber's* termination of employment, for any reason other than gross misconduct; or

   b. Loss of coverage under an employer's health plan due to a reduction in the *subscriber's* work hours.

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

   a. The *agreement* expressly includes coverage for retirees; and

   b. Such cancellation or reduction of benefits occurs within one year before or after the *group's* filing for bankruptcy.

3. **For Family Members:**

   a. The death of the *subscriber;*

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

   c. The end of a *domestic partner's* partnership with the *subscriber;*

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

   e. The *subscriber's* entitlement to Medicare.

ELIGIBILITY FOR COBRA CONTINUATION

A *subscriber* or *family member* may choose to continue coverage under the *agreement* if your coverage would otherwise end due to a Qualifying Event.

TERMS OF COBRA CONTINUATION

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

1. For Qualifying Events 1, or 2, the *group* or its administrator will notify the *subscriber* of the right to continue coverage.

2. For Qualifying Events 3(a) or 3(d) above, a *family member* will be notified of the COBRA continuation right.

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

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

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

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

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

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

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

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

2. A *domestic partner* whose COBRA continuation began due to the end of the domestic partnership or death of the *subscriber;*

3. A *child* if neither the *subscriber* nor the *spouse* has enrolled for this COBRA continuation coverage (if more than one *child* is so enrolled, the subscription charge will be the two-party or three-party rate depending on the number of *children* enrolled); and

4. A *child* whose COBRA continuation began due to the person no longer meeting the dependent *child* definition.

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

For example, a *child* may have been originally eligible for this COBRA continuation due to termination of the *subscriber's* employment, and enrolled for this COBRA continuation as a Qualified Beneficiary. If, during the COBRA continuation period, the *child* reaches the upper age limit of the *plan,* the *child* is eligible for an extended continuation period which would end no later than 36 months from the date of the original Qualifying Event (the termination of employment).

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

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

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

1. The end of 18 months from the Qualifying Event, if the Qualifying Event was termination of employment or reduction in work hours;*

2. The end of 36 months from the Qualifying Event, if the Qualifying Event was the death of the *subscriber,* divorce or legal separation, or the end of dependent *child* status;*

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

4. The date the *agreement* terminates;

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

6. The date, following the election of COBRA, the *member* first becomes covered under any other group health plan; or

7. The date, following the election of COBRA, the *member* first becomes entitled to Medicare. However, entitlement to Medicare will

not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

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

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

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 the SPECIAL ENROLLMENT PERIODS provision. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

EXTENSION OF CONTINUATION DURING TOTAL DISABILITY

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

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

1. Satisfy the legal requirements for being totally and permanently disabled under the Social Security Act; and

2. Be determined and certified to be so disabled by the Social Security Administration.

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

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

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

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

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

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

1. The end of the month following a period of 30 days after the Social Security Administration's final determination that you are no longer totally disabled;

2. The end of 29 months from the Qualifying Event*;

3. The date the *agreement* terminates;

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

5. The date, following the election of COBRA, the *member* first becomes covered under any other group health plan; or

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

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

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

CALCOBRA CONTINUATION OF COVERAGE

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

1. 18 months after the qualifying event, if the qualifying event was termination of employment or reduction in work hours; or

2. 29 months after the qualifying event, if you qualified for the extension of COBRA continuation during total disability.

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

TERMS OF CALCOBRA CONTINUATION

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

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in higher cost or you could be denied coverage entirely.

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

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

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

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

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

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

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

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

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

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

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

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

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

1. The date that is 36 months after the date of your qualifying event under federal COBRA*;

2. The date the *agreement* terminates;

3. The date the *group* no longer provides coverage to the class of *members* to which you belong;

4. The end of the period for which subscription charges are last paid (your coverage will be cancelled upon written notification, as explained under "Payment Dates", above);

5. The date you become covered under any other health plan;

6. The date you become entitled to Medicare; or

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

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

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

EXTENSION OF BENEFITS

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

1. If you are confined as an inpatient in a *hospital* or *skilled nursing facility*, you are considered totally disabled as long as the inpatient *stay* is *medically necessary*, and no written certification of the total disability is required. If you are discharged from the *hospital* or *skilled nursing facility*, you may continue your total disability benefits by submitting written certification by your *physician* of the total disability within 90 days of the date of your discharge. Thereafter, we must receive proof of your continuing total disability at least once every 90 days while benefits are extended.

2. If you are not confined as an inpatient but wish to apply for total disability benefits, you must do so by submitting written certification by your *physician* of the total disability. We must receive this certification within 90 days of the date coverage ends under this *plan*. At least once every 90 days while benefits are extended, we must receive proof that your total disability is continuing.

3. Your extension of benefits will end when any one of the following circumstances occurs:

   a. You are no longer totally disabled.

   b. The maximum benefits available to you under this *plan* are paid.

   c. You become covered under another group health plan that provides benefits without limitation for your disabling condition.

   d. A period of up to 12 months has passed since your extension began.

GENERAL PROVISIONS

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

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

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

Inter-Plan Programs.

- **Out of Area Services.** We have a variety of relationships with other Blue Cross and/or Blue Shield 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, which include the BlueCard® Program and may include negotiated National Account arrangements available between us and other Blue Cross and Blue Shield Licensees.

  Typically, when accessing care outside our service area, you may 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.

- **BlueCard® Program.** Under the BlueCard® Program, when you access 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.

Whenever you access covered healthcare services outside our service area and the claim is processed through the BlueCard® Program, the amount you pay for covered healthcare services 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 consist of a simple discount which reflects the actual price paid by the Host Blue to your healthcare provider. But 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 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 law or the law in a small number of states may require the Host Blue to add a surcharge to the calculation. If any federal law or any state law mandates other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

- **Non-Participating Health Care Providers Outside Our Service Area.**

  Member Liability Calculation. When covered health care services are provided outside of California by non-participating health care providers, the amount you pay for such services will generally be based on either the Host Blue's non-participating health care 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 health care 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 health care services had been obtained within California, 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 health care providers. In these situations, you may be liable for the difference between the amount that the non-participating health care 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.

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

Terms of Coverage

1. In order for you to be entitled to benefits under the *agreement,* both the *agreement* and your coverage under the *agreement* must be in effect on the date the expense giving rise to a claim for benefits is incurred.

2. The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date you receive the service or supply for which the charge is made.

3. The *agreement* is subject to amendment, modification or termination according to the provisions of the *agreement* without your consent or concurrence.

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

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

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

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

Other forms of payment arrangement are Payment Innovation Programs. These programs may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner. The 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 a *participating provider's* total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, *participating 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 the *member's* access to health care. The program payments are not made as payment for specific covered services provided to the *member*, but instead, are based on the *participating provider's* achievement of these pre-defined standards. The *member* is not responsible for any co-payment amounts related to payments made by us or to us under the programs and the member does not share in any payments made by *participating providers* to us under the programs.

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

Medical Necessity. The benefits of this *plan* are provided only for services which we determine to be *medically necessary*. The services must be ordered by the attending *physician* for the direct care and treatment of a covered condition. They must be standard medical practice where received for the condition being treated and must be legal

in the United States. The process used to authorize or deny health care services under this *plan* is available to you upon request.

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

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

Notice of Claim. You or the provider of service must send properly and fully completed claim forms to us within 90 days of the date you receive the service or supply for which a claim is made. Services received and charges for the services must be itemized, and clearly and accurately described. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed. We are not liable for the benefits of the *agreement* if you do not file claims within the required time period. Claim forms must be used; canceled checks or receipts are not acceptable.

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

Payment to Providers. We will pay the benefits of this *plan* directly to *contracting hospitals*, *participating providers* and medical transportation providers. If you or one of your *family members* receives services from *non-contracting hospitals* or *non-participating providers,* payment may be made directly to the *subscriber* and you will be responsible for payment to the provider. Any assignment of benefits, even if assignment includes the providers right to receive payment, is void. We will pay *non-contracting hospitals* and other providers of service directly when *emergency services* and care are provided to you or one of your *family members.* We will continue such direct payment until the emergency care results in stabilization. If you are a MediCal beneficiary and you assign benefits in writing to the State Department of Health Services, we will pay the benefits of this *plan* to the State Department of Health Services. These payments will fulfill our obligation to you for those covered services.

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

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

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

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

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

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

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

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

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

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

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.

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

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

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

Medical Policy and Technology Assessment. Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria is used to determine the investigational status or medical necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 physicians from various medical specialties including Anthem's medical directors,

physicians in academic medicine and physicians in private practice. Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to *medical necessity* criteria used to determine whether a procedure, service, supply or equipment is covered.

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

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

2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Anthem in consultation with you and the *non-participating provider* and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time you enroll with Anthem.

3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.

5. The care of a newborn *child* between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the time the *child* enrolls with Anthem.

6. Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the time you enroll with Anthem.

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

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

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

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

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

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

2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full

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

3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.

5. The care of a newborn *child* between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.

6. Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the date the provider's contract terminates.

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

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

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

grievance with us by following the procedures described in the section entitled GRIEVANCE PROCEDURES.

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 *physician*) 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.

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.

BINDING ARBITRATION

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

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

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

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

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

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

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

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

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

DEFINITIONS

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

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

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

Ambulatory surgical center is a freestanding outpatient surgical facility. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing

surgical services. It must also meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations or the Accreditation Association of Ambulatory Health Care.

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

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

- there is no *participating provider* who practices in the appropriate specialty, or there is no *contracting hospital* which provides the required services or has the necessary facilities;
- that meets the adequacy and accessibility requirements of state or federal law; and
- you are referred to *hospital* or *physician* that does not have an agreement with Anthem for a covered service by a *participating provider*.

Benefits for *medically necessary* and appropriate *authorized referral* services received from a *non-participating provider* will be payable as shown in the Exceptions under the SUMMARY OF BENEFITS: CO-PAYMENTS.

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

Such authorized referrals are not available to bariatric surgical services. These services are only covered when performed at a designated bariatric *BDCSC*.

Bariatric BDCSC Coverage Area is the area within the 50-mile radius surrounding a designated bariatric *BDCSC*.

Blue Distinction Centers for Specialty Care (BDCSC) are health care providers designated by us as a selected facility for specified medical services. A provider participating in a BDCSC network has an agreement in effect with us at the time services are rendered or is available through our affiliate companies or our relationship with the Blue Cross and Blue Shield Association. BDCSC agree to accept the *maximum allowed amount* as payment in full for covered services.

Benefits for services performed at a designated *BDCSC* will be the same as for *participating providers*. A *participating provider* in the Prudent

Buyer Plan network or the Blue Cross and/or Blue Shield Plan is not necessarily a *BDCSC* facility.

Brand name prescription drug (brand name drug) is a *prescription drug* that has been patented and is only produced by one manufacturer.

Centers of Medical Excellence (CME) are health care providers designated by us as a selected facility for specified medical services. A provider participating in a CME network has an agreement in effect with us at the time services are rendered or is available through our affiliate companies or our relationship with the Blue Cross and Blue Shield Association. CME agree to accept the *maximum allowed amount* as payment in full for covered services.

Benefits for services performed at a designated *CME* will be the same as for *participating providers*. A *participating provider* in the Prudent Buyer Plan network or the Blue Cross and/or Blue Shield Plan is not necessarily a *CME* facility.

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

Chiropractic services means medically necessary care by means of adjustment of the spine (to correct a subluxation) performed by a legally licensed chiropractor pursuant to the terms of their license. (Subluxation is a term used in the chiropractic field to describe what happens when one of the vertebrae in your spine moves out of position.)

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.

Contracting hospital is a *hospital* which has a Standard Hospital Contract in effect with us to provide care to *members*. A contracting hospital is not necessarily a *participating provider*. A list of contracting hospitals will be sent on request.

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, 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, or 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, credit, coverage for on-site medical clinics, disability income, coverage only for a specified disease

or condition, hospital indemnity or other fixed indemnity insurance, Medicare supplement, long-term care insurance, dental, vision, workers' compensation insurance, automobile insurance, no-fault insurance, or any medical coverage designed to supplement other private or governmental plans. Creditable coverage is used to set up eligibility 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 provided primarily to meet your personal needs. This includes help in walking, bathing or dressing. It also includes: preparing food or special diets; feeding by utensil, tube or gastrostomy; suctioning and administration of medicine which is usually self-administered or any other care which does not require continuing services of medical personnel.

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

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

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

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

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

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

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

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

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

Formulary drug is a *drug* listed on the *prescription drug formulary*.

Full-time employee meets the *plan's* eligibility requirements for full-time employees as outlined under HOW COVERAGE BEGINS AND ENDS.

Generic prescription drug (generic drug) is a pharmaceutical equivalent of one or more *brand name drugs* and must be approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength, and effectiveness 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.

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

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

Hospice is an agency or organization providing a specialized form of interdisciplinary health care that provides palliative care (pain control and symptom relief) and alleviates the physical, emotional, social, and spiritual discomforts of a terminally ill person, as well as providing supportive care to the primary caregiver and the patient's family. A

hospice must be: currently licensed as a hospice pursuant to Health and Safety Code section 1747 or a licensed *home health agency* with federal Medicare certification pursuant to Health and Safety Code sections 1726 and 1747.1. A list of hospices meeting these criteria is available upon request.

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

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

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

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

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

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease;
3. Provided for the diagnosis or direct care and treatment of the medical condition;
4. Within standards of good medical practice within the organized medical community;
5. Not primarily for your convenience, or for the convenience of your *physician* or another provider;

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

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

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

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

Member is the *subscriber* or *family member*. A member may enroll under only one health plan provided by Anthem, or any of its affiliates, which is sponsored by the *group*.

Multi-source brand name drugs are drugs with at least one generic substitute.

Mental or nervous disorders, including substance abuse, for the purposes of this *plan*, 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").

Non-contracting hospital is a *hospital* which does not have a Standard Hospital Contract in effect with us at the time services are rendered.

Non-participating pharmacy is a *pharmacy* which does not have a contract in effect with the *pharmacy benefits manager* at the time services are rendered. In most cases, you will be responsible for a larger portion of your pharmaceutical bill when you go to a non-participating pharmacy.

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

- A *hospital*
- A *physician*

- An *ambulatory surgical center*
- A *home health agency*
- A facility which provides diagnostic imaging services
- A durable medical equipment outlet
- A *skilled nursing facility*
- A clinical laboratory
- A *home infusion therapy provider*
- An *urgent care center*
- A *retail health clinic*
- A *hospice*
- A licensed ambulance company
- A licensed qualified autism service provider

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

Other health care provider is one of the following providers:

- A certified registered nurse anesthetist
- A blood bank

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

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

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

- A *hospital*
- A *physician*
- An *ambulatory surgical center*
- A *home health agency*
- A facility which provides diagnostic imaging services
- A durable medical equipment outlet
- A *skilled nursing facility*

- A clinical laboratory
- A *home infusion therapy provider*
- An *urgent care center*
- *Centers for Medical Excellence (CME)*
- *Blue Distinction Centers for Specialty Care (BDCSC)*
- A *retail health clinic*
- A *hospice*
- A licensed ambulance company
- A licensed qualified autism service provider

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

Pharmacy means a licensed retail pharmacy.

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.

Physician means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or

2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license and such license is required to render that service, and is providing a service for which benefits are specified in this booklet:

    - A dentist (D.D.S. or D.M.D.)
    - An optometrist (O.D.)
    - A dispensing optician
    - A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)

- A licensed clinical psychologist
- A licensed educational psychologist for the provision of behavioral health treatment services for the treatment of pervasive developmental disorder or autism only
- A chiropractor (D.C.)
- An acupuncturist (A.C.)
- A licensed clinical social worker (L.C.S.W.)
- A marriage and family therapist (M.F.T.)
- A licensed professional clinical counselor (L.P.C.C.)*
- A physical therapist (P.T. or R.P.T.)*
- A speech pathologist*
- An audiologist*
- An occupational therapist (O.T.R.)*
- A respiratory care practitioner (R.C.P.)*
- A nurse midwife**
- A nurse practitioner
- A physician assistant
- A *psychiatric mental health nurse* (R.N.)*
- 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.
- A registered dietitian (R.D.)* or another nutritional professional* with a master's or higher degree in a field covering clinical nutrition sciences, from a college or university accredited by a regional accreditation agency, who is deemed qualified to provide these services by the referring M.D. or D.O. A registered dietitian or other nutritional professional as described here are covered for the provision of diabetic medical nutrition therapy and nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa only.

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

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

Plan is the set of benefits described in this booklet and in the amendments to this booklet, if any. This plan is subject to the terms and conditions of the *agreement* we have issued to the *group*. If changes are made to the plan, an amendment or revised booklet will be issued to the

group for distribution to each *subscriber* affected by the change. (The word "plan" here does not mean the same as "plan" as used in ERISA.)

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

Prescription drug 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 PRESCRIPTION DRUG FORMULARY: PRIOR AUTHORIZATION 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.

Prescription drug covered expense is the expense you incur for a covered *prescription drug*, but not more than the *prescription drug maximum allowed amount*. Expense is incurred on the date you receive the service or supply.

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 determine the prescription drug maximum allowed amount of a particular drug by calling 1-800-700-2541 (or TTY/TDD 1-800-905-9821).

Prescription drug formulary (formulary) is a list which we have developed of outpatient *prescription drugs* which may be cost-effective, therapeutic choices. Any *participating pharmacy* can assist you in purchasing *drugs* listed on the formulary. You may also get information about covered formulary drugs by calling 1-800-700-2541 or going to our internet website anthem.com/ca.

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. Sources for determining which services are recommended include the following:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF);
2. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. 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
4. 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

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

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

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

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

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

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

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

Residential treatment center is an inpatient treatment facility where the patient resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation as the result of a *mental or nervous disorder* or substance abuse. The facility must be licensed to provide psychiatric treatment of

mental or nervous disorders or rehabilitative treatment of substance abuse according to state and local laws.

Retail Health Clinic - A facility that provides limited basic medical care services to *members* on a "walk-in" basis. These clinics normally operate in major pharmacies or retail stores.

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

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

1. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community and is at risk of being removed from the home or has already been removed from the home or the mental disorder has been present for more than six months or is likely to continue for more than one year without treatment.

2. The child is psychotic, suicidal, or potentially violent.

3. The child meets special education eligibility requirements under California law (Government Code Section 7570).

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

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

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

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.

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

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

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

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

Totally disabled subscriber is a *subscriber* who, because of illness or injury, is unable to work for income in any job for which he/she is qualified or for which he/she becomes qualified by training or experience, and who is in fact unemployed.

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

Urgent care center is a physician's office or a similar facility which meets established ambulatory care criteria and provides medical care outside of a hospital emergency department, usually on an unscheduled, walk-in basis. Urgent care centers are staffed by medical doctors, nurse practitioners and physician assistants primarily for the purpose of treating patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room.

To find an urgent care center, please call us at the customer service number listed on your ID card or you can also search online using the "Provider Finder" function on our website at **www.anthem.com/ca**. Please call the *urgent care center* directly for hours of operation and to verify that the center can help with the specific care that is needed.

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

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

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

GRIEVANCE PROCEDURES

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

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

All grievances received by us will be acknowledged in writing, together with a description of how we propose to resolve the grievance. Except for grievances that concern the *prescription drug formulary*, we will review and respond to your grievance within the following timeframes:

- After we have received your grievance, we will send you a written statement on its resolution within 30 days.
- If your case is urgent and involves an imminent threat to your health, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, review of your grievance will be expedited and resolved within three days.

You have the right to review all documents that are part of your grievance file and to present evidence and testimony as part of the grievance process.

If you are dissatisfied with the resolution of your grievance, or if your grievance has not been resolved after at least 30 days (or within three days for urgent cases), you may submit your grievance to the California Department of Managed Health Care for review prior to binding

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

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

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

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

Prescription Drug List Exceptions. Please refer to the "Exception Request for a Drug not on the Prescription Drug Formulary" section in HOW TO USE YOUR PRESCRIPTION DRUG BENEFITS 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 determine that the treatment is *experimental* or *investigative*, you may ask that the

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

- You have a life-threatening or seriously debilitating condition, described as follows:
    - A life-threatening condition is a condition or disease where the likelihood of death is high unless the course of the disease is interrupted or a condition or disease with a potentially fatal outcome where the end point of clinical intervention is the patient's survival.
    - A seriously debilitating condition is a disease or condition that causes major, irreversible morbidity.
- Your *physician* must certify that either (a) standard treatment has not been effective in improving your condition, (b) standard treatment is not medically appropriate, or (c) there is no more beneficial standard treatment covered by this *plan* than the proposed treatment.
- The proposed treatment must either be:
    - Recommended by a *participating provider* who certifies in writing that the treatment is likely to be more beneficial than standard treatments, or
    - Requested by you or by a licensed board certified or board eligible *physician* qualified to treat your condition. The treatment requested must be likely to be more beneficial for you than standard treatments based on two documents of scientific and medical evidence from the following sources:
        a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized standards;

b) Medical literature meeting the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database of Health Services Technology Assessment Research (HSTAR);

c) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;

d) Either of the following: (i) The American Hospital Formulary Service's Drug Information, or (ii) the American Dental Association Accepted Dental Therapeutics;

e) Any of the following references, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: (i) the Elsevier Gold Standard's Clinical Pharmacology, (ii) the National Comprehensive Cancer Network Drug and Biologics Compendium, or (iii) the Thomson Micromedex DrugDex;

f) Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and

g) Peer reviewed abstracts accepted for presentation at major medical association meetings.

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

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

Within three business days of receiving notice from the DMHC of your request for review we will send the reviewing panel all relevant medical records and documents in our possession, as well as any additional information submitted by you or your *physician*. Any newly developed or discovered relevant medical records identified by us or by a *participating provider* after the initial documents are sent will be immediately

forwarded to the reviewing panel. The external independent review organization will complete its review and render its opinion within 30 days of its receipt of request for review (or within seven days if your *physician* determines that the proposed treatment would be significantly less effective if not provided promptly). This timeframe may be extended by up to three days for any delay in receiving necessary records.

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

Independent Medical Review of Grievances Involving a Disputed Health Care Service

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

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

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

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

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

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

   (c) You have been seen by a *participating provider* for the diagnosis or treatment of the medical condition for which you seek independent review;

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

3. You have filed a grievance with us and the disputed decision is upheld or the grievance remains unresolved after 30 days. If your grievance requires expedited review you need not participate in our grievance process for more than three days. The DMHC may waive the requirement that you follow our grievance process in extraordinary and compelling cases.

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

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

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

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

Department of Managed Health Care

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

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

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 *physician* (e.g., your *physician*, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

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

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

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