

**LOS ANGELES CITY EMPLOYEES' RETIREMENT
SYSTEM**

January 1, 2018

Member with Medicare Parts A & B and Part D

***Assurance
Plus 1***

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

CERTIFICATE OF INSURANCE

**Anthem Blue Cross Life and Health Insurance Company
(Anthem Blue Cross Life and Health Insurance)
21555 Oxnard Street
Woodland Hills, California 91367**

This Certificate of Insurance, including any amendments and endorsements to it, is a summary of the important terms of your health plan. It replaces any older certificates issued to you for the coverages described in the Summary of Benefits. The Group Policy, of which this certificate is a part, must be consulted to determine the exact terms and conditions of coverage. Your employer will provide you with a copy of the Group Policy upon request.

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

COMPLAINT NOTICE

Should you have any complaints or questions regarding your coverage, and this certificate was delivered by a broker, you should first contact the broker. You may also contact us at:

**Anthem Blue Cross Life and Health Insurance Company
Member Services
21555 Oxnard Street
Woodland Hills, CA 91367
818-234-2700**

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

**California Department of Insurance
Claims Service Bureau, 11th Floor
300 South Spring Street
Los Angeles, California 90013**

1-800-927-HELP (4357) – In California

1-213-897-8921 – Out of California

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

**E-mail Inquiry: “Consumer Services” link at
www.insurance.ca.gov**

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YOUR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE BENEFITS

This plan is intended only for *insured persons* who have *Medicare* Part A and Part B coverage. The benefits described in this certificate are payable only for covered services to supplement *Medicare* benefits, except as specifically stated in HOSPITAL BENEFITS AFTER MEDICARE IS EXHAUSTED, BENEFITS OUTSIDE THE UNITED STATES and CHRISTIAN SCIENCE BENEFITS.

The benefits of this *plan* are provided only for services that *Medicare* determines to be allowable and *medically necessary*, except as specifically stated in this certificate. For covered services for which *Medicare* does not provide coverage (as described in HOSPITAL BENEFITS AFTER MEDICARE IS EXHAUSTED, BENEFITS OUTSIDE THE UNITED STATES and CHRISTIAN SCIENCE BENEFITS), the benefits of this *plan* are provided only for services that are *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 is a covered expense. Consult this certificate 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”) that are defined in the DEFINITIONS section. When reading through this certificate, consult the DEFINITIONS section to be sure that you understand the meanings of these italicized words.

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.

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 <i>plan</i> are subject to the REIMBURSEMENT FOR ACTS OF THIRD PARTIES section.
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LIFETIME MAXIMUM

The combined total for all benefits of this *plan* is limited to a maximum amount of **\$2,000,000.00** during each *insured person's* lifetime.

BENEFITS TO SUPPLEMENT MEDICARE

In the following benefit sections, we provide a summary of what you pay, what *Medicare* pays, and what we pay. However, for complete information about *Medicare*, you should contact your local Social Security office or the Centers for Medicare & Medicaid Services, or refer to its publications.

HOSPITAL INPATIENT BENEFITS (PART A)

Part A refers to the portion of the *Medicare* program which provides benefits for inpatient *hospital* services and *skilled nursing facility* care.

We will provide payment for our portion of the Part A benefits whether or not a *hospital stay* has been approved by *Medicare* or services were received in a *hospital* participating in the *Medicare* program. However, SERVICES MUST BE *MEDICALLY NECESSARY*, AND ARE SUBJECT TO THE EXCLUSIONS AND LIMITATIONS OF THIS CERTIFICATE.

The following paragraphs describe what you pay, what *Medicare* pays and what we pay:

HOSPITAL INPATIENT BENEFITS FOR CONDITIONS OTHER THAN MENTAL OR NERVOUS DISORDERS

You Pay:

- Any amounts in excess of *Medicare's* allowable charge amount for the first three pints of unreplaced whole blood.

Medicare Pays:

- Covered inpatient *hospital* services received for the first 60 days of each *benefit period* during an approved *stay*, EXCEPT FOR THE *MEDICARE* PART A DEDUCTIBLE and the first three pints of unreplaced blood.
- Covered inpatient *hospital* services received for the 61st through 90th day of each *benefit period*, EXCEPT FOR THE *MEDICARE* CO-PAYMENT.
- If you exercise your option to use the 60 day lifetime reserve, covered inpatient *hospital* services received for the 91st through 150th day, EXCEPT FOR THE *MEDICARE* CO-PAYMENT. *MEDICARE* DOES NOT PAY ANY BENEFITS AFTER THE 150TH DAY.

We Pay:

- The *Medicare* Part A deductible.
- Benefits (UP TO *MEDICARE'S* ALLOWABLE CHARGE AMOUNT) for the first three pints of **unreplaced** whole blood, packaged red blood cells or any other blood derivative received during each *year* unless already paid for under Part B.

- The *Medicare co-payment* for *hospital stays* from the 61st through 90th day.
- If you choose to use the 60-day lifetime reserve, the *Medicare co-payment* for *hospital stays* from the 91st through 150th day. See HOSPITAL BENEFITS AFTER MEDICARE IS EXHAUSTED for inpatient *hospital* benefits after the 150th day.

HOSPITAL INPATIENT BENEFITS FOR MENTAL OR NERVOUS DISORDERS

You Pay:

- Any additional inpatient *mental or nervous disorder* services you receive after *Medicare* has paid either (a) the first 90 days of coverage during any one *benefit period*, provided you have no additional lifetime reserve days remaining; or (b) the first 150 days of coverage during any one *benefit period*, provided you have all of your lifetime reserve days remaining and choose to use them. If you have fewer than 60 lifetime reserve days available, or choose to use fewer than the number you have available, your payment responsibility increases accordingly.
- Any additional inpatient *mental or nervous disorder* services you receive after *Medicare* has paid the 190 day lifetime maximum for these services.

Medicare Pays:

- Covered inpatient *hospital* services received for the first 60 days of each *benefit period* during an approved *stay*, EXCEPT FOR THE *MEDICARE PART A DEDUCTIBLE*.
- Covered inpatient *hospital* services received for the 61st through 90th day of each *benefit period*, EXCEPT FOR THE *MEDICARE CO-PAYMENT*.
- If you exercise your option to use the 60 day lifetime reserve, covered inpatient *hospital* services received for the 91st through 150th day, EXCEPT FOR THE *MEDICARE CO-PAYMENT*.

MEDICARE DOES NOT PAY ANY BENEFITS AFTER THE 150TH DAY OF EACH BENEFIT PERIOD OR BEYOND THE LIFETIME MAXIMUM OF 190 DAYS.

We Pay:

- The *Medicare Part A deductible*.

- The *Medicare co-payment* for *hospital stays* from the 61st day through 90th day.
- If you choose to use the 60-day lifetime reserve, the *Medicare co-payment* for *hospital stays* from the 91st through 150th day.

Skilled Nursing Facility Benefits

You Pay:

- Any additional *skilled nursing facility* services you receive after *Medicare* has paid the 100 day maximum allowance during a *benefit period* for these services.

Medicare Pays:

- When you are admitted within 30 days of a covered inpatient *hospital stay* of three or more consecutive days, covered Part A services for up to 100 days for each *benefit period*, EXCEPT FOR THE *MEDICARE CO-PAYMENT FROM THE 21ST TO THE 100TH DAY. MEDICARE DOES NOT PAY FOR SERVICES BEYOND THE 100TH DAY DURING A BENEFIT PERIOD.*

We Pay:

- The *Medicare Part A co-payment* for *skilled nursing facility* services received from the 21st to the 100th day per *benefit period*.

MEDICAL BENEFITS (PART B)

Part B refers to the portion of the *Medicare* Program which provides benefits for *physician* services, outpatient *hospital* care, outpatient X-rays and laboratory procedures, local ground ambulance and other specified health services and supplies.

After you have met the *Medicare* Part B deductible each *year*, we pay for *medically necessary* Part B services and supplies as described in the following pages under **Hospital Outpatient Benefits** and **Professional Services and Supplies**. We will also pay benefits (up to *Medicare's* Allowable Charge amount) for the first three pints of unreplaced blood, packaged red blood cells or any other blood derivative received during each *year* unless already paid for under Part A.

We will provide payment for our portion of the Part B benefits only when services are allowed by *Medicare* and *Medicare* has provided benefits for the same services. The following paragraphs describe what you pay, what *Medicare* pays, and what we pay.

HOSPITAL OUTPATIENT BENEFITS

You Pay:

- The *Medicare* Part B deductible.

Medicare Pays:

- **80%** of *Medicare's* Allowable Charge amount for covered *hospital* outpatient services listed below.

We Pay:

- **20%** of *Medicare's* Allowable Charge amount for the covered *hospital* outpatient services listed below, after you have met the *Medicare* Part B deductible.

Covered Services:

- Outpatient medical care.
- Outpatient surgical treatment.
- Radiation therapy, chemotherapy and hemodialysis treatment.

PROFESSIONAL SERVICES AND SUPPLIES

Important Information Regarding the Prudent Buyer Plan Network (Part B Professional Services Only)

We provide a different payment allowance for Part B Professional services described under this *plan* when you receive these services from a *physician* or other provider who is a member of the Prudent Buyer Plan network (*participating provider*). *Participating providers* have agreed to accept our *negotiated rate* as payment in full for covered services. A list of *participating providers* is available from us on request.

Professional Services of a Participating Provider:

When you receive Professional services from a *participating provider*, that provider has agreed to accept our and *Medicare's* combined payments as payment in full. You cannot be billed for any amounts exceeding the Prudent Buyer Plan *negotiated rate*. You will be responsible only for charges applied to the *Medicare* Part B deductible, charges in excess of the yearly maximum allowances stated in the section entitled COVERED SERVICES, and charges for services that are not covered.

Professional Services of a Non-Participating Provider:

When you receive Professional services from a *non-participating provider*, that provider is not obligated to accept our and *Medicare's* combined payments as payment in full, and may bill you for the balance of any unpaid charges. However, some *physicians* accept assignment of *Medicare* benefits. A *physician* who accepts *Medicare* assignment may not collect more than *Medicare's* Allowable Charge. If you use a provider who is not part of the Prudent Buyer Plan network and who does not accept *Medicare* assignment, you will be responsible for any charges applied to the *Medicare* Part B deductible, amounts exceeding *Medicare's* Allowable Charge, charges in excess of the yearly maximum allowances stated in the section entitled COVERED SERVICES, and charges for services that are not covered.

The following describes what you pay, what *Medicare* pays and what we pay for covered Part B professional services:

Professional Services and Supplies (*Participating Providers*)

You Pay:

- The *Medicare* Part B deductible.
- Amounts in excess of our yearly maximum benefits for certain services as stated in the section entitled COVERED SERVICES.
- A \$100 deductible for private duty nursing.
- A \$10 copayment for chiropractic services.

Note. You will not have to pay the *Medicare* Part B deductible in order to be covered for the routine physical exam benefit and hearing aid benefit.

Medicare Pays:

- **80%** of *Medicare's* Allowable Charge for covered professional services and supplies.

We Pay:

1. When Professional Services are rendered by a *participating provider* who accepts *Medicare* assignment:

- The difference between what *Medicare* pays and the lesser of either: (1) *Medicare's* Allowable Charge; or (2) the Prudent Buyer Plan *negotiated rate* for covered professional services and supplies, subject to the stated maximums described in the section entitled COVERED SERVICES.

2. When Professional Services are rendered by a *participating provider* who does not accept *Medicare* assignment:

- The difference between what *Medicare* pays and the Prudent Buyer Plan *negotiated rate* for covered professional services and supplies, subject to the stated maximums described in the section entitled COVERED SERVICES.

Note: *Participating providers* will consider the combined *Medicare* and Anthem Blue Cross Life and Health Insurance payments noted above as payment in full for covered services. You will be responsible for charges applied to the *Medicare* Part B deductible and charges in excess of the stated maximums in the section entitled COVERED SERVICES.

Professional Services and Supplies (*Non-Participating Providers*)

You Pay:

- The *Medicare* Part B deductible.
- Amounts in excess of our yearly maximum benefits for certain services as stated in the section entitled COVERED SERVICES.
- Amounts in excess of *Medicare's* Allowable Charge amount.
- A \$100 deductible for private duty nursing.

Note. You will not have to pay the *Medicare* Part B deductible in order to be covered for the routine physical exam benefit and hearing aid benefit.

Medicare Pays:

- **80%** of *Medicare's* Allowable Charge for covered professional services and supplies.

We Pay:

When Professional Services are rendered by a *non-participating provider* (whether or not the *physician* or provider accepts *Medicare* assignment):

- **20%** of *Medicare's* Allowable Charge for covered professional services and supplies, subject to the stated maximums described in the section entitled COVERED SERVICES.

Exceptions. We provide payment for **100%** of billed *reasonable charges* for routine physical exams, hearing aids, and routine hearing tests.

Note: *Non-participating providers* may not consider the combined *Medicare* and Anthem Blue Cross Life and Health Insurance payments noted above to be payment in full, and may bill you for the balance of any unpaid charges. You will be responsible for charges applied to the *Medicare* Part B deductible, billed amounts in excess of *Medicare's* allowable charge, and charges in excess of the stated maximums in the section entitled COVERED SERVICES.

Special Note Regarding *Participating* or *Non-Participating Providers* Who Accept *Medicare* Assignment:

If the provider accepts *Medicare* assignment, we will not pay more than the difference between *Medicare's* allowable charge and the amount *Medicare* pays, even when services are rendered by a *participating provider*.

Covered Services:

- *Physicians'* services for surgery and surgical assistance.
- Anesthesia during surgery.
- Consultations requested by the attending *physician*.
- Visits of a *physician* during a covered *hospital stay*, including a *hospital stay* for *mental or nervous disorders*.
- Radiation therapy and chemotherapy.
- A *physician's* services for outpatient *emergency care*.
- A *physician's* services for home or office visits.
- Diagnostic radiology and laboratory services.
- Routine and diagnostic mammograms, mastectomy, complications from a mastectomy, reconstructive surgery of both breasts following mastectomy, and breast prostheses following mastectomy.
- Medical supplies, rental or purchase of durable medical equipment, including therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications.
- Injectable drugs and implants for birth control administered in a *physician's* office if *medically necessary*.

- Diabetic equipment and supplies, including (1) blood glucose monitors, including monitors designed to assist the visually impaired, and blood glucose testing strips; (2) insulin pumps; (3) podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes-related complications; (4) visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin; (5) test strips; (6) lancets; (7) alcohol swabs; and (8) insulin syringes, including pen delivery systems for insulin administration. Charges for the insulin itself are not covered.
- Diabetes instruction program which: (1) is designed to teach a *insured person* who is a patient and covered members of the patient's family about the disease process and the daily management of diabetic therapy; (2) includes self-management training, education, and medical nutrition therapy to enable the *insured person* to properly use the equipment, supplies, and medications necessary to manage the disease; and (3) is supervised by a *physician*.
- Ground ambulance services of a licensed ambulance company to or from the nearest *hospital* or *skilled nursing facility*. *Emergency services* or transportation services that are provided to you by a licensed ambulance company as a result of a "911" emergency response system request for assistance if you believe you have an *emergency* medical condition requiring such assistance.

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.

Base charge, mileage and non-reusable supplies of a licensed air ambulance company to transport you from the area where you are first disabled to the nearest *hospital* where appropriate treatment is provided if, and only if, such services are *medically necessary*, you have an *emergency* medical condition requiring such assistance, and ground ambulance service is inadequate.

- Blood and blood plasma beginning with the fourth pint during any *year*.
- The first pair of contact lenses or the first pair of eyeglasses following eye surgery.
- Physical therapy and occupational therapy.
- Speech therapy.

- Chiropractic care, up to 30 visits a year, after Medicare's allowable number of visits are exhausted. If you go to a *participating provider*, you will have to pay a **\$10** copayment. If you go to a *non-participating provider*, your copayment will be **30%** of covered expense incurred.
- Outpatient care for *mental or nervous disorders*.
- Hearing aids and routine hearing tests, limited to a **\$2,000** annual maximum, per ear, every 36 months.
- Private duty nursing, limited to a **\$1,000** annual maximum.
- Allergy testing and treatment, including allergy serum.
- Prescription drugs for home infusion therapy.
- 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*, and for up to a maximum of **\$30** for all covered services rendered during each visit.

CHRISTIAN SCIENCE BENEFITS

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. Benefits are provided at 80% of billed *reasonable charges*. These benefits are subject to all provisions of the *agreement*, which may limit benefits or result in benefits not being payable.

- For services of practitioners**\$25**
per visit, for up to 70 visits
per *calendar year*
- For nursing care.....**\$20**
per visit, for up to 70 visits
per *calendar year*
- Sanatorium**70 days**
per *calendar year*

Christian Science Benefit. Benefits for the following services will be provided when a *member* manifests symptoms of a covered illness or injury and receives Christian Science treatment for such symptoms.

Christian Science Sanatorium

Services provided by a Christian Science sanatorium, and other nursing homes which may be approved by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc., if the *member* is admitted for active care of an illness or injury. Services are limited to 70 days per *calendar year*.

Christian Science Practitioner

Office visits for services of a Christian Science practitioner providing treatment for a diagnosed illness or injury according to the healing practices of Christian Science.

1. Services of a Christian Science Practitioner, other than a nurse, are limited to one visit per day, not to exceed a maximum payment of **\$25** per day and 70 visits per *calendar year*.
2. Services of a Christian Science nurse who is authorized by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. and who is not a part of the *member's* family, are limited to one visit per day, not to exceed a maximum payment of **\$20** per day and 70 visits per *calendar year*.

A Christian Science sanatorium will be considered a *hospital* under the *plan* if it is accredited by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.

The term *physician* includes a Christian science practitioner approved and accredited by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.

NO BENEFITS ARE AVAILABLE FOR TELEPHONE CONSULTATIONS OR SPIRITUAL REFRESHMENT. All other provisions of the EXCLUSIONS AND LIMITATIONS section apply equally to Christian Science benefits as to all other benefits and providers of care.

HOSPITAL BENEFITS AFTER MEDICARE IS EXHAUSTED

When you have used all of your *Medicare* Part A benefit days during a *benefit period* and all of your *Medicare* lifetime reserve days are exhausted, we will provide additional *hospital* benefits for the remainder of that *benefit period*.

1. Days Covered

THE COVERED SERVICES LISTED BELOW ARE LIMITED TO A LIFETIME MAXIMUM OF 365 DAYS.

2. Payment

We provide payment for **100%** of billed *reasonable charges* for *medically necessary* inpatient services listed below when provided by a *hospital*. You will pay only covered expenses in excess of *reasonable charges*.

3. Covered Services

The following services of a *hospital* are covered:

- Accommodations in a room of two or more beds, or the prevailing charge for two-bed room accommodations in that *hospital* if a private room is used.
- Services in *special care units*.
- Operating and special treatment rooms.

- Supplies and ancillary services including laboratory, cardiology, pathology, radiology and any professional component of these services.
- Physical therapy, radiation therapy, chemotherapy, and hemodialysis treatment.
- Drugs and medicines (equivalent to those approved for general use by the Food and Drug Administration in the *United States*) which are supplied by the *hospital* for use during your *stay*.
- Blood transfusions, but not the cost of blood, blood products or blood processing.

4. Conditions of Service

- Services must be those which are regularly provided and billed by a *hospital*.
- Services are provided only for the number of days required to treat your illness, injury or condition.
- Services must not be provided for treatment of *mental or nervous disorders*.

BENEFITS OUTSIDE THE UNITED STATES

We provide the benefits listed below when you require medical care outside the *United States* during a temporary absence of less than six (6) months. These benefits are subject to all provisions of the *policy*, which may limit benefits or result in benefits not being payable.

Special Instructions for Foreign Claims Submission

When you submit a claim to us for medical care services rendered outside the *United States*, you must include any canceled checks, receipts or other documents you receive in connection with those services along with your properly completed claim form.

If you receive drugs or medicines during an inpatient or outpatient hospital admission outside the *United States*, you should ask the provider of service to include the chemical or generic name of the drug on your bill.

INPATIENT HOSPITAL SERVICES

Your *hospital* care must be rendered in a facility which is properly licensed and accredited as a *hospital* in the country where services are rendered. We provide benefits for services of a *hospital* as follows:

1. Days Covered

THE COVERED SERVICES LISTED BELOW ARE LIMITED TO A TOTAL OF 90 DAYS FOR EACH *HOSPITAL STAY*. IF THERE ARE FEWER THAN 60 DAYS BETWEEN *HOSPITAL STAYS*, THAT ENTIRE PERIOD WILL BE CONSIDERED TO BE ONE *HOSPITAL STAY*.

2. Payment

We provide payment for 100% of billed *reasonable charges* for *medically necessary* inpatient services listed below when provided by a *hospital*. You pay any amounts in excess of *reasonable charges*.

3. Covered Services

The following services of a *hospital* are covered:

- Accommodations in a room of two or more beds, or the prevailing charge for two-bed room accommodations in that *hospital* if a private room is used.
- Services in *special care units*.
- Operating and special treatment rooms.
- Supplies and ancillary services including laboratory, cardiology, pathology, radiology and any professional component of these services.
- Physical therapy, radiation therapy, chemotherapy and hemodialysis treatment.
- Drugs and medicines (equivalent to those approved for general use by the Food and Drug Administration in the *United States*) which are supplied by the *hospital* for use during your *stay*.
- Blood transfusions, but not the cost of blood, blood products or blood processing.

4. Conditions of Service

- Services must be those which are regularly provided and billed by a *hospital*.
- Services are provided only for the number of days required to treat your illness, injury or condition.

OUTPATIENT HOSPITAL SERVICES

1. Payment

We provide payment for 100% of billed *reasonable charges* for *medically necessary* outpatient services listed below when provided by a *hospital*. You pay any amounts in excess of *reasonable charges*.

2. Covered Services

- *Emergency* room use, supplies, ancillary services, drugs and medicines as listed under Inpatient Hospital Covered Services.
- Care received when outpatient surgery is performed. Covered services are operating room use, supplies, ancillary services, drugs and medicines as listed under Inpatient Hospital Covered Services.

3. Conditions of Service

- Services must be those which are regularly provided and billed by a *hospital*.
- *Emergency* room care must be for the first treatment of an *emergency*.

PROFESSIONAL MEDICAL BENEFITS

Your professional medical care must be rendered by a provider who is properly licensed and accredited as a *physician* in the country where services are provided. We provide benefits for professional medical services as follows:

1. Payment

We provide payment for 100% of covered expense incurred for *medically necessary* services listed below. Covered expense is expense incurred for a covered service, but not more than a *reasonable charge*.

2. Covered Services

- Surgery and surgical assistance.
- Anesthesia during surgery.
- Visits during a covered *hospital stay* (except those relating to surgery), limited to one per day unless additional visits are needed due to your medical condition.

EXCLUSIONS AND LIMITATIONS

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.

Air Ambulance. Services of or transportation by an air ambulance except as specifically stated under “Covered Services” in the “Professional Services and Supplies” provision of MEDICAL BENEFITS (PART B).

Experimental or Investigative. Any *experimental* or *investigative* procedure or medication.

Services outside the United States. Services and supplies provided outside the *United States*, except as specifically stated in the section entitled BENEFITS OUTSIDE THE UNITED STATES.

Crime or Nuclear Energy. Conditions that result from: (1) your commission of or attempt to commit a felony; 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.

Excess Amounts. Any amounts in excess of:

1. Allowable Charges as determined by *Medicare*, for benefits provided under the sections entitled HOSPITAL INPATIENT BENEFITS (PART A) and MEDICAL BENEFITS (PART B); and
2. The *negotiated rate*, for professional Part B services of a *participating provider* who does not accept *Medicare* assignment; and

3. *Reasonable charges*, as we determine, for benefits provided under the sections entitled HOSPITAL BENEFITS AFTER MEDICARE IS EXHAUSTED, CHRISTIAN SCIENCE BENEFITS and BENEFITS OUTSIDE THE UNITED STATES; and
4. The Lifetime Maximum for all covered services as stated in the "Lifetime Maximum" provision of YOUR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE BENEFITS, and any other maximum payments and benefits stated elsewhere in this certificate.

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*. This will not apply to services provided by a Veterans Administration Medical Center or a Military Treatment Facility for *emergency services* or for care that is related to a non-service connected condition.

Services of Relatives. Professional services received from a person who lives in your home or who is related to you by blood or marriage.

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.

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

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

Mental or Nervous Disorders or Substance Abuse. Academic or educational testing, counseling, and remediation. Any treatment of *mental or nervous disorders* or substance abuse, including rehabilitative care in relation to these conditions, except as specifically stated in the "Hospital Inpatient Benefits for Mental or Nervous Disorders" provision of HOSPITAL INPATIENT BENEFITS (PART A) and in the "Professional Services and Supplies" provision of MEDICAL BENEFITS (PART B). Any educational treatment or any services that are educational, vocational, or training in nature except as specifically provided or arranged by us.

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

Orthodontia. Braces and other orthodontic appliances or services.

Dental Services or Supplies. Cosmetic dental surgery or other dental services for beautification. Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth or treatment to the teeth or gums, except for surgery of the jaw or related structures, setting fractures of the jaw or facial bones, or services that would be covered when provided by a *physician*.

This exclusion also does not apply to general anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a *hospital* or ambulatory surgical center. This applies only if you are developmentally disabled or your health is compromised and general anesthesia is *medically necessary*. Charges for the dental procedure itself, including professional fees of a dentist, are not covered.

Important: If you decide to receive dental services that are not covered under this *plan*, a *participating provider* who is a dentist may charge you

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

Hearing Aids or Tests. Hearing aids and routine hearing tests, except as specifically stated under “Covered Services” in the “Professional Services and Supplies” provision of MEDICAL BENEFITS (PART B).

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics, routine eye exams and routine eye refractions. Eyeglasses or contact lenses, except as specifically stated in the “Professional Services and Supplies” provision of MEDICAL BENEFITS (PART B).

Outpatient Physical and Occupational Therapy. Outpatient physical and occupational therapy, except as specifically stated in the “Professional Services and Supplies” provision of MEDICAL BENEFITS (PART B).

Outpatient Speech Therapy. Outpatient speech therapy, except as specifically stated in the “Professional Services and Supplies” provision of MEDICAL BENEFITS (PART B).

Cosmetic Surgery. Cosmetic surgery or other services performed to alter or reshape normal (including aged) structures or tissues of the body to improve appearance.

Obesity. Services primarily for weight reduction or treatment of obesity. This exclusion will not apply to treatment of morbid obesity as determined by us if we authorize the treatment in advance as *medically necessary* and appropriate.

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.

Orthopedic Supplies. Orthopedic shoes (other than shoes joined to braces) or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications as specifically stated under “Covered Services” in the “Professional Services and Supplies” provision of MEDICAL BENEFITS (PART B).

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

Custodial Care and Rest Cures. Inpatient room and board charges in connection with a *hospital stay* primarily for environmental change, physical therapy. *Custodial care* or rest cures. 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 under in the “Skilled Nursing Facility” provision of HOSPITAL INPATIENT BENEFITS (PART A).

Chronic Pain. Inpatient room and board charges in connection with a *hospital stay* primarily for treatment of chronic pain.

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

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

Education or Counseling. Any educational treatment, nutritional counseling or food supplements. Any services that are educational, vocational, or training in nature except as specifically provided or arranged by us.

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 under “Covered Services” in the “Professional Services and Supplies” provision of MEDICAL BENEFITS (PART B).

Acupuncture. Acupuncture, 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 dermatoses or acupuncture points, except as specifically stated under “Covered Services” in the “Professional Services and Supplies” provision of MEDICAL BENEFITS (PART B).

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

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, dietary supplements, health or beauty aids.

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse, except as specifically stated under “Covered Services” in the “Professional Services and Supplies” provision of MEDICAL BENEFITS (PART B).

Contraceptive Devices. Contraceptive devices prescribed for birth control.

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.

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

Clinical Trials. Services and supplies provided in connection with a clinical trial except for routine costs associated with a clinical trial for which *Medicare* provides benefits.

Medicare Part B Deductible. Any charges you incur that are applied toward your *Medicare* Part B deductible.

REIMBURSEMENT FOR ACTS OF THIRD PARTIES

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

1. We will automatically have a lien, to the extent of benefits provided, upon any recovery, whether by settlement, judgment or otherwise,

that you receive from the third party, the third party's insurer, or the third party's guarantor. The lien will be in the amount of benefits we paid under this *plan* for the treatment of the illness, disease, injury or condition for which the third party is liable, reduced by the fees and costs associated with the recovery, but, not more than the amount allowed by California Civil Code Section 3040.

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.

COORDINATION OF BENEFITS

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

DEFINITIONS

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

Allowable Expense is any necessary, reasonable and customary item of expense which is at least partially covered by at least 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 trustee plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.

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

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.
2. A plan which covers you as an employee pays before a plan which covers you as a dependent. But, if you are a Medicare beneficiary and also a dependent of an employee with current employment status under another plan, this rule might change. If, according to Medicare's rules, Medicare pays after that plan which covers you as a dependent then, the plan which covers you as a dependent pays before a plan which covers you as an employee.

For example: You are covered as a retired employee under this plan and a Medicare beneficiary (Medicare would pay first, this plan would pay second). You are also covered as a dependent of an active employee under another plan provided by an employer group of 20 or more employees (then, according to Medicare's rules, Medicare would pay second). In this situation, the plan which covers you as a dependent of an active employee will pay first, Medicare will pay second and the plan which covers you as a retired employee will pay last, after Medicare.

3. 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 5 applies.
4. 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.
5. 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.

HOW COVERAGE BEGINS AND ENDS

HOW COVERAGE BEGINS

ELIGIBLE STATUS

1. **Insured Employees.** You are in an eligible status if you are a *retired employee* who is actively enrolled under both Part A and Part B of *Medicare*. A *retired employee* is retired from active full-time or part time employment, is eligible to receive health plan benefits as part of the *group's* pension plan.
2. **Family Member.** The *retired employee's spouse, domestic partner* or unmarried *child* are eligible to enroll as *family members*, provided that the *spouse, domestic partner* or unmarried *child* is actively enrolled under both Part A and Part B of *Medicare*.

Definition of Family Member

1. **Spouse** is the *retired employee's* spouse under a legally valid marriage. This includes same sex spouses when legally married in a state that recognizes same-sex marriages. Spouse does not include any person who is covered as a *retired employee* or *domestic partner*.
2. **Domestic partner** is the *retired employee's* domestic partner under a legally registered and valid domestic partnership and actively enrolled under both Part A and Part B of *Medicare*. Domestic partner does not include any person who is: (a) covered as a *retired employee*; or (b) in active service in the armed forces.
3. **Child** is the *retired employee's, spouse's* or *domestic partner's* unmarried natural child, stepchild, grandchild, legally adopted child or a child for whom the *retired employee, spouse* or *domestic partner* has been appointed legal guardian by a court of law, and actively enrolled under both Part A and Part B of *Medicare*, 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 *retired employee* under another plan or health insurer, or has six or more months of other *creditable coverage*, (ii) is chiefly dependent on the *retired employee, 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 *retired employee* 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 *retired employee, 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 *retired employee, 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 *retired employee's, spouse's* or the *domestic partner's* right to control the health care of the child.
- d. A child for whom the *retired employee, 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.
- e. The term "child" does not include any person who is: (i) covered as a *retired employee*; or (ii) in active service in the armed forces.
- f. If both parents are covered as *retired employees*, their children may be covered as the *family members* of either, but not of both.

ELIGIBILITY DATE

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

ENROLLMENT

To enroll as a *retired employee*, or to enroll *family members*, the *retired employee* 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. We must receive this application from the *group* within 90 days. If any of these steps are not followed, your coverage may be denied.

EFFECTIVE DATE

Subject to the timely payment of premiums on your behalf, your coverage will begin 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 *retired employees*, on your eligibility date; and (b) for *family members*, on the later of (i) the date the *retired employee's* coverage begins, or (ii) the first day of the month after the *family member* becomes eligible. If you become eligible before the *policy* takes effect, coverage begins on the effective date of the *policy*.
2. **Late Enrollment.** If you enroll more than 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 must wait until the *group's* next Open Enrollment Period to enroll. 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 *insured employee* (or *spouse* or *domestic partner*, if the *spouse* or *domestic partner* is enrolled) is already covered: (1) any *child* born to the *retired employee*, *spouse* or *domestic partner* will be enrolled from the moment of birth; and (2) any *child* being adopted by the *retired employee*, *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 *retired employee*, *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 *retired employee's*, *spouse's* or *domestic partner's* right to control the health care of the *child* may be used); or (b) the *retired employee*, *spouse* or *domestic partner* assumed a legal obligation for full or partial financial responsibility for the *child* in anticipation of the *child's* adoption. The "written document" referred to above includes, but is not limited to, a

health facility minor release report, a medical authorization form, or relinquishment form.

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

SPECIAL ENROLLMENT PERIODS

You may enroll without 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 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 continuation, coverage ended because you lost eligibility under the other plan, your coverage under a COBRA continuation was exhausted, or employer contributions toward coverage under the other plan terminated. You must properly file an application with the *group* within 31 days after the date your coverage ends or the date employer contributions toward coverage under the other plan terminate.

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

- ii. If the other health plan was a state Medicaid plan or a state child health insurance program (SCHIP), including the Healthy Families Program or the Access for Infants and Mothers (AIM) Program, coverage ended because you lost eligibility under the program. You must properly file an application with the *group* within 60 days after the date your coverage ended.
2. A court has ordered coverage be provided for a *spouse, domestic partner* or dependent *child* under your employee health plan and an application is filed within 31 days from the date the court order is issued.
3. We do not have a written statement from the *group* stating that prior to declining coverage or disenrolling, you received and signed acknowledgment of a written notice specifying that if you do not enroll for coverage within 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 31 days of the date of marriage or domestic partnership. Your *domestic partner* must meet the *plan's* eligibility requirements for *domestic partners* as outlined under HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE BEGINS. 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. Coverage will be effective on the first day of the month following the date you file the enrollment application.

- b. If you are enrolling following the birth, adoption, or placement for adoption of a *child*, your *spouse* (if you are already married) or *domestic partner*, who is eligible but not enrolled, may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above. Application must be made within 31 days of the birth or date of adoption or placement for adoption; coverage will be effective as of the date of birth, 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. The date the *retired employee* reaches the age of 55 or the *employee* reaches the age of 65.
7. You become eligible for assistance, with respect to the cost of coverage under the employer's group *plan*, under a state Medicaid or SCHIP health plan, including any waiver or demonstration project conducted under or in relation to these plans. You must properly file an application with the *group* within 60 days after the date you are determined to be eligible for this assistance.

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

OPEN ENROLLMENT PERIOD

The *group* has an open enrollment period once each *year*, during the month of October. During that time, an individual who meets the eligibility requirements as a *subscriber* under this *plan* may enroll in this *plan*. The *subscriber* may also enroll an eligible *spouse* or *domestic partner* at that time. Persons eligible to enroll as a *spouse* or *domestic partner* may enroll only under the *subscriber's plan*. For anyone so enrolling, coverage under this *plan* will begin on the first of January following your Open Enrollment. For anyone so enrolling, coverage under this *plan* will begin on the first day of January following the end of the Open Enrollment Period.

HOW COVERAGE ENDS

Your coverage under the *policy* can be cancelled immediately upon written notice by us if we learn that you do not have coverage under Part A and Part B of *Medicare*. You are responsible for notifying us if you do not have, or lose, coverage under either Part A and Part B of *Medicare*.

Additionally, your coverage ends without notice from us as provided below:

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

Exception to item 6:

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

physical or mental condition, but not more often than once each year. This exception will last until the *child* is no longer chiefly dependent on the *subscriber, spouse or domestic partner* for support and maintenance or a physical or mental condition no longer exists. A *child* is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

Note: If a marriage or domestic partnership terminates, the *insured person* must give or send to the *group* written notice of the termination. Coverage for a former *spouse or domestic partner*, if any, ends according to the "Eligible Status" provisions. If Anthem Blue Cross Life and Health Insurance suffers a loss because of the *insured person* failing to notify the *group* of the termination of their marriage or domestic partnership, Anthem Blue Cross Life and Health Insurance may seek recovery from the *insured person* 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 *insured person* notifies the *group* in writing to cancel coverage for a former *spouse or domestic partner*, if any, immediately upon termination of the *insured person'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 and EXTENSION OF BENEFITS.

Unfair Termination of Coverage. If you believe that your coverage has been or will be improperly terminated, you may request a review of the matter by the California Department of Insurance (CDI). You may contact the CDI using the address and telephone numbers listed in the COMPLAINT NOTICE. You must make your request for review with the CDI within 180 days from the date you receive notice that your coverage will end, or the date your coverage is actually cancelled, whichever is later, but you should make your request as soon as possible after you receive notice that your coverage will end. This 180 day timeframe will not apply if, due to substantial health reasons or other incapacity, you are unable to understand the significance of the cancellation notice and act upon it. If you make your request for review within 30 days after you receive notice that your coverage will end, or your coverage is still in effect when you make your request, we will continue to provide coverage to you under the terms of this *plan* until a final determination of your request for review has been made by the CDI (this does not apply if your coverage is cancelled for non-payment of premium). If your coverage is maintained in force pending outcome of the review, premium must still be paid to us on your behalf.

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.

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 a period of continuation of coverage. Check with your employer for details. Your employer must provide you with the name of your Health Plan Administrator. Your Health Plan Administrator will give you notice of your right to continue coverage after certain "Qualifying Events". You must notify your health Plan Administrator of the occurrence of any subsequent Qualifying Events. (See the "Terms of COBRA Continuation" provision 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 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 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 Retired Employees and Family Members.** Cancellation or a substantial reduction of retiree benefits under the *plan* due to the *group's* filing for Chapter 11 bankruptcy, provided that:
 - a. The *agreement* expressly includes coverage for retirees; and
 - b. Such cancellation or reduction of benefits occurs within one year before or after the *group's* filing for bankruptcy.
2. **For Family Members:**
 - a. The death of the *subscriber*;
 - b. The *spouse's* divorce or legal separation from the *subscriber*; or
 - 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

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 Health Plan 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 above, the *subscriber* will be notified of the continuation right.
2. For Qualifying Events 2(a) or 2(d) above, a *family member* will be notified of the continuation right.
3. For Qualifying Events 2(b) or 2(c) above, you must inform the Health Plan Administrator within 60 days of the Qualifying Event if you wish to continue coverage. The Health Plan Administrator, in turn, will promptly give you official notice of the continuation right.

If you choose to continue coverage, you must notify us within 60 days of the date you receive notice of your COBRA continuation right from your Health Plan Administrator. 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.

You must remit the initial subscription charge to us within 45 days after you elect COBRA continuation coverage.

Additional Family Members. A *spouse, domestic partner or child* acquired during the COBRA continuation period is eligible to be enrolled, provided that the *spouse, domestic partner or child* meets the eligibility requirements specified in HOW COVERAGE BEGINS. The standard enrollment provisions of the *agreement* apply to enrollees during the COBRA continuation period.

Cost of Coverage. You are required to pay the entire cost of your COBRA continuation coverage. You must remit this cost (called the "subscription charge") to us each month during the COBRA continuation period. In addition to the subscription charge, we will add a monthly administrative fee equal to two percent of that charge. We must receive payment of the subscription charge and administrative fee each month 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.

Payment Dates. The first payment is due along with your enrollment form within 45 days after you elect continuation coverage. We will bill you for any retroactive charges which may be due. Succeeding subscription charges are due on the first day of each following month (the Subscription Charge Due Date).

Grace Period. For every Subscription Charge Due Date, except the first, there is a 31-day grace period in which to pay subscription charges. If subscription charges are not received by the end of the grace period, your coverage will be canceled at the end of the period for which subscription charges are last paid.

Change of Subscription Charge. The amounts of the subscription charges may be changed by us as of any Subscription Charge Due Date. Your Health Plan Administrator agrees to provide you with written notice at least 30 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.

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 36 months from the Qualifying Event, if the Qualifying Event was the death of the *subscriber*, divorce or legal separation, the end of a domestic partnership or the end of dependent *child* status;*
2. The date the *agreement* terminates;
3. The end of the period for which subscription charges are last paid;
4. The date, following the election of COBRA, the *member* first becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the *member*, in which case this COBRA continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied.

*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*.

Subject to the *agreement* remaining in effect, a retired *subscriber* whose COBRA continuation coverage began due to Qualifying Event 1 may be covered for the remainder of his or her life; that person's enrolled *family member* may continue coverage for 36 months after the *subscriber's* death. But coverage could terminate prior to such time for the *subscriber, spouse or domestic partner* in accordance with any of the items above.

EXTENSION OF BENEFITS

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

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

GENERAL PROVISIONS

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

Independent Contractors. Our relationship with providers is that of an independent contractor. *Physicians* and other health 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*.

Terms of Coverage

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

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

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

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

licensed according to appropriate state and local laws. 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*).

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

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

Benefits Not Transferable. Only *insured persons* are entitled to receive benefits under this *plan*. The right to benefits cannot be transferred.

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

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

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

Proof of Loss. You or the provider of service must send us properly and fully completed claim forms within 90 days of the date you receive the service or supply for which a claim is made. If it is not reasonably

possible to submit the claim within that time frame, an extension of up to 12 months will be allowed. Except in the absence of legal capacity, we are not liable for the benefits of the *plan* if you do not file claims within the required time period. We will not be liable for benefits if we do not receive written proof of loss on time.

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

Timely Payment of Claims. Any benefits due under this *plan* shall be due once we have received proper, written proof of loss, together with such reasonably necessary additional information we may require to determine our obligation.

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

Care Coordination. We pay *participating providers* in various ways to provide covered services to you. For example, sometimes we may pay *participating providers* a separate amount for each covered service they provide. We may also pay them one amount for all covered services related to treatment of a medical condition. Other times, we may pay a periodic, fixed pre-determined amount to cover the costs of covered services. In addition, we may pay *participating providers* financial incentives or other amounts to help improve quality of care and/or promote the delivery of health care services in a cost-efficient manner, or compensate *participating providers* for coordination of your care. In some instances, *participating providers* may be required to make payment to us because they did not meet certain standards. You do not share in any payments made by *participating providers* to us under these programs.

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

deduct or offset any amounts paid in error from any pending or future claim.

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

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

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

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

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

Prepayment Fees. The *group* is responsible for paying premiums to us for all coverage provided to you and your eligible *spouse* or *domestic partner*. The *group* may require that you contribute all or part of the costs of these premiums. You should consult the *group* for details.

Liability of Insured Person to Pay Providers. In accordance with California law, you will not be required to pay any *participating 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* or *other health care providers* any amounts not paid to them by us.

Renewal Provisions. The *group's* health plan *policy* with us is subject to renewal at certain intervals. We may change the premiums or other terms of the *plan* from time to time.

Entitlement to Medicare Benefits. We have the right to require that you furnish information concerning your entitlement to *Medicare* benefits. We may need this information to determine your eligibility under the *policy* and to process your claims.

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

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

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

Under arrangements with some health care providers and suppliers (hereafter referred to together as "Providers") certain discounts, payments, rebates, settlements, incentives, adjustments and/or allowances, including, but not limited to, pharmacy rebates, may be based on aggregate payments made by Anthem Blue Cross Life and Health or an affiliate in respect to all health care services rendered to all persons who have coverage through a program provided or administered by Anthem Blue Cross Life and Health or an affiliate. They are not attributed to specific claims or plans and do not inure to the benefit of any covered individual or group, but may be considered by Anthem Blue

Cross Life and Health or an affiliate in determining its fees or subscription charges or premiums.

Confidentiality and Release of Medical Information. We will use reasonable efforts, and take the same care to preserve the confidentiality of the *insured person'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 *insured person*. Medical information may be released only with the written consent of the *insured person* 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. *Insured persons* 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.

Medical Policy and Technology Assessment. Anthem Blue Cross Life and Health Insurance 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 Blue Cross Life and Health Insurance'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 Blue Cross Life and Health Insurance'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.

Continuity of Care after Termination of Provider: Subject to the terms and conditions set forth below, we will provide benefits at the *participating provider* level for covered services (subject to applicable copayments, coinsurance, deductibles and other terms) received from a provider at the time we terminate the provider's contract (unless the provider's contract is terminated for reasons of medical disciplinary cause or reason, fraud, or other criminal activity). This does not apply to a provider who voluntarily terminates his or her contract.

You must be under the care of the *participating provider* at the time the provider's contract terminates. The terminated provider must agree in

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

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

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by us in consultation with you and the terminated provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.
3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.
4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.
5. Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the date the provider's contract terminates.

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

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

BINDING ARBITRATION

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

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

THIS MEANS THAT YOU AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AND/OR ANTHEM BLUE CROSS AGREE TO BE BOUND BY THIS ARBITRATION PROVISION AND ACKNOWLEDGE THAT THE RIGHT TO A JURY TRIAL OR TO PARTICIPATE IN A CLASS ACTION IS WAIVED FOR BOTH

DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND MEDICAL MALPRACTICE CLAIMS.

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

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

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

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

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, we will assume all or a portion of the Insured's costs of the arbitration. Unless you, Anthem Blue Cross Life and Health Insurance Company and/or Anthem Blue Cross agree otherwise, the arbitrator may not consolidate more than one person's claims, and may not otherwise preside over any form of a representative or class proceeding. Anthem Blue Cross Life and Health and/or Anthem Blue Cross will provide Insureds, upon request, with an application, or information on how to obtain an application from the neutral arbitration entity, for relief of all or a portion of their share of the

fees and expenses of the neutral arbitration entity. Approval or denial of an application in the case of extreme financial hardship will be determined by the neutral arbitration entity.

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

NOTE: If you wish to appeal a decision made by *Medicare* and not by us, you must initiate the appeal process by contacting your local Social Security Administration office.

DEFINITIONS

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

Benefit period, as defined by *Medicare* for inpatient *hospital* and *skilled nursing facility* services (Part A), begins when you first enter a *hospital* after your *Medicare* insurance begins. In no event will a new benefit period start until you have been discharged and have remained out of the *hospital* or other facility as an inpatient for at least 60 consecutive days. For medical services (Part B), Benefit period is defined as a calendar year.

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

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

Contracting hospital is a hospital which has a Standard Hospital Contract with us to provide care to you.

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

Creditable coverage is any individual or group plan that provides medical, hospital and surgical coverage, including continuation 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.

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

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 *insured person* reasonably perceives could permanently endanger health if medical treatment is not received immediately. We will have sole and final determination as to whether services were rendered in connection with an emergency.

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

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

Family member means the *insured employee's* enrolled *spouse or domestic partner*.

Group refers to the business entity to which we have issued this *policy*. The name of the group is LOS ANGELES CITY EMPLOYEES' RETIREMENT SYSTEM (LACERS).

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 for the acute phase of a *mental or nervous disorder*, or substance abuse, "hospital" also includes *psychiatric health facilities*.

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 to a live birth after a year or more of regular sexual relations without contraception.

Insured employee (employee) is the primary insured; that is, the person who is allowed to enroll under this *plan* for himself or herself and his or her eligible *spouse or domestic partner*.

Insured person is the *retiree or covered spouse or domestic partner* of the retiree. An insured person may enroll under only one health plan provided by Anthem Blue Cross Life and Health, or any of its affiliates, which is sponsored by the *group*.

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

Medically necessary services, procedures, equipment or supplies are those which are:

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 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.

NOTE: We will accept *Medicare's* determination of medical necessity.

Medicare is the name commonly used to describe "Health Insurance Benefits for the Aged and Disabled" provided under Public Law 89-97 and its amendments.

Medicare co-payment is that portion of the Medicare approved amount not paid by Medicare for covered inpatient *hospital* days, lifetime reserve days, *skilled nursing facility* days and Professional (Part B) services, not including amounts applied to the Part A or Part B deductibles. Medicare may increase the co-payment amounts for certain services.

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").

Negotiated rate is the amount *participating providers* agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by Prudent Buyer Plan Participating Provider Agreements.

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 providers are licensed health care providers which are not *participating providers*. They do not have a Prudent Buyer Plan Participating Provider Agreement in effect with us at the time services are rendered.

Participating providers are licensed health care providers that have a Prudent Buyer Plan Participating Provider Agreement in effect with us at the time services are rendered.

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 chiropractor (D.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**
- 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 Member Services 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 *policy* we have issued to the *group*. If changes are made to the plan, an amendment or revised booklet will be issued to the *group* for distribution to each *employee* affected by the change. (The word "plan" here does not mean the same as "plan" as used in ERISA.)

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

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

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 charge is a charge we consider not to be excessive based on the circumstances of the care provided, including: (1) level of skill; experience involved; (2) the prevailing or common cost of similar services or supplies; and (3) any other factors which determine value.

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.

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

Severe mental disorders include the following psychiatric diagnoses specified in California Insurance Code section 10144.5: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, and bulimia.

"Severe mental disorders" also includes serious emotional disturbances of a child as indicated by the presence of one or more mental disorders as identified in the 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).

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. The term “skilled nursing facility” includes *residential treatment center*.

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

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

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

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

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

United States means all the States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, the Northern Mariana Islands, Guam and American Samoa.

We (us, our) refers to Anthem Blue Cross Life and Health Insurance Company.

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

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

INDEPENDENT MEDICAL REVIEW OF DENIALS OF EXPERIMENTAL OR INVESTIGATIVE TREATMENT

If coverage for a proposed treatment is denied because we determine that the treatment is *experimental* or *investigative*, you may ask that the denial be reviewed by an external independent medical review organization contracting with the California Department of Insurance ("CDI"). Your request for this review may be submitted to the CDI. You pay no application or processing fees of any kind for this review. You have the right to provide information in support of your request for review. A decision not to participate in this review process may cause you to forfeit any statutory right to pursue legal action against us regarding the disputed health care service. We will send you an application form and an addressed envelope for you to use to request this review with any grievance disposition letter denying coverage for this reason. You may also request an application form by calling us at the telephone number listed on your identification card or write to us at Anthem Blue Cross Life and Health Insurance Company, 21555 Oxnard Street, Woodland Hills, CA 91367. To qualify for this review, all of the following conditions must be met:

- You have a life-threatening or seriously debilitating condition, 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 be requested by you or by a licensed board certified or board eligible *physician* qualified to treat your condition. The treatment requested must be likely to be more beneficial for you than standard treatments based on two documents of scientific and medical evidence from the following sources:
 - a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized standards;

- b) Medical literature meeting the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database of Health Services Technology Assessment Research (HSTAR);
- c) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;
- d) Either of the following: (i) The American Hospital Formulary Service's Drug Information, or (ii) the American Dental Association Accepted Dental Therapeutics;
- e) Any of the following references, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: (i) the Elsevier Gold Standard's Clinical Pharmacology, (ii) the National Comprehensive Cancer Network Drug and Biologics Compendium, or (iii) the Thomson Micromedex DrugDex;
- f) Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and
- g) Peer reviewed abstracts accepted for presentation at major medical association meetings.

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

You are not required to go through our grievance process for more than 30 days. If your grievance needs expedited review, you are not required to go through our grievance process for more than three days.

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

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

INDEPENDENT MEDICAL REVIEW OF GRIEVANCES INVOLVING A DISPUTED HEALTH CARE SERVICE

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

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

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

1. (a) Your provider has recommended a health care service as *medically necessary*, or
(b) You have received *urgent care* or *emergency services* that a provider determined was *medically necessary*, or
(c) You have been seen by a provider for the diagnosis or treatment of the medical condition for which you seek independent review;
2. The disputed health care service has been denied, modified, or delayed by us, based in whole or in part on a decision that the health care service is not *medically necessary*; and

3. You have filed a grievance with us and the disputed decision is upheld or the grievance remains unresolved after 30 days. If your grievance requires expedited review you need not participate in our grievance process for more than three days. The CDI may waive the requirement that you follow our grievance process in extraordinary and compelling cases.

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

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

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

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

FOR YOUR INFORMATION

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. 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. Obtain 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.

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

LANGUAGE ASSISTANCE PROGRAM

Anthem Blue Cross Life and Health introduced its Language Assistance Program to provide certain written translation and oral interpretation services to California *insured persons* with limited English proficiency.

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

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

- Spanish
- Chinese
- Vietnamese
- Korean
- Tagalog

Oral interpretation services are available in additional languages.

To requesting a written or oral translation, please 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.

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

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IDENTITY PROTECTION SERVICES

Identity protection services are available with our Anthem health plans. To learn more about these services, please visit www.anthem.com/resources.

STATEMENT OF RIGHTS UNDER THE NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However the plan or issuer may pay for a shorter stay if the attending *physician* (e.g., your *physician*, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

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

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

This *plan*, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the

breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). If you have any questions about this coverage, please call us at the member services telephone number listed on your ID card.



Get help in your language

Notice of Language Assistance

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

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

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

Spanish

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

Arabic

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

Armenian

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

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

Chinese

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

Farsi

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

Hindi

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

Hmong

Tsis Xam Tus Nqi Cov Kev Pab Cuam Ntsig Txog Hom Lus. Koj muaj peev xwm tau txais ib tus neeg txhais lus. Koj muaj peev xwm tau txais cov ntaub ntauv nyeem ua koj hom lus rau koj mloog thiab yuav xa ib co ntaub ntauv sau ua koj hom lus tuaj rau koj. Txog rau kev pab, hu rau peb tus nab npawb xov tooj teev tseg cia nyob rau ntawm koj daim ID los sis 1-888-254-2721. Txog rau kev pab ntxiv, hu xov tooj rau Pab Kas Phais Lub Chaw Ua Hauj Lwm CA tus xov tooj 1-800-927-4357. (TTY/TDD: 711)

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Japanese

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

Khmer

សេវាភាសាភាគីភីភី។ អ្នកអាចទទួលបានសេវាបកប្រែឬអ្នកបកប្រែ។ អ្នកអាចឱ្យអ្នកអាចទទួលបានសេវាបកប្រែឬអ្នកបកប្រែ និងស្តីពីការស្នើសុំឱ្យអ្នកជាភាសាបកប្រែ។ ដើម្បីទទួលបានជំនួយ សូមហៅទូរស័ព្ទមកយើងតាមលេខដែលបានរាយនាមនៅលើប័ណ្ណ ID របស់អ្នក ឬលេខ 1-888-254-2721។ ដើម្បីទទួលបានជំនួយបន្ថែម សូមហៅទូរស័ព្ទទៅ CA Dept. of Insurance តាមលេខ 1-800-927-4357។(TTY/TDD: 711)

Korean

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

Punjabi

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

Russian

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

Tagalog

Mga Libreng Serbisyo para sa Wika. Maaari kayong kumuha ng interpreter. Maaari ninyong ipabasa ang mga dokumento at ipadala ang ilan sa mga ito sa inyo sa wikang ginagamit ninyo. Para sa tulong,

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tawagan kami sa numerong nakalista sa inyong ID card o sa 1-888-254-2721. Para sa higit pang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. (TTY/TDD: 711)

Thai

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

Vietnamese

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

It's important we treat you fairly

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