

**LOS ANGELES CITY EMPLOYEES' RETIREMENT
SYSTEM**

January 1, 2018

***Non-CA PPO – Member age 65+ with only
Medicare Part B and Part D***

PPO
(non-California resident)

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

COMPLAINT NOTICE

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

**Anthem Blue Cross Life and Health Insurance Company
Member Services
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 Division, 11th Floor
300 South Spring Street
Los Angeles, California 90013**

1-800-927-HELP (4357) – In California

1-213-897-8921 – Out of California

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

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

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CERTIFICATE OF INSURANCE

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

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TYPES OF PROVIDERS

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

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

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

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

- If your *plan* identification card (ID card) shows a PPO suitcase logo and:
 - You go to a PPO Provider, you will get the higher level of benefits of this *plan*.
 - You go to a Traditional Provider because there are no PPO Providers in your area, you will get the higher level of benefits of this *plan*.
- If your ID card does NOT have a PPO suitcase logo, you must go to a Traditional Provider to get the higher level of benefits of this *plan*.
- **How to Access Primary and Specialty Care Services**
- Your health plan covers care provided by primary care *physicians* and specialty care providers. To see a primary care *physician*, simply visit any *participating provider physician* who is a general or family practitioner, internist or pediatrician. Your health plan also covers care provided by any *participating provider* specialty care provider you choose (certain providers' services are covered only upon referral of an M.D. (medical doctor) or D.O. (doctor of osteopathy), see "Physician," below). Referrals are never needed to visit any *participating provider* specialty care provider including a behavioral health care provider.

- To make an appointment call your *physician's* office:
- Tell them you are a Prudent Buyer Plan *member*.
- Have your Member ID card handy. They may ask you for your group number, member I.D. number, or office visit copay.
- Tell them the reason for your visit.
- When you go for your appointment, bring your Member ID card.
- After hours care is provided by your *physician* who may have a variety of ways of addressing your needs. Call your *physician* for instructions on how to receive medical care after their normal business hours, on weekends and holidays. This includes information about how to receive non-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.

Please call the toll-free BlueCard Provider Access number on your ID card to find a *participating provider* in your area. A directory of PPO Providers is available. You can get a directory from your plan administrator (usually your employer).

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

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

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

Physicians. "Physician" means more than an M.D. Certain other practitioners are included in this term as it is used throughout the *plan*. This doesn't mean they can provide every service that a medical doctor could; it just means that we'll cover expense you incur from them when they're practicing within their specialty the same as we would if the care were provided by a medical doctor.

Other Health Care Providers. "Other Health Care Providers" are neither *physicians* nor *hospitals*. See the definition of "Other Health Care Providers" in the DEFINITIONS section for a complete list of those providers. *Other health care providers* are not participating providers.

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

Care Outside the United States— Blue Cross Blue Shield Global Core

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

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

Payment Information

- **Participating Blue Cross Blue Shield Global Core hospitals.** In most cases, you should not have to pay upfront for inpatient care at participating Blue Cross Blue Shield Global Core *hospitals* except for the out-of-pocket costs you normally pay (noncovered services, deductible, copays, and coinsurance). The *hospital* should submit your claim on your behalf.
- **Doctors and/or non-participating hospitals.** You will have to pay upfront for outpatient services, care received from a *physician*, and inpatient care from a *hospital* that is not a participating Blue Cross Blue Shield Global Core *hospital*. Then you can complete a Blue Cross Blue Shield Global Core claim form and send it with the original bill(s) to the Blue Cross Blue Shield Global Core Service Center (the address is on the form).

Claim Filing

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

Additional Information About Blue Cross Blue Shield Global Core Claims.

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

Claim Forms

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

www.bcbsglobalcore.com.

The address for submitting claims is on the form.

Timely Access to Care

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

- **Urgent Care appointments for services that do not require prior authorization:** within forty-eight (48) hours of the request for an appointment;
- **Urgent Care appointments for services that require prior authorization:** within ninety-six (96) hours of the request for an appointment;
- **Non-Urgent appointments for primary care:** within ten (10) business days of the request for an appointment;
- **Non-Urgent appointments with specialists:** within fifteen (15) business days of the request for an appointment;

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

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

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

SUMMARY OF BENEFITS

THIS PLAN IS INTENDED ONLY FOR *MEMBERS* WHO HAVE *MEDICARE* PART B COVERAGE. THE BENEFITS DESCRIBED IN THIS BOOKLET ARE PAYABLE FOR COVERED SERVICES TO SUPPLEMENT *MEDICARE* PART B BENEFITS, EXCEPT AS SPECIFICALLY STATED IN THE SECTION ENTITLED BENEFITS NOT COVERED UNDER *MEDICARE* PART B.

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

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

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

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

The benefits provided in this certificate are subject to applicable federal and California laws. There are some states that require more generous benefits be provided to their residents even if the master policy was not issued in their state. If your state has such requirements, we will adjust your benefits to meet the minimum requirements.

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

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

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

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

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

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

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> may be subject to the REIMBURSEMENT FOR ACTS OF THIRD PARTIES section.

LIFETIME MAXIMUM

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

MEDICARE PART B MEDICAL BENEFITS

BENEFITS TO SUPPLEMENT MEDICARE PART B

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 Center for Medicare and Medicaid Services, or refer to its publications.

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 **100%** of the difference between *Medicare’s* Allowable Charge(s) and the amount *Medicare* pays for *medically necessary* Part B services and supplies, SUBJECT TO ANY MAXIMUMS STATED BELOW.

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 BlueCard PPO 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 BlueCard PPO network (*participating provider*). *Participating providers* have agreed to accept our *maximum allowed amount* 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 *maximum allowed amount*.

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.

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 *maximum allowed amount* 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 *maximum allowed amount* 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 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.

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.

Note: *Non-participating providers* may not consider the combined *Medicare* and Anthem Blue Cross Life and Health 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 health conditions*.
- 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
- Contraceptive services and supplies, limited to injectable drugs and implants for birth control, IUDs and diaphragms dispensed by a *physician*, and the services of a *physician* in connection with the prescribing, fitting, and insertion of intrauterine contraceptive devices or diaphragms.

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

- Diabetes instruction program which: (1) is designed to teach a *member* who is a patient and covered members of the patient's family about the disease process and the daily management of diabetic therapy; (2) includes self-management training, education, and medical nutrition therapy to enable the *member* to properly use the equipment, supplies, and medications necessary to manage the disease; and (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.
- Home Health Care (limited to our maximum benefit of 60 visits per calendar year)
- The first pair of contact lenses or the first pair of eyeglasses following eye surgery.
- Physical therapy and occupational therapy.
- Chiropractic Care when approved by Medicare.

- Speech therapy.
- Temporomandibular Joint Disorders
- Outpatient care for *mental health conditions*.*
- Outpatient care for substance abuse.*

***Exception:** Medicare will pay 50% of *Medicare's* Allowable Charge for covered professional services and supplies for mental health conditions and Substance Abuse. We will pay 50% of *Medicare's* Allowable Charge for covered professional services and supplies for mental health conditions and substance abuse. In addition, the section entitled **Important Information Regarding the BlueCard PPO Network (Part B Professional Services Only)** as stated above will also apply.

BENEFITS NOT COVERED BY MEDICARE PART B

- Non-Certification Deductible **\$300**

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

- The Non-Certification Deductible will not apply to *emergency* admissions or services. See UTILIZATION REVIEW PROGRAM.

CO-PAYMENTS

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

- *Participating Providers* **10%**
- *Other Health Care Providers* **20%**
- *Non-Participating Providers* **30%**

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

***Exceptions:**

- Office visits for chiropractic care services, to a *physician* who is a *participating provider*, will be paid at **100%** of the *maximum allowed amount* after you have made a **\$15** co-payment.

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

- Your Co-Payment for inpatient hospital benefits provided by *non-participating providers* will be **20%**. You will be responsible for charges which exceed the *maximum allowed amount*.
- Your Co-Payment for the services of all providers will be **20%** of the *maximum allowed amount* incurred, when those services are provided for home infusion therapy *drugs*.
- Your Co-Payment for the services of all providers will be **20%** of the *maximum allowed amount* incurred, when those services are provided for private duty nursing.
- You will not be required to pay a Co-Payment for:
 - a. Preventive Care services; and
 - b. Hearing Aids.
- Your Co-Payment for *non-participating providers* will be the same as for *participating providers* for the following services. You will be responsible for charges which exceed the *maximum allowed amount*.
 - a. All *emergency services*; or
 - b. An *authorized referral* from us to a *non-participating provider*; or
 - c. *Non-emergency services* received at a *participating hospital* or facility at which, or as a result of which, you receive services from a *non-participating provider*, in specified circumstances. Please see “Cost Share” in the YOUR MEDICAL BENEFITS section for more information.
- If you receive services from an *other health care provider* of a type participating in a Blue Cross and/or Blue Shield Plan, your Co-Payment if you go to a provider participating in the Blue Cross and/or Blue Shield Plan will be the same as for a *participating provider* shown above. But, if you go to a provider not participating in the Blue Cross and/or Blue Shield Plan, your

Co-Payment will be the same as for *non-participating provider* shown above.

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

Inpatient Services

- *Participating Providers*.....10%
- *Non-Participating Providers*.....30%

Outpatient Office Visit Services

- *Participating Providers*.....10%
- *Non-Participating Providers*.....30%

Other Outpatient Items and Services

- *Participating Providers*..... 10%
- *Non-Participating Providers*.....30%

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

- Your Co-Payment for *non-participating providers* will be the same as for *participating providers* for the following services. You may be responsible for charges which exceed the *maximum allowed amount*.
 - a. All *emergency services*;
 - b. An *authorized referral* from a *physician* who is a *participating provider* to a *non-participating provider*;
 - c. Charges by a type of *physician* not represented in the Prudent Buyer Plan network or the Blue Cross and/or Blue Shield Plan;
 - d. Cancer Clinical Trials; or

- e. *Non-emergency services* received at a *participating hospital* or facility at which, or as a result of which, you receive services from a *non-participating provider*, in specified circumstances. Please see “Cost Share” in the YOUR MEDICAL BENEFITS section for more information.
- If you receive services from a category of provider defined in this certificate as an *other health care provider* but such a provider participates in the Blue Cross and/or Blue Shield Plan in that service area, your Co-Payment will be as follows:
 - a. if you go to a *participating provider*, your Co-payment will be the same as for *participating providers*.
 - b. if you go to a *non-participating provider*, your Co-Payment will be the same as for *non-participating providers*.
- If you receive services from a category of provider defined in this certificate as a *participating provider* that is **not** available in the Blue Cross and/or Blue Shield Plan in that service area, your Co-Payment will be the same as for *participating providers*.
- Co-Payments do not apply to transgender travel expenses authorized by us. Transgender travel expense coverage is available when the facility at which the surgery or series of surgeries will be performed is 75 miles or more from the *insured person’s* residence.

Out-of-Pocket Amount*. After you have made **\$5,000** in total out-of-pocket payments for covered services you incur during a *calendar year*, you will no longer be required to pay a Co-Payment for the remainder of that *year*, but you remain responsible for costs in excess of the *maximum allowed amount*.

***Exception:**

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

MEDICAL BENEFIT MAXIMUMS

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

Skilled Nursing Facility

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

Hospice Care

- For bereavement counseling**\$25**
per visit; up to four visits during
the 12 months following your death

Private Duty Nursing

- For covered private duty nursing care**\$1,000**
per calendar year

Hearing Aids

- Hearing aids and all services related to making
and fitting hearing aids**\$2,000**
per ear, per 36 month period

Christian Science Benefit

- 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*

Acupuncture

- For all covered services..... **\$30**
per visit, for up to 12 visits
per *calendar year*

Chiropractic Care

- For covered outpatient services **30**
combined visits per *calendar year after*
Medicare approved visits are exhausted

YOUR MEDICAL BENEFITS

MAXIMUM ALLOWED AMOUNT

General

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

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

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

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

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

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

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

Provider Network Status

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

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

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

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

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

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

Non-Participating Providers and Other Health Care Providers.*

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

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

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

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

Please see the "Inter-Plan Arrangements" section in the Part entitled "GENERAL PROVISIONS" for additional information.

***Exceptions:**

- **Emergency Services Provided by Non-Participating Providers.** For *emergency services* provided by *non-participating providers*, reimbursement is based on the greater of the following:
 1. the median of our *participating provider* rates for the *emergency service*, excluding any *participating provider* copayment or coinsurance;
 2. the amount for the *emergency service* calculated using the same method we generally use to determine payments for *non-participating provider* services, excluding any *participating provider* copayment or coinsurance;
 3. the amount that would be paid under Medicare for the *emergency service*, excluding any *participating provider* copayment or coinsurance.
- **Cancer Clinical Trials.** The *maximum allowed amount* for services and supplies provided in connection with Cancer Clinical Trials will be the lesser of the billed charge or the amount that ordinarily applies when services are provided by a *participating provider*.
- **If Medicare is the primary payor, the *maximum allowed amount* does not include any charge:**
 1. By a *hospital*, in excess of the approved amount as determined by Medicare; or

2. By a *physician* who is a *participating provider* who accepts Medicare assignment, in excess of the approved amount as determined by Medicare; or
 3. By a *physician* who is a *non-participating provider* or *other health care provider* who accepts Medicare assignment, in excess of the lesser of *maximum allowed amount* stated above, or the approved amount as determined by Medicare; or
 4. By a *physician* or *other health care provider* who does not accept Medicare assignment, in excess of the lesser of the *maximum allowed amount* stated above, or the limiting charge as determined by Medicare.
- **Services received in *participating* hospitals or facilities from *non-participating* providers.** If you receive covered non-emergency services at a *participating hospital* or facility at which, or as a result of which, you receive services from a *non-participating provider*, the *maximum allowed amount* will be based on the greater of the average contracted rate or 125 percent of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered.

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

Cost Share

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

Anthem Blue Cross Life and Health will not provide any reimbursement for non-covered services. You may be responsible for the total amount billed by your provider for non-covered services, regardless of whether such services are performed by a *participating provider* or *non-participating provider*. Non-covered services include services specifically

excluded from coverage by the terms of your plan and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, Medical Benefit Maximums or day/visit limits.

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

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

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

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

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

(5) The consent and estimate shall be provided to you in the language spoken by you, if the language is a Medi-Cal threshold language, as

defined in state law (subdivision (d) of Section 128552 of the Health and Safety Code).

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

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

Authorized Referrals

In some circumstances we may authorize *participating provider* cost share amounts (Deductibles or Co-Payments) to apply to a claim for a covered service you receive from a *non-participating provider*. In such circumstance, you or your *physician* must contact us in advance of obtaining the covered service. It is your responsibility to ensure that we have been contacted. If we authorize a *participating provider* cost share amount to apply to a covered service received from a *non-participating provider*, you also may still be liable for the difference between the *maximum allowed amount* and the *non-participating provider's* charge. In certain situations, however, if you receive non-emergency covered services at a *participating hospital* or facility at which, or as a result of which, you receive services from a *non-participating provider*, you will pay no more than the cost sharing that you would pay for the same covered services received from a *participating provider*. Please see "Cost Share" in the YOUR MEDICAL BENEFITS section for more information. If you receive prior authorization for a *non-participating provider* due to network adequacy issues, you will not be responsible for the difference between the *non-participating provider's* charge and the *maximum allowed amount*. Please call the Member Services telephone number on your ID card for *authorized referral* information or to request authorization.

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

(NOT APPLICABLE TO BENEFITS COVERED BY MEDICARE PART B)

After we subtract any applicable deductible and your Co-Payment, we will pay benefits up to the *maximum allowed amount*, not to exceed the applicable Medical Benefit Maximum. The Deductible amounts, Co-Payments, Out-Of-Pocket Amounts and Medical Benefit Maximums are set forth in the SUMMARY OF BENEFITS.

DEDUCTIBLE

Each time you are admitted to a *hospital* or have outpatient surgery at an *ambulatory surgical center* without properly obtaining certification, you are responsible for paying the Non-Certification Deductible. This deductible will not apply to an *emergency* admission or procedure. Certification is explained in UTILIZATION REVIEW PROGRAM.

CO-PAYMENTS

After you have satisfied any applicable deductible, we will subtract your Co-Payment from the *maximum allowed amount* remaining.

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

OUT-OF-POCKET AMOUNTS

Satisfaction of the Out-Of-Pocket Amount. If, after you pay Co-Payments equal to your Out-Of-Pocket Amount per *insured person* during a *calendar year*, you will no longer be required to make Co-Payments for any additional covered services or supplies during the remainder of that *year* except as specifically stated under Charges Which Do Not Apply Toward the Out-of-Pocket Amount below.

Participating Providers and Other Health Care Providers. Only covered charges up to the *maximum allowed amount* for the services of a *participating provider* or *other health care provider* will be applied to the *participating provider* and *other health care provider* Out-Of-Pocket Amount.

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

Non-Participating Providers. Only covered charges up to the *maximum allowed amount* for the services of a *non-participating provider* will be applied to the *non-participating provider* Out-Of-Pocket Amount. After this Out-Of-Pocket Amount per *insured person* has been satisfied during a *calendar year*, you will no longer be required to make any Co-Payment for the covered services provided by a *non-participating provider* for the remainder of that *year*.

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

- Charges for services or supplies not covered under this plan;
- Charges which exceed the *maximum allowed amount*; and
- Any expense applied to a deductible.

MEDICAL BENEFIT MAXIMUMS

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

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

CONDITIONS OF COVERAGE

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

1. You must incur this expense while you are covered under this *plan*. Expense is incurred on the date you receive the service or supply for which the charge is made.
2. The expense must be for a medical service or supply furnished to you as a result of illness or injury or pregnancy, unless a specific exception is made.
3. The expense must be for a medical service or supply included in MEDICAL CARE THAT IS COVERED. Additional limits on covered charges are included under specific benefits and in the SUMMARY OF BENEFITS.

4. The expense must not be for a medical service or supply listed in MEDICAL CARE THAT IS NOT COVERED. If the service or supply is partially excluded, then only that portion which is not excluded will be covered under this plan.
5. The expense must not exceed any of the maximum benefits or limitations of this *plan*.
6. Any services received must be those which are regularly provided and billed by the provider. In addition, those services must be consistent with the illness, injury, degree of disability and your medical needs. Benefits are provided only for the number of days required to treat your illness or injury.
7. All services and supplies must be ordered by a *physician*.

**MEDICAL CARE THAT IS COVERED (NOT COVERED UNDER
MEDICARE PART B)**

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

Hospital

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

*Including 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*.

2. Services in *special care units*.

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

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

*Including 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*.

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

1. Interdisciplinary team care with the development and maintenance of an appropriate plan of care.
2. Short-term inpatient *hospital* care when required in periods of crisis or as respite care. Coverage of inpatient respite care is provided on an occasional basis and is limited to a maximum of five consecutive days per admission.
3. Skilled nursing services provided by or under the supervision of a registered nurse. Certified home health aide services and homemaker services provided under the supervision of a registered nurse.
4. Social services and counseling services provided by a qualified social worker.
5. Dietary and nutritional guidance. Nutritional support such as intravenous feeding or hyperalimentation.
6. Physical therapy, occupational therapy, speech therapy, and respiratory therapy provided by a licensed therapist.
7. Volunteer services provided by trained *hospice* volunteers under the direction of a *hospice* staff member.
8. Pharmaceuticals, medical equipment, and supplies necessary for the management of your condition. Oxygen and related respiratory therapy supplies.
9. Bereavement services, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following the *employee's* or the *insured family member's* death. Bereavement services are available to surviving members of the immediate family for a period of one year after the death. Your immediate family means your spouse, children, step-children, parents, and siblings. Bereavement counseling for your family, limited to four visits in the 12-month period after your death. Benefits are limited to **\$25** for each visit.
10. Palliative care (care which controls pain and relieves symptoms, but does not cure) which is appropriate for the illness.

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

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

1. Medication, ancillary medical supplies and supply delivery, (not to exceed a 14-day supply); but medication which is delivered but not administered is not covered;
2. Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications.
3. Total Parenteral Nutrition (TPN), Enteral Nutrition Therapy, antibiotic therapy, pain management, chemotherapy, and may also include injections (intra-muscular, subcutaneous, or continuous subcutaneous).

Hospital and home clinical visits related to the administration of infusion therapy, rental or purchase of durable medical equipment (including maintenance and repair) and laboratory services to monitor the patient's response to therapy regimen are paid at 20% of the *maximum allowed amount* after the Medicare Part B deductible is paid.

Home infusion therapy provider services are subject to prior authorization to determine medical necessity. See UTILIZATION REVIEW PROGRAM for details.

Hearing Aids. Hearing aids or services related to the fitting or making of a hearing aid, limited to **\$2,000** per ear, per 36 month period.

Pregnancy and Maternity Care

1. All medical benefits for an enrolled *insured person* when provided for pregnancy or maternity care, including the following services:
 - Prenatal, postnatal and postpartum care;
 - Prenatal testing administered by the California Prenatal Screening Program, which is a statewide prenatal testing program administered by the State Department of Public Health. The *calendar year* deductible will not apply and no copayment will be required for services you receive as part of this program;

- Ambulatory care services (including ultrasounds, fetal non-stress tests, *physician* office visits, and other *medically necessary* maternity services performed outside of a *hospital*);
 - Involuntary complications of pregnancy;
 - Diagnosis of genetic disorders in cases of high-risk pregnancy; and,
 - Inpatient *hospital* care including labor and delivery.
1. Inpatient *hospital* benefits in connection with childbirth will be provided for at least 48 hours following a normal delivery or 96 hours following a cesarean section, unless the mother and her *physician* decide on an earlier discharge. Please see the section entitled FOR YOUR INFORMATION for a statement of your rights under federal law Medical *hospital* benefits for routine nursery care of a newborn *child*, if the *child's* natural mother is an *insured person*. Routine nursery care of a newborn child includes screening of a newborn for genetic diseases, congenital conditions, and other health conditions provided through a program established by law or regulation.

Organ and Tissue Transplants. Services provided in connection with a non-investigative organ or tissue transplant, if you are: (1) the organ or tissue recipient; or (2) the organ or tissue donor.

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

The *maximum allowed amount* does not include charges for services received without first obtaining prior authorization from us, or which are provided at a facility other than an approved transplant center. See UTILIZATION REVIEW PROGRAM.

Mental Health Conditions or Substance Abuse. Covered services shown below for the treatment of *mental health conditions* or substance abuse, provided such services: 1) are for inpatient *hospital* services as stated in the "Hospital" provision of this section, 2) offer a reasonable expectation of improvement, and 3) are the lowest level of care consistent with safe medical practice.

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

UTILIZATION REVIEW PROGRAM for details). No benefits are payable for these services if pre-service review is not obtained.

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

Preventive Care. In addition to any services specified elsewhere in the certificate, we will pay for the following services

1. A *physician's* services for routine physical examinations.
2. Immunizations given as standard medical practice.
3. Vision and hearing screenings.
4. Radiology and laboratory services and tests ordered by the examining *physician* in connection with a routine physical examination.

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

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

Allergy. Allergy testing and treatment, including allergy serum.

Christian Science Benefit. Benefits for the following services will be provided when an *insured person* 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 *insured person* 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 *insured person'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 MEDICAL CARE THAT IS NOT COVERED apply equally to Christian Science benefits as to all other benefits and providers of care.

Acupuncture. The services of a *physician* for acupuncture treatment to treat a disease, illness or injury, including a patient history visit, physical examination, treatment planning and treatment evaluation, electro-acupuncture, cupping and moxibustion.

Chiropractic Care. The services of a *physician* for outpatient chiropractic care provided to treat a disease, illness or injury. This includes care which is provided by osteopaths and chiropractors within the chiropractic scope of practice. Benefits for chiropractic care is limited to 30 visits per *year* after you have exhausted your Medicare approved visits.

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

Private Duty Nursing. Inpatient services of a private duty nurse during a *hospital* or *skilled nursing facility* stay. Our maximum payment for private duty nursing is limited to **\$1,000** per *calendar year*.

MEDICAL CARE THAT IS NOT COVERED

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

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

Experimental or Investigative. Any *experimental* or *investigative* procedure or medication. But, if you are denied benefits because it is determined that the requested treatment is *experimental* or *investigative*, you may request an independent medical review as described in REVIEW OF DENIALS OF EXPERIMENTAL OR INVESTIGATIVE TREATMENT.

Services Received Outside of the United States Services rendered by providers located outside the United States, unless the services are for an *emergency*, emergency ambulance or *urgent care*.

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

Uninsured. Services received before your *effective date* or after your coverage ends, except as specifically stated under EXTENSION OF BENEFITS.

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

Excess Amounts. Any amounts in excess of:

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

3. The Lifetime Maximum for all covered services as stated in the “Lifetime Maximum” provision under SUMMARY OF BENEFITS, and any other maximum payments and benefits stated elsewhere in this booklet.

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

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

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

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

Voluntary Payment. Services for which you are not legally obligated to pay. Services for which you are not charged. Services for which no charge is made in the absence of insurance coverage, except services received at a non-governmental charitable research *hospital*. Such a *hospital* must meet the following guidelines:

1. It must be internationally known as being devoted mainly to medical research;
2. At least **10%** of its yearly budget must be spent on research not directly related to patient care;
3. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;

4. It must accept patients who are unable to pay; and
5. Two-thirds of its patients must have conditions directly related to the *hospital's* research.

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

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

Residential accommodations. Residential accommodations to treat medical or behavioral health conditions, except when provided in a *hospital, hospice, skilled nursing facility or residential treatment center*.

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

Orthodontia. Braces and other orthodontic appliances or services.

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

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

This exclusion does not apply to the following:

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

Hearing Tests. Routine hearing tests, except as specifically provided under the "Preventive Care" provision.

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

Outpatient Speech Therapy. Outpatient speech therapy, except as specifically stated in the “Professional Services and Supplies” provision of MEDICAL BENEFITS (PART B). This exclusion also does not apply to the *medically necessary* treatment of *severe mental disorders*, or to the *medically necessary* treatment of pervasive developmental disorder or autism, to the extent stated in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.

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

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

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

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

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

Sterilization Reversal. Reversal of an elective sterilization.

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

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

Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Orthopedic Supplies. Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes as specifically stated 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 or Rest Cures. Inpatient room and board charges in connection with a *hospital stay* primarily for environmental change or physical therapy. *Custodial care* or rest cures, except as specifically provided under the "Hospice Care" provision of MEDICAL CARE THAT IS COVERED. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a *skilled nursing facility*, except as specifically stated in the "Skilled Nursing Facility" provision of MEDICAL CARE THAT IS COVERED.

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

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

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

Educational or Academic Services. This plan does not cover:

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

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

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

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

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specifically stated under "Covered Services" in the "Professional Services and Supplies" provision of MEDICAL BENEFITS (PART B).

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

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

Drugs Given to you by a Medical Provider. The following exclusions apply to *drugs* you receive from a medical provider:

- **Delivery Charges.** Charges for the delivery of *prescription drugs*.
- **Clinically-Equivalent Alternatives.** Certain *prescription drugs* may not be covered if you could use a clinically equivalent *drug*, unless required by law. "Clinically equivalent" means *drugs* that for most *insured persons*, will give you similar results for a disease or condition. If you have questions about whether a certain *drug* is covered and which *drugs* fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com.

If you or your *physician* believes you need to use a different *prescription drug*, please have your *physician* or pharmacist get in touch with us. We will cover the other *prescription drug* only if we agree that it is *medically necessary* and appropriate over the clinically equivalent *drug*. We will review benefits for the *prescription drug* from time to time to make sure the *drug* is still *medically necessary*.

- **Drugs Contrary to Approved Medical and Professional Standards.** *Drugs* given to you or prescribed in a way that is against approved medical and professional standards of practice.
- **Drugs Over Quantity or Age Limits.** *Drugs* which are over any quantity or age limits set by the *plan* or us.
- **Drugs Over the Quantity Prescribed or Refills After One Year.** *Drugs* in amounts over the quantity prescribed or for any refill given more than one year after the date of the original *prescription*.
- **Drugs Prescribed by Providers Lacking Qualifications, Registrations and/or Certifications.** *Prescription drugs* prescribed by a provider that does not have the necessary qualifications, registrations and/or certifications as determined by us.

- **Drugs That Do Not Need a Prescription.** *Drugs* that do not need a *prescription* by federal law (including *drugs* that need a *prescription* by state law, but not by federal law), except for injectable insulin. This exclusion does not apply to over-the-counter *drugs* that we must cover under state law, or federal law when recommended by the U.S. Preventive Services Task Force, and prescribed by a *physician*.
- **Lost or Stolen Drugs.** Refills of lost or stolen *drugs*.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specifically stated in the "Home Infusion Therapy" provision of MEDICAL CARE THAT IS COVERED section of this booklet. Non-prescription, over-the-counter patent or proprietary drugs or medicines. Cosmetics, health or beauty aids.

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specifically stated under "Covered Services" in the "Professional Services and Supplies" provision of MEDICAL BENEFITS (PART B).

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

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

BENEFITS FOR MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE

This *plan* provides coverage for the *medically necessary* treatment of *mental health conditions* and substance abuse. This coverage is provided according to the terms and conditions of this *plan* that apply to all other medical conditions, except as specifically stated in this section.

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

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

SERVICES FOR MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE THAT ARE COVERED

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

- **Inpatient Services:** Inpatient *hospital* services and services from a *residential treatment center* (including crisis residential treatment) for inpatient services and supplies, and *physician* visits during a covered inpatient *stay*.
- **Outpatient Office Visits** for the following:
 - individual and group mental health evaluation and treatment,
 - nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa,
 - drug therapy monitoring,
 - individual and group chemical dependency counseling,
 - medical treatment for withdrawal symptoms,
 - methadone maintenance treatment, and
 - Behavioral health treatment for pervasive Developmental Disorder or autism delivered in an office setting.
- **Other Outpatient Items and Services:**
 - *Partial hospitalization programs*, including *intensive outpatient programs* and visits to a *day treatment center*.
 - Psychological testing,
 - Multidisciplinary treatment in an intensive outpatient psychiatric treatment program,
 - Behavioral health treatment for Pervasive Developmental Disorder or autism delivered at home.
- **Behavioral health treatment for pervasive developmental disorder or autism.** Inpatient services, office visits, and other outpatient items and services are covered under this section. See the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM for a description of the services that are covered. **Note:** You must obtain pre-service review for all inpatient facility and residential treatment related to behavioral health treatment services for pervasive developmental disorder or autism in order for these

services to be covered by this *plan* (see UTILIZATION REVIEW PROGRAM for details). No benefits are payable for these services if pre-service review is not obtained.

- Diagnosis and all *medically necessary* treatment of *severe mental disorder* of a person of any age and serious emotional disturbances of a child.
- Treatment for substance abuse does not include smoking cessation programs, nor treatment for nicotine dependency or tobacco use. Certain services are covered under the “Preventive Care Services” benefit or as specified in the “Preventive Prescription Drugs and Other Items” covered under YOUR PRESCRIPTION DRUG BENEFITS. Please see those provisions for further details.

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

BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM

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

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

You must obtain pre-service review for all inpatient facility and residential treatment related to behavioral health treatment services for the treatment of Pervasive Developmental Disorder or autism in order for these services to be covered by this *plan* (see UTILIZATION REVIEW PROGRAM for details).

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

DEFINITIONS

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

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

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

Qualified Autism Service Provider is either of the following:

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

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

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

- Provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a Qualified Autism Service Provider.
- Is supervised by a Qualified Autism Service Provider,

- Provides treatment according to a treatment plan developed and approved by the Qualified Autism Service Provider,
- Is a behavioral service provider who meets the education and experience qualifications defined in the state regulations for an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program, or who meets equivalent criteria in the state in which he or she practices if not providing services in California,
- Has training and experience in providing services for Pervasive Developmental Disorder or autism pursuant to applicable state law, and
- Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

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

- Is supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional at a level of clinical supervision that meets professionally recognized standards of practice,
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider,
- Meets the education and training qualifications set forth in any applicable state regulations adopted pursuant to state law concerning the use of paraprofessionals in group practice provider behavioral intervention services,
- Has adequate education, training, and experience, as certified by a Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers, and
- Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

BEHAVIORAL HEALTH TREATMENT SERVICES COVERED

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

functioning of an individual with Pervasive Developmental Disorder or autism and that meet all of the following requirements:

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

REIMBURSEMENT FOR ACTS OF THIRD PARTIES

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

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

from or for the account of such third party as compensation for the injury, illness or condition is less than the actual loss you suffered.

COORDINATION OF BENEFITS

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

DEFINITIONS

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

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

The following are not Allowable Expense:

1. Use of a private hospital room is not an Allowable Expense unless the patient's stay in a private *hospital* room is *medically necessary* in terms of generally accepted medical practice, or one of the plans routinely provides coverage for *hospital* private rooms.
2. If you are covered by two plans that calculate benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method, any amount in excess of the higher of the reasonable and customary amounts.
3. If a person is covered by two plans that provide benefits or services on the basis of negotiated rates or fees, an amount in excess of the lower of the negotiated rates.
4. If a person is covered by one plan that calculates its benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method and another plan provides its benefits or

services on the basis of negotiated rates or fees, any amount in excess of the negotiated rate.

5. The amount of any benefit reduction by the Principal Plan because you did not comply with the plan's provisions is not an Allowable Expense. Examples of these types of provisions include second surgical opinions, utilization review requirements, and network provider arrangements.
6. If you advise us that all plans covering you are high deductible health plans as defined by Section 223 of the Internal Revenue Code, and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code, any amount that is subject to the primary high deductible health plan's deductible.

Other Plan is any of the following:

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

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

1. If This Plan is the Principal Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan.
2. If This Plan is not the Principal Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed Allowable Expense.

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

ORDER OF BENEFITS DETERMINATION

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

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

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

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

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

- a. If the parent with custody of that *child* for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that *child* as a dependent pays first.
- b. If the parent with custody of that *child* for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:
 - i. The plan which covers that *child* as a dependent of the parent with custody.

- ii. The plan which covers that *child* as a dependent of the stepparent (married to the parent with custody).
 - iii. The plan which covers that *child* as a dependent of the parent without custody.
 - iv. The plan which covers that *child* as a dependent of the stepparent (married to the parent without custody).
- c. Regardless of a and b above, if there is a court decree which establishes a parent's financial responsibility for that *child's* health care coverage, a plan which covers that *child* as a dependent of that parent pays first.
4. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But if either plan does not have a provision regarding laid-off or retired employees, provision 6 applies.
5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan do not agree under these circumstances with the Order of Benefit Determination provisions of This Plan, this rule will not apply.
6. When the above rules do not establish the order of payment, the plan on which you have been enrolled the longest pays first unless two of the plans have the same effective date. In this case, Allowable Expense is split equally between the two plans.

OUR RIGHTS UNDER THIS PROVISION

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

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

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

paid under This Plan, and such payment will fully satisfy our liability under this provision.

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

UTILIZATION REVIEW PROGRAM

Your *plan* includes the process of utilization review to decide when services are *medically necessary* or *experimental / investigative* as those terms are defined in this booklet. Utilization review aids the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed. A service must be *medically necessary* to be a covered service. When level of care, setting or place of service is part of the review, services that can be safely given to you in a lower level of care or lower cost setting / place of care, will not be *medically necessary* if they are given in a higher level of care, or higher cost setting / place of care.

Certain services must be reviewed to determine medical necessity in order for you to get benefits. Utilization review criteria will be based on many sources including medical policy and clinical guidelines. We may decide that a treatment that was asked for is not *medically necessary* if a clinically equivalent treatment that is more cost-effective is available and appropriate.

If you have any questions about the information in this section, you may call the Member Services phone number on the back of your Identification Card.

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

1. You must be eligible for benefits;
2. The service or supply must be a covered service under your *plan*;
3. The service cannot be subject to an exclusion under your *plan* (please see MEDICAL CARE THAT IS NOT COVERED for more information); and
4. You must not have exceeded any applicable limits under your *plan*.

TYPES OF REVIEWS

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

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

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

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

- **Continued Stay / Concurrent Review** – A utilization review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment.
 - Both pre-service and continued stay / concurrent reviews may be considered urgent when, in the view of the treating provider or any *physician* with knowledge of your medical condition, without such care or treatment, your life or health or your ability to regain maximum function could be seriously threatened or you could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.
- **Post-service Review** – A review of a service, treatment or admission for a benefit coverage that is conducted after the service has been provided. Post-service reviews are performed when a service, treatment or admission did not need a precertification, or when a needed precertification was not obtained. Post-service reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

Services for which precertification is required (i.e., services that need to be reviewed by us to determine whether they are *medically necessary*) include, but are not limited to, the following:

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

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

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

- ◆ Maternity care of 48 hours or less following a normal delivery or 96 hours or less following a cesarean section, and
- ◆ Mastectomy and lymph node dissection.
- Diagnostic treatment, wherever performed, except when needed for *mental health conditions* and substance abuse.
- Surgical procedures, wherever performed.
- Organ and tissue transplants. Authorizations for organ and tissue transplants will be provided only if the *physicians* on the surgical team and the facility in which the transplant is to take place are approved for the transplant requested.
- Infusion therapy or home infusion therapy, if the attending physician has submitted both a prescription and a plan of treatment before services are rendered.
- Select imaging procedures, including but not limited to: Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scan), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and Nuclear Cardiac Imaging. You may call the toll-free member services telephone number on your identification card to find out if an imaging procedure requires pre-service review.
- All interventional spine pain, elective hip, knee, and shoulder arthroscopic/open sports medicine, and outpatient spine surgery procedures must be authorized in advance.

- Partial hospitalization, intensive outpatient programs, transcranial magnetic stimulation (TMS).
- Behavioral health treatment for pervasive developmental disorder or autism, as specified in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.

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

WHO IS RESPONSIBLE FOR PRECERTIFICATION?

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

Provider Network Status	Responsibility to Get Precertification	Comments
<i>Participating Providers</i>	Provider	<ul style="list-style-type: none"> • The provider must get precertification when required.
<i>Non-Participating Providers</i>	<i>Insured Person</i>	<ul style="list-style-type: none"> • <i>Insured person</i> must get precertification when required. (Call Member Services.) • <i>Insured person</i> may be financially responsible for charges or costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be <i>medically necessary</i>.

Provider Network Status	Responsibility to Get Precertification	Comments
Blue Card Provider	<i>Insured Person</i> (Except for Inpatient Admissions)	<ul style="list-style-type: none"> • <i>Insured person</i> must get precertification when required. (Call Member Services.) • <i>Insured person</i> may be financially responsible for charges or costs related to the service and/or setting in whole or in part if the service and or setting is found to not be <i>medically necessary</i>. • Blue Card Providers must obtain precertification for all Inpatient Admissions.

NOTE: For an *emergency* admission, precertification is not required. However, you, your authorized representative or *physician* must tell us within 24 hours of the admission or as soon as possible within a reasonable period of time.

Failure to Obtain Precertification Penalty for Services from Non-Participating Providers: If you or your *non-participating provider* do not obtain the required precertification for a service from a *non-participating provider*, we will reduce the payment allowance of the *maximum allowed amount* up to **\$300**. Any preauthorization penalty does not apply to *medically necessary* inpatient facility services from a BlueCard provider.

HOW DECISIONS ARE MADE

We use our clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make our medical necessity decisions. This includes decisions about *prescription drugs* as detailed in the section “Prescription Drugs Obtained From Or Administered By a Medical Provider.” Medical policies and clinical guidelines reflect the standards of practice and

medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time.

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

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

DECISION AND NOTICE REQUIREMENTS

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

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

Concurrent Review	of the request
Post-Service Review	30 calendar days from the receipt of the request

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

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

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

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

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

HEALTH PLAN INDIVIDUAL CASE MANAGEMENT

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

HOW HEALTH PLAN INDIVIDUAL CASE MANAGEMENT WORKS

Our health plan individual case management program (Case Management) helps coordinate services for *insured persons* with health

care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate *insured persons* who agree to take part in the Case Management program to help meet their health-related needs.

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

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

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

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

HOW COVERAGE BEGINS AND ENDS

HOW COVERAGE BEGINS

ELIGIBLE STATUS

1. **Insured Employees.** You are eligible to enroll if you are a *retired employee* who is over age 65 and actively enrolled under Part B of *Medicare*, whose usual residence is not in the State of California. A *retired employee* is retired from active full-time or part time employment, and eligible to receive health plan benefits as part of the *group's* pension plan.

2. **Family Members.** The *retired employee's family members* are eligible to enroll provided that the *family members* are actively enrolled under Part A and Part B of *Medicare*.

Definition of Family Member

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

For a domestic partnership, other than one that is legally registered and valid, in order for the *retired employee* to include their domestic partner as a *family member*, the *retired employee* and domestic partner must provide the *group* with a signed LACERS domestic partnership affidavit.

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, 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, the 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 *retired employees*, 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 *retired employee* 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*, provided the enrollment application is on time and in order.
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* 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 or CalCOBRA continuation; or
 - ii. A state Medicaid plan or under a state child health insurance program (SCHIP), including the Healthy Families Program or the Access for Infants and Mothers (AIM) Program.
 - b. You certified in writing at the time you became eligible for coverage under this *plan* that you were declining coverage under this *plan* or disenrolling because you were covered under another health plan as stated above and you were given written notice that if you choose to enroll later, you may be required to wait until the *group's* next open enrollment period to do so.
 - c. Your coverage under the other health plan wherein you were covered as an individual or dependent ended as follows:
 - i. If the other health plan was another employer group health plan or health insurance coverage, including coverage under a COBRA or CalCOBRA continuation, coverage ended because you lost eligibility under the other plan, your coverage under a COBRA or CalCOBRA continuation was exhausted, or employer contributions toward coverage under the other plan terminated. You must properly file an application with the *group* within 60 days after the date your coverage ends or the date employer contributions toward coverage under the other plan terminate.

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

- ii. If the other health plan was a state Medicaid plan or a state child health insurance program (SCHIP), including the Healthy Families Program or the Access for Infants and Mothers (AIM) Program, coverage ended because you lost eligibility under the program. You must properly file an application with the *group* within 60 days after the date your coverage ended.
2. A court has ordered coverage be provided for a *spouse*, *domestic partner* or dependent *child* under your employee health plan and an application is filed within 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.
 - b. If you are enrolling following the birth, adoption, or placement for adoption of a *child*, your *spouse* (if you are already married) or *domestic partner*, who is eligible but not enrolled, may also enroll at that time. Other children may not enroll at that time unless

they qualify under another of these circumstances listed above. Application must be made within 31 days of the birth or date of adoption or placement for adoption.

5. You meet or exceed a lifetime limit on all benefits under another health plan. Application must be made within 31 days of the date a claim or a portion of a claim is denied due to your meeting or exceeding the lifetime limit on all benefits under the other plan.
6. The date the *retired 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, except as specified below:

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

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 *retired employee* under this *plan* may enroll in this *plan*. The *retired employee* may also enroll an eligible *spouse* or *domestic partner* at that time. Persons eligible to enroll as *family members* may enroll only under the *retired employee's plan*. For anyone so enrolling, coverage under this *plan* will begin on the first of January following the end of the Open Enrollment Period.

HOW COVERAGE ENDS

Your coverage ends without notice from us as provided below:

1. If the *policy* terminates, your coverage ends at the same time. This *policy* may be canceled or changed without notice to you.
2. If the *group* no longer provides coverage for the class of *insured persons* to which you belong, your coverage ends on the effective date of that change. If this *policy* is amended to delete coverage for *family members*, a *family member's* coverage ends on the effective date of that change.
3. Coverage for *family members* ends when the *retired 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) still chiefly dependent on the *retired employee, 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 *retired employee* 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 *retired employee* must send proof of the *child's* physical or mental condition within 60-days of the date the *retired employee* 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 *retired employee, 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 *retired employee* 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 suffers a loss because of the *retired employee* failing to notify the *group* of the termination of their marriage or domestic partnership, Anthem Blue Cross Life and Health may seek recovery from the *retired employee* 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 *retired employee* notifies the *group* in writing to cancel coverage for a former *spouse or domestic partner*, if any, immediately upon termination of the *retired employee'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.

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 *policy* 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 *policy* as either an *insured employee* or *insured family member*; and (b) a *child* who is born to or placed for adoption with the *insured employee* during the COBRA continuation period. Qualified Beneficiary does not include 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 *policy*. The events will be referred to throughout this section by number.

1. **For Retired Employees and Insured Family Members.** Cancellation or a substantial reduction of retiree benefits under the *plan* due to the *group's* filing for Chapter 11 bankruptcy, provided that:
 - a. The *policy* expressly includes coverage for retirees; and

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

2. For Family Members:

- a. The death of the *insured employee*;
- b. The *spouse's* divorce or legal separation from the *insured employee*; or
- c. The end of a *domestic partner's* partnership with the *insured employee*.
- d. The end of a *child's* status as a dependent *child*, as defined by the *policy*; or

ELIGIBILITY FOR COBRA CONTINUATION

An *insured employee* or *insured family member* may choose to continue coverage under the *policy* if 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 *insured employee* or *family member* of the right to continue coverage under COBRA, as provided below:

- 1. For Qualifying Events 1 or 2 above, the *insured employee* 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 Insured Family Members. A *spouse, domestic partner or child* acquired during the COBRA continuation period is eligible to be enrolled as a *family member*. The standard enrollment provisions of the *policy* apply to enrollees during the COBRA continuation period.

Cost of Coverage. 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 *insured employee*, the *insured employee's* rate also applies to:

1. A *spouse* whose COBRA continuation began due to divorce, separation or death of the *insured employee*;
2. A *domestic partner* whose COBRA continuation began due to the end of the domestic partnership or death of the *insured employee*;
3. A *child*, if neither the *employee* nor the *spouse* has enrolled for this COBRA continuation coverage (if more than one *child* is so enrolled, the premium will be the two-party or three-party rate depending on the number of *children* enrolled); and
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 Premium Due Date).

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

Premium Rate Change. The premium rates may be changed by us as of any Premium Due Date. Your Health Plan Administrator agrees to provide you with written notice at least 60 days prior to the date any premium rate increase goes into effect.

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

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

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 *policy*.

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 *insured employee*, divorce or legal separation, the end of a domestic partnership, or the end of dependent *child* status;*
2. The date the *policy* terminates;
3. The end of the period for which premiums 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 *policy* remaining in effect, a retired *employee* 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 *employee's* death. But coverage could terminate prior to such time for the *employee*, *spouse* or *domestic partner* in accordance with any of the items above.

Other Coverage Options Besides COBRA Continuation Coverage. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a *spouse's* plan) through the conditions listed under the

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

EXTENSION OF 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 care professionals, *hospitals*, *skilled nursing facilities* and other community agencies are not our agents nor are we, or any of our employees, an employee or agent of any *hospital*, medical group or medical care provider of any type.

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

Inter-Plan Arrangements

Out-of-Area Services

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

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

Inter-Plan Arrangements Eligibility – Claim Types

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

A. BlueCard[®] Program

Under the BlueCard[®] Program, when you receive covered services within the geographic area served by a Host Blue, we will still fulfill our contractual obligations. But, the Host Blue is responsible for: (a)

contracting with its providers; and (b) handling its interactions with those providers.

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

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

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

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

B. Negotiated (non–BlueCard Program) Arrangements

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

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

C. Special Cases: Value-Based Programs

BlueCard[®] Program

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

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

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

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

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

E. Non-participating Providers Outside Our Service Area

1. Allowed Amounts and Member Liability Calculation

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

2. Exceptions

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

F. Blue Cross Blue Shield Global Core[®] Program

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

When you are traveling abroad and need medical care, you can call the Blue Cross Blue Shield Global Core Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177.

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

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

How Claims are Paid with Blue Cross Blue Shield Global Core

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

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

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

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

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

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

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

Terms of Coverage

1. In order for you to be entitled to benefits under the *policy*, both the *policy* and your coverage under the *policy* must be in effect on the date the expense giving rise to a claim for benefits is incurred.

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

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

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

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

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

Other forms of payment arrangement are Payment Innovation Programs. These programs may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner. The programs may vary in methodology and subject area of focus and may be modified by us from time to time, but they will be generally designed to tie a certain portion of a *participating provider's* total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, *participating providers* may be required to make payment to us under the program as a consequence of failing to meet these pre-defined standards. The programs are not intended to affect the *insured person's* access to health care. The

program payments are not made as payment for specific covered services provided to the *insured person*, but instead, are based on the *participating provider's* achievement of these pre-defined standards. The *insured person* is not responsible for any co-payment amounts related to payments made by us or to us under the programs and the member does not share in any payments made by *participating providers* to us under the programs.

Availability of Care. If there is an epidemic or public disaster and you cannot obtain care for covered services, we refund the unearned part of the 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, the provider of service or someone on your behalf, must give us written notice of a claim within 20 days after you incur covered charges under this plan, or as soon as reasonably possible thereafter.

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

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

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

Payment to Providers. We will pay the benefits of this *plan* directly to *contracting hospitals, participating providers,* and medical transportation providers. Also, we may pay *non-contracting hospitals* and other providers of service directly when you assign benefits in writing. If another party pays for your medical care and you assign benefits in writing, we may pay the benefits of this *plan* to that party. These payments will fulfill our obligation to you for those covered services.

Exception: Under certain circumstances we will pay the benefits of this *plan* directly to a provider or third party even without your assignment of benefits in writing. To receive direct payment, the provider or third party must provide us the following:

1. Proof of payment of medical services and the provider's itemized bill for such services;
2. If the *insured employee* does not reside with the patient, either a copy of the judicial order requiring the *insured employee* to provide coverage for the patient or a state approved form verifying the existence of such judicial order which would be filed with us on an annual basis;
3. If the *insured employee* does not reside with the patient, and if the provider is seeking direct reimbursement, an itemized bill with the signature of the custodian or guardian certifying that the services

have been provided and supplying on an annual basis, either a copy of the judicial order requiring the *insured employee* to provide coverage for the patient or a state approved form verifying the existence of such judicial order;

4. The name and address of the person to be reimbursed, the name and policy number of the *insured employee*, the name of the patient, and other necessary information related to the coverage.

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.

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

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

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

We have oversight responsibility for compliance with provider and vendor and subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain

any recoveries made from a provider, vendor, or subcontractor resulting from these audits if the return of the overpayment is not feasible.

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

Plan Administrator - COBRA and ERISA. In no event will we be plan administrator for the purposes of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) or the Employee Retirement Income Security Act (ERISA). The term "plan administrator" refers either to the *group* or to a person or entity other than us, engaged by the *group* to perform or assist in performing administrative tasks in connection with the *group's* health plan. The *group* is responsible for satisfaction of notice, disclosure and other obligations of administrators under ERISA.

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

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

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

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

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

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

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

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

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

Also, under arrangements with some Providers certain discounts, payments, rebates, settlements, incentives, adjustments and/or allowances, including, but not limited to, pharmacy rebates, may be based on aggregate payments made by Anthem 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.

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

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

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

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

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

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

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

GRIEVANCE PROCEDURES

Except where an *insured person's* life or health would be seriously jeopardized, you must first exhaust our internal grievance process before we will grant your request for an external review (see the COMPLAINT NOTICE at the end of this booklet). In no event shall your rights to an external review be any more restrictive than those set forth in the Uniform External Review Model Act established by the National Association of Insurance Commissioners (NAIC), by the Secretary of the federal Department of Health and Human Services (HHS), or within the California state external review act, as applicable under state and federal law. There is no fee for an external review. If you have a question about our internal grievance process, filing a grievance, or the external review process, please call Member Services at the Member Services number listed on your ID card or you may write to us at Anthem Blue Cross Life and Health Insurance Company, 21555 Oxnard Street, Woodland Hills, CA 91367.

If, after our denial, we consider, rely on or generate any new or additional evidence in connection with your claim, we will provide you with that new

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

INDEPENDENT MEDICAL REVIEW OF DENIALS OF EXPERIMENTAL OR INVESTIGATIVE TREATMENT

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

- You have a life-threatening or seriously debilitating condition, described as follows:
 - ◆ A life-threatening condition is a condition or disease where the likelihood of death is high unless the course of the disease is interrupted or a condition or disease with a potentially fatal outcome where the end point of clinical intervention is the patient's survival.
 - ◆ A seriously debilitating condition is a disease or condition that causes major, irreversible morbidity.
- Your *physician* must certify that either (a) standard treatment has not been effective in improving your condition, (b) standard treatment is not medically appropriate, or (c) there is no more beneficial standard treatment covered by this *plan* than the proposed treatment.
- The proposed treatment must either be:

- ◆ Recommended by a *participating provider* who certifies in writing that the treatment is likely to be more beneficial than standard treatments, or
- ◆ Requested by you or by a licensed board certified or board eligible *physician* qualified to treat your condition. The treatment requested must be likely to be more beneficial for you than standard treatments based on two documents of scientific and medical evidence from the following sources:
 - a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized standards;
 - b) Medical literature meeting the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database of Health Services Technology Assessment Research (HSTAR);
 - c) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;
 - d) Either of the following: (i) The American Hospital Formulary Service's Drug Information, or (ii) the American Dental Association Accepted Dental Therapeutics;
 - e) Any of the following references, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: (i) the Elsevier Gold Standard's Clinical Pharmacology, (ii) the National Comprehensive Cancer Network Drug and Biologics Compendium, or (iii) the Thomson Micromedex DrugDex;
 - f) Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and
 - g) Peer reviewed abstracts accepted for presentation at major medical association meetings.

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

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

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

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

INDEPENDENT MEDICAL REVIEW OF GRIEVANCES INVOLVING A DISPUTED HEALTH CARE SERVICE

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

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

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

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

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

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

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

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

BINDING ARBITRATION

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

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

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

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

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

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

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

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

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

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.

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

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

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

- there is no *participating provider* who practices in the appropriate specialty, or there is no *contracting hospital* which provides the required services or has the necessary facilities;
- that meets the adequacy and accessibility requirements of state or federal law; and
- you are referred to *hospital* or *physician* that does not have an agreement with Anthem for a covered service by a *participating provider*.

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

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

Compound Medication is a mixture of *prescription drugs* and other ingredients, wherein one or more ingredients are FDA-approved, a prescription is required to dispense, and the compound medication is not essentially the same as an FDA-approved product from a *drug manufacturer*.

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.

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

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

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

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

Emergency is a sudden, serious, and unexpected acute illness, injury, or condition (including without limitation sudden and unexpected severe pain), or a *psychiatric emergency medical condition*, which the *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 are those that are mainly limited to laboratory and/or animal research.

Full-time employee meets the *plan's* eligibility requirements for full-time employees as outlined under HOW COVERAGE BEGINS AND ENDS.

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).

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

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

Hospice is an agency or organization primarily engaged in providing palliative care (pain control and symptom relief) to terminally ill persons and supportive care to those persons and their families to help them cope with terminal illness. This care may be provided in the home or on an inpatient basis. A hospice must be: (1) certified by Medicare as a hospice; (2) recognized by Medicare as a hospice demonstration site; or (3) accredited as a hospice by the Joint Commission on Accreditation of Hospitals. A list of hospices meeting these criteria is available upon request.

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

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

Infertility is: (1) the presence of a condition recognized by a *physician* as a cause of infertility; or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception or after 3 cycles of artificial insemination.

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 *family members*.

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

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

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

Intensive Outpatient Program is a short-term behavioral health treatment that provides a combination of individual, group and family therapy.

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

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

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

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease;
3. Provided for the diagnosis or direct care and treatment of the medical condition;
4. Within standards of good medical practice within the organized medical community;
5. Not primarily for your convenience, or for the convenience of your *physician* or another provider;
6. Not more costly than an equivalent service or sequence of services that is medically appropriate and is likely to produce equivalent therapeutic or diagnostic results in regard to the diagnosis or treatment of the patient's illness, injury, or condition; and
7. The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:
 - a. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and
 - b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable.

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 Professional (Part B) services, not including amounts applied to Part B deductibles. Medicare may increase the co-payment amounts for certain services.

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

Non-participating provider is a *hospital* or *physician* NOT participating in a Blue Cross and/or Blue Shield Plan at the time services are rendered. They are not *participating providers*. Remember that the *maximum allowed amount* may only represent a portion of the amount which a *non-participating provider* charges for services. See YOUR MEDICAL BENEFITS: MAXIMUM ALLOWED AMOUNT.

Other health care provider is one of the following providers:

1. A certified registered nurse anesthetist;
2. A facility which provides diagnostic radiology services;
3. A blood bank;
4. A durable medical equipment outlet;
5. A clinical laboratory;
6. A *skilled nursing facility*;
7. A *home health agency*;
8. A licensed ambulance company;
9. A *hospice*;
10. An *ambulatory surgical center*;
11. A *home infusion therapy provider*; or
12. A licensed birth center.
13. A Christian Science practitioner/sanatorium.

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

Part time employee meets the *plan's* eligibility requirements for part time employees as outlined under HOW COVERAGE BEGINS AND ENDS.

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

Participating provider is a *hospital* or *physician* participating in a Blue Cross and/or Blue Shield Plan at the time services are rendered. *Participating providers* agree to accept the *maximum allowed amount* as payment for covered services. A directory of *participating providers* is available upon request.

Physician means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or
2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license and such license is required to render that service, and is providing a service for which benefits are specified in this booklet:
 - A dentist (D.D.S. or D.M.D.)
 - An optometrist (O.D.)
 - A dispensing optician
 - A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
 - A licensed clinical psychologist
 - A licensed educational psychologist or other provider permitted by California law to provide behavioral health treatment services for the treatment of pervasive developmental disorder or autism only
 - A chiropractor (D.C.)
 - An acupuncturist (A.C.)
 - A licensed clinical social worker (L.C.S.W.)
 - A marriage and family therapist (M.F.T.)
 - A licensed professional clinical counselor (L.P.C.C.)*
 - A physical therapist (P.T. or R.P.T.)*
 - A speech pathologist*
 - An audiologist*
 - An occupational therapist (O.T.R.)*
 - A respiratory care practitioner (R.C.P.)*
 - A nurse midwife
 - A nurse practitioner
 - A physician assistant
 - A *psychiatric mental health nurse* (R.N.)*

- A registered dietitian (R.D.)* or another nutritional professional* with a master's or higher degree in a field covering clinical nutrition sciences, from a college or university accredited by a regional accreditation agency, who is deemed qualified to provide these services by the referring M.D. or D.O. A registered dietitian or other nutritional professional as described here are covered for the provision of diabetic medical nutrition therapy and nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa only.
- A qualified autism service provider, qualified autism service professional, and a qualified autism service paraprofessional, as described under the benefits for pervasive developmental disorder or autism section.

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

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

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

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

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

Psychiatric emergency medical condition is a *mental health condition* 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 health condition*.

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

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

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

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

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

- Room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24 hour availability;
- A staff with one or more *doctors* available at all times;
- Residential treatment that takes place in a structured facility-based setting;
- The resources and programming to adequately diagnose, care and treat a *mental health conditions* or substance abuse;
- Facilities that are designated for residential, sub-acute, or intermediate care and that may occur in care systems that provide multiple levels of care; and
- Accreditation by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

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

- Nursing care

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

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 severe mental illness specified in California Insurance Code section 10144.5: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, and bulimia.

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

1. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community and is at risk of being removed from the home or has already been removed from the home or the mental disorder has been present for more than six months or is likely to continue for more than one year without treatment.
2. The child is psychotic, suicidal, or potentially violent.
3. The child meets special education eligibility requirements under California law (Education Code Section 56320).

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

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

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

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

Totally disabled employees are *employees* who, because of illness or injury, are unable to work for income in any job for which they are qualified or for which they become qualified by training or experience, and who are in fact unemployed.

Totally disabled family members are *family members* who are 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.

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

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

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

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

FOR YOUR INFORMATION

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

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

These are your rights and responsibilities:

You have the right to:

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

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

You have the responsibility to:

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

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

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

We want to provide high quality benefits and member services to our *insured persons*. Benefits and coverage for services given under the

plan are governed by the Certificate and not by this Member Rights and Responsibilities statement.

WEB SITE

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

LANGUAGE ASSISTANCE PROGRAM

Anthem 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.

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

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

IDENTITY PROTECTION SERVICES

Identity protection services are available with our Anthem health plans. To learn more about these services, please visit 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.



AMENDMENT

Anthem Blue Cross Life and Health Insurance Company (“Anthem Blue Cross Life and Health”) agrees to modify your certificate by this amendment, which replaces relevant provisions in your certificate with the provisions in this amendment. All other provisions of certificate which are not inconsistent with this amendment remain in effect. Officers of Anthem Blue Cross Life and Health have approved this amendment.

- I. **In the section entitled UTILIZATION REVIEW PROGRAM, the first three paragraphs of the section are replaced with the following:**

UTILIZATION REVIEW PROGRAM

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

REVIEWING WHERE SERVICES ARE PROVIDED

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

- A service may be denied on an inpatient basis at a *hospital* but may be approvable if provided on an outpatient basis at a *hospital*.

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

Utilization review criteria will be based on many sources including medical policy and clinical guidelines. A treatment that was asked for may not be *medically necessary*, based on the utilization review criteria, if a clinically equivalent treatment that is more cost-effective is available and appropriate.

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

II. In the section entitled FOR YOUR INFORMATION, the LANGUAGE ASSISTANCE PROGRAM provision is replaced in its entirety with the following:

LANGUAGE ASSISTANCE PROGRAM

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

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

Written materials available for translation include grievance and appeal letters, consent forms, claim denial letters, and explanations of benefits. These materials are available in the top 15 languages as determined by state law.

Oral interpretation services are also available in these languages.

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

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

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

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

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

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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.

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للحصول على مزيد من المساعدة، يُرجى الاتصال بإدارة كاليفورنيا للتأمين على الرقم 927-4357-1-800.
(TTY/TDD: 711)

Armenian

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

Chinese

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

Farsi

خدمات رایگان زبانی. می‌توانید یک مترجم شفاهی بگیرید. می‌توانید 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 को कॉल 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 ntawv sau ua koj hom lus tuaj rau koj. Txog rau kev pab, hu rau peb tus nab npawb xov tooj teev tseg cia nyob rau ntawm koj daim ID los sis 1-888-254-2721. Txog

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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)

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

សេវាកម្មភាសាខ្មែរឥតគិតថ្លៃ។ អ្នកអាចទទួលបានសេវាបកប្រែប្រាស់។ អ្នកអាចឱ្យអ្នកអានឯកសារផ្សេងៗទៀតឱ្យស្តាប់ និងស្តាប់សារផ្សេងៗជាភាសាខ្មែរ។ ដើម្បីទទួលបានជំនួយ សូមហៅ
ទូរស័ព្ទមកយើងតាមលេខដែលបានរាយនៅលើប័ណ្ណ ID របស់អ្នក ឬក៏លេខ 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 ਔਫ਼ 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

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Association.

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

Thai

ไม่มีค่าบริการเกี่ยวกับภาษา ท่านสามารถขอใช้บริการล่ามได้
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>.