COMPLAINT NOTICE

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

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

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

California Department of Insurance
Claims Service Bureau, 11th Floor
300 South Spring Street
Los Angeles, California 90013
1-800-927-HELP (4357) – In California
1-213-897-8921 – Out of California
1-800-482-4833 – Telecommunication Device for the Deaf

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

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

Non-Participating Providers. Non-participating providers are providers which have not agreed to participate in our Prudent Buyer Plan network. They have not agreed to the reimbursement rates and other provisions of a Prudent Buyer Plan contract.

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

Other Health Care Providers. "Other Health Care Providers" are neither physicians nor hospitals. They are mostly free-standing facilities or service organizations. See the definition of "Other Health Care Providers" in the DEFINITIONS section for a complete list of those providers. Other health care providers are not part of our Prudent Buyer Plan provider network.

Contracting and Non-Contracting Hospitals. As a health care plan, Anthem Blue Cross (an affiliate of Anthem Blue Cross Life and Health), has traditionally contracted with most hospitals to obtain certain advantages for patients covered by Anthem Blue Cross and its affiliates, including Anthem Blue Cross Life and Health. 90% of California hospitals are contracting hospitals.

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

Participating and Non-Participating Pharmacies. "Participating Pharmacies" agree to charge only the prescription drug maximum allowed amount to fill the prescription. After you have met your Benefit Year Deductible, you pay only your co-payment amount.

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

Centers of Medical Excellence. We are providing access to the following separate Centers of Medical Excellence (CME) networks. The facilities included in each of these CME networks are selected to provide the following specified medical services:

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

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

A participating provider in the Prudent Buyer Plan network is not necessarily a CME facility.

Care Outside the United States—BlueCard Worldwide

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

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

- Always carry your current ID card.

- In an emergency, seek medical treatment immediately.

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

Payment Information

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

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

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

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

Claim Forms

- International claim forms are available from us, from the BlueCard Worldwide Service Center, or online at:

  www.bcbs.com/bluecardworldwide.

  The address for submitting claims is on the form.
SUMMARY OF BENEFITS

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

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.

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.

Care After Hours. If you need care after your physician’s normal office hours and you do not have an emergency medical condition or need urgent care, please call your physician’s office for instructions.

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

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

The benefits of this plan may be subject to the REIMBURSEMENT FOR ACTS OF THIRD PARTIES section.
MEDICAL AND PRESCRIPTION DRUG BENEFITS

DEDUCTIBLES

Calendar Year Deductibles Applicable to Medical and Prescription Drug Benefits

- Insured Person Deductibles:
  - Participating providers, participating pharmacies and other health care providers..................$1,500
  - Non-participating providers and non-participating pharmacies..................................................$3,000

- Family Deductible:
  - Participating providers, participating pharmacies and other health care providers..................$3,000
  - Non-participating providers and non-participating pharmacies..................................................$6,000

Exception: In certain circumstances, the Calendar Year Deductibles may not apply, as described below:

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

CO-PAYMENTS APPLICABLE TO MEDICAL AND PRESCRIPTION DRUG BENEFITS

Medical Co-Payments.* After you have met your Benefit Year Deductible, you will be responsible for the following percentages of the maximum allowed amount:

- Participating Providers..........................................................10%
- Other Health Care Providers..................................................10%
- 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:

- There will be no Co-Payment for any covered services provided by a participating provider under the Preventive Care benefit.
– Your Co-Payment for durable medical equipment and supplies will be **50%** of the *maximum allowed amount*.

– 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
  d. Cancer Clinical Trials.

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

  **NOTE:** No Co-Payment will be required for the transplant travel expenses authorized by us in connection with a specified transplant performed at a designated CME. Transplant travel expense coverage is available when the closest CME is 250 miles or more from the recipient's or donor's residence.

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

  **NOTE:** Co-Payments do not apply to bariatric travel expenses authorized by us. Bariatric travel expense coverage is available when the closest CME is 50 miles or more from the insured person’s residence.
Prescription Drug Co-Payments. The following co-payments apply for each prescription after you have met your Medical and Prescription Drug Calendar Year Deductible:

Retail Pharmacies: The following co-payments apply for a 30-day supply of medication. Note: Specified specialty drugs must be obtained through the specialty pharmacy program. However, the first two month supply of a specialty drug may be obtained through a retail pharmacy, after which the drug is available only through the specialty pharmacy program unless an exception is made.

Participating Pharmacies

- Tier 1 drugs..........................................................$10
- Tier 2 drugs..........................................................$30
- Tier 3 drugs..........................................................$50
- Tier 4 drugs..........................................................30% of the prescription drug maximum allowed amount for each prescription
- Compound Medications............................................$50
- Diabetic Supplies....................................................$10

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

Non-Participating Pharmacies*.................................................30%

prescription drug covered expense
Home Delivery Prescriptions: The following co-payments apply for a 90-day supply of medication.

- Tier 1 drugs.................................................................$10
- Tier 2 drugs.................................................................$60
- Tier 3 drugs.................................................................$100
- Tier 4 drugs.................................................................30% of the prescription drug maximum allowed amount for each prescription
- Diabetic Supplies ..........................................................$10

Exception to Prescription Drug Co-payments

* Prescription Contraceptives ........................................... No charge
  (Generic or single source contraceptives only)

*Important Note About Prescription Drug Covered Expense and Your Co-Payment: Prescription drug covered expense for non-participating pharmacies is significantly lower than what providers customarily charge, so you will almost always have a higher out-of-pocket expense when you use a non-participating pharmacy.

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

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

Preferred Generic Program

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

Special Programs

From time to time, we may initiate various programs to encourage you to utilize more cost-effective or clinically-effective drugs including, but, not limited to, generic drugs, home delivery drugs, over-the-counter drugs or preferred drug products. Such programs may involve reducing or waiving co-payments for those generic drugs, over-the-counter drugs, or the preferred drug products for a limited time. If we initiate such a program, and we determine that you are taking a drug for a medical condition affected by the program, you will be notified in writing of the program and how to participate in it.

Half-tab Program

The Half-Tablet Program allows you to pay a reduced co-payment on selected “once daily dosage” medications. The Half-Tablet Program allows you to obtain a 30-day supply (15 tablets) of a higher strength version of your medication when the prescription is written by the physician to take “½ tablet daily” of those medications on an list approved by us. The Pharmacy and Therapeutics Process will determine additions and deletions to the approved list. The Half-Tablet Program is strictly voluntary and your decision to participate should follow consultation with and the concurrence of your physician. To obtain a list of the products available on this program call 1-800-700-2541 (or TTY/TDD 1-800-905-9821) or go to our internet website www.anthem.com/ca.

MEDICAL AND PRESCRIPTION DRUG OUT-OF-POCKET AMOUNT

Out-of-Pocket Amount*. After you have made the following total out-of-pocket payments for all medical and the prescription drug maximum allowed amount 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.

Per insured person:

- Participating provider, participating pharmacy and other health care provider ................................................................. $3,000
- Non-participating provider and non-participating pharmacy ....................................................................................... $9,000
Per family:

- *Participating provider, participating pharmacy and other health care provider* ................................................................. $6,000
- *Non-participating provider and non-participating pharmacy* ................................................................. $18,000

*Exception:* Expense 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

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

**Home Infusion Therapy**
- For all covered services and supplies received during any one day .......................................................... $600*
  *Non-participating providers only

**Ambulatory Surgical Center**
- For all covered services and supplies ........................................... $350*
  *Non-participating providers only

**Outpatient Hemodialysis**
- For all covered services and supplies ........................................... $350* per visit
  *Non-participating providers only
Advanced Imaging Procedures

- For all covered services .......................................................... $800* per procedure
  *Non-participating providers only

Ambulance

- For air ambulance transportation that is not related to an emergency ........................................ $50,000* per trip
  *Non-participating providers only

Physical Therapy, Physical Medicine and Occupational Therapy

- For covered outpatient services ............................................. 24 visits per calendar year

- For each covered visit when provided by a non-participating provider ........................................... $25 per visit

Acupuncture

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

Transplant Travel Expense

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

Unrelated Donor Searches

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

- For all travel expenses authorized by us in connection with a specified bariatric surgery performed at a designated CME up to $3,000 per surgery

Lifetime Maximum

- For all medical benefits Unlimited

MEDICAL AND PRESCRIPTION DRUG DEDUCTIBLE

Calendar Year Deductibles. Each year, you will be responsible for satisfying the insured person’s Calendar Year Deductible before we begin to pay medical and prescription drug benefits. If members of an enrolled family pay deductible expense in a year equal to the Family Deductible, the Calendar Year Deductible for all family members will be considered to have been met.

Participating Providers, CMEs, Participating Pharmacies and Other Health Care Providers. Only covered charges up to the maximum allowed amount for the services of participating providers, CMEs, participating pharmacies and other health care providers will be applied to the participating provider, participating pharmacy and other health care provider Calendar Year Deductibles. When these deductibles are met, we will pay benefits only for the services of participating providers, CMEs, participating pharmacies and other health care providers. We will not pay any benefits for non-participating providers and non-participating pharmacies unless the separate non-participating provider and non-participating pharmacy Calendar Year Deductibles (as applicable) are met.

Non-Participating Providers and Non-Participating Pharmacies. Only covered charges up to the maximum allowed amount for the services of non-participating providers and non-participating pharmacies will be applied to the non-participating provider and non-participating pharmacy Calendar Year Deductibles. We will pay benefits for the services of non-participating providers and non-participating pharmacies only when the applicable non-participating provider and non-participating pharmacy deductibles are met.

Prior Plan Calendar Year Deductibles. If you were covered under the prior plan any amount paid during the same calendar year toward your calendar year deductible under the prior plan, will be applied toward your Calendar Year Deductible under this plan; provided that, such payments were for charges that would be covered under this plan.
MEDICAL AND PRESCRIPTION DRUG OUT-OF-POCKET AMOUNTS

Satisfaction of the Out-of-Pocket Amount. If, after you have met your Calendar Year Deductibles, 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 covered services and supplies during the remainder of that year.

Participating Providers, CMEs, Participating Pharmacies and Other Health Care Providers. Only covered charges up to the maximum allowed amount for the services of participating providers, CMEs, participating pharmacies and other health care providers will be applied to the participating provider, CME, participating pharmacy and other health care provider Out-of-Pocket Amount.

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

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

Family Maximum Out-of-Pocket Amount. When the insured employee and one or more members of the employee’s family are insured under this plan, if members of an insured family satisfy the family Out-of-Pocket Amount during a calendar year, no further Out-of-Pocket Amount will be required for any insured member of that family for expenses incurred during that year.

Charges Which Do Not Apply Toward the Out-of-Pocket Amount. Charges for services or supplies not covered under this plan and charges which exceed the maximum allowed will not be applied toward satisfaction of an Out-of-Pocket Amount.
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 and CME. For covered services performed by a participating provider or CME the maximum allowed amount for this plan will be the rate the participating provider or CME has agreed with us to accept as reimbursement for the covered services. Because participating providers have agreed to accept the maximum allowed amount as payment in full for those covered services, they should not send you a bill or collect for amounts above the maximum allowed amount. However, you may receive a bill or be asked to pay all or a portion of the maximum allowed amount to the extent you have not met your Deductible or have a Co-Payment. Please call the customer service telephone number on your ID card for help in finding a participating provider or visit www.anthem.com/ca.

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

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

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.

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

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

*Exceptions:

- **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.

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 customer service telephone number on your ID card to learn how this plan’s benefits or cost share amount may vary by the type of provider you use.

Anthem Blue Cross 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 go to a participating hospital or facility and receive covered services from a non-participating provider such as a radiologist, anesthesiologist or pathologist providing services at the hospital or facility, you will pay the participating provider cost share percentage of the maximum allowed amount for those covered services.
However, you also may be liable for the difference between the maximum allowed amount and the non-participating provider’s charge.

Authorized Referrals

In some circumstances we may authorize participating provider cost share amounts (Deductibles or Co-Payments) to apply to a claim for a covered service you receive from a non-participating provider. In such circumstance, you or your physician must contact us in advance of obtaining the covered service. It is your responsibility to ensure that we have been contacted. If we authorize a participating provider cost share amount to apply to a covered service received from a non-participating provider, you also may still be liable for the difference between the maximum allowed amount and the non-participating provider's charge. Please call the customer service telephone number on your ID card for authorized referral information or to request authorization.

CO-PAYMENTS AND MEDICAL BENEFIT MAXIMUMS

After you satisfy your Medical and Prescription Drug Deductible, we will subtract your Co-Payment and we will pay benefits up to the maximum allowed amount, not to exceed any applicable Medical Benefit Maximum. The Co-Payments, and Medical Benefit Maximums are set forth in the SUMMARY OF BENEFITS.

CO-PAYMENTS

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

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

MEDICAL BENEFIT MAXIMUMS

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

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

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

1. You must incur this expense while you are covered under this plan. Expense is incurred on the date you receive the service or supply for which the charge is made.

2. The expense must be for a medical service or supply furnished to you as a result of illness or injury or pregnancy, unless a specific exception is made.

3. The expense must be for a medical service or supply included in MEDICAL CARE THAT IS COVERED. Additional limits on covered charges are included under specific benefits and in the SUMMARY OF BENEFITS.

4. The expense must not be for a medical service or supply listed in MEDICAL CARE THAT IS NOT COVERED. If the service or supply is partially excluded, then only that portion which is not excluded will be covered under this plan.

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

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

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

MEDICAL CARE THAT IS COVERED

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

Urgent Care. Services and supplies received to prevent serious deterioration of your health or, in the case of pregnancy, the health of the unborn child, resulting from an unforeseen illness, medical condition, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed. Urgent care services are not emergency services. Services for urgent care are typically provided by an urgent care center or other facility such as a physician’s office. Urgent care can be obtained from participating providers or non-participating providers.
Hospital

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

2. Services in special care units.

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

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.

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

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

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

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

2. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy, or respiratory therapy.

3. Services of a medical social service worker.

4. Services of a health aide who is employed by (or who contracts with) a home health agency. Services must be ordered and supervised by a registered nurse employed by the home health agency as professional coordinator. These services are covered only if you are also receiving the services listed in 1 or 2 above.

5. Medically necessary supplies provided by the home health agency.
In no event will benefits exceed 100 visits during a calendar year. A visit of four hours or less by a home health aide shall be considered as one home health visit.

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

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

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

**Hospice Care.** The services and supplies listed below are covered when provided by a hospice for the palliative treatment of pain and other symptoms associated with a terminal disease. You must be suffering from a terminal illness 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.

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, medication related to illness or injury, chemotherapy, antibiotic therapy, aerosol therapy, tocolytic therapy, special therapy, intravenous hydration, or pain management:

1. Medication(specialty drugs) must be obtained through the specialty drug program, ancillary medical supplies and supply delivery, (not to exceed a 14-day supply); however, medication which is delivered but not administered is not covered;

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

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

4. Rental and purchase charges for durable medical equipment (as shown below); maintenance and repair charges for such equipment;

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

Our maximum payment will not exceed $600 for the services or supplies received during any one day when provided by a home infusion therapy provider which is not a participating provider.
Home infusion therapy provider services are subject to pre-service review to determine medical necessity. See UTILIZATION REVIEW PROGRAM for details.

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

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

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

**Retail Health Clinic.** Services and supplies provided by medical professionals who provide basic medical services in a retail health clinic including, but not limited to:

1. Exams for minor illnesses and injuries.
2. Preventive services and vaccinations.
3. Health condition monitoring and testing.

**Online Care Services.** When available in your area, covered services will include medical consultations using the internet via webcam, chat, or voice. Online care services are covered under plan benefits for office visits to physicians.

Non-covered services include, but are not limited to, the following:

- Reporting normal lab or other test results.
- Office visit appointment requests or changes.
- Billing, insurance coverage, or payment questions.
- Requests for referrals to other physicians or healthcare practitioners.
- Benefit precertification.
- Consultations between physicians.
- Consultations provided by telephone, electronic mail, or facsimile machines.

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

1. Services of a physician.

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

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

Ambulance. The following ambulance services:

1. Base charge, mileage and non-reusable supplies of a licensed ambulance company for ground service to transport you to and from a hospital.

2. 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.

3. 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 and ground ambulance service is inadequate. Pre-service review is required for air ambulance in a non-medical emergency. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

Our maximum payment will not exceed $50,000 per trip for air ambulance transportation that is not related to an emergency when performed by a non-participating provider.

4. Monitoring, electrocardiograms (EKGs; ECGs), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriately licensed person must render the services.

* If you have an emergency medical condition that requires an emergency response, please call the “911” emergency response system if you are in an area where the system is established and operating.
**Diagnostic Services.** Outpatient diagnostic imaging and laboratory services. This does not include services covered under the "Advanced Imaging Procedures" provision of this section.

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

Advanced imaging procedures, when performed by a non-participating provider, will have a maximum benefit of $800 per procedure.

**Radiation Therapy**

**Chemotherapy**

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

**Prosthetic Devices**

1. Breast prostheses following a mastectomy.
2. Prosthetic devices to restore a method of speaking when required as a result of a covered medically necessary laryngectomy.
3. Wigs for alopecia resulting from chemotherapy or radiation therapy.
4. We will pay for other medically necessary prosthetic devices, including:
   a. Surgical implants;
   b. Artificial limbs or eyes;
   c. The first pair of contact lenses or eye glasses when required as a result of a covered medically necessary eye surgery;
   d. Therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications; and
   e. Orthopedic footwear used as an integral part of a brace; shoe inserts that are custom molded to the patient.
Durable Medical Equipment. Rental or purchase of dialysis equipment; dialysis supplies. Rental or purchase of other medical equipment and supplies which are:

1. Of no further use when medical needs end;
2. For the exclusive use of the patient;
3. Not primarily for comfort or hygiene;
4. Not for environmental control or for exercise; and
5. Manufactured specifically for medical use.

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

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

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

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

Dental Care

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

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

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

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

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

**Pregnancy and Maternity Care**

1. All medical benefits for an insured person when provided for pregnancy or maternity care, including the following services:
   a. Prenatal and postnatal care;
   b. Ambulatory care services (including ultrasounds, fetal non-stress tests, physician office visits, and other medically necessary maternity services performed outside of a hospital);
c. Involuntary complications of pregnancy;

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

e. Inpatient hospital care including labor and delivery.

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

2. Medical hospital benefits for routine nursery care of a newborn child, if the child's natural mother is an 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.

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

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

1. The recipient; or

2. The donor.

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 for a donor, including donor testing and donor search, is limited to expense incurred for medically necessary medical services only. The maximum allowed amount for services incident to obtaining the transplanted material from a living donor or a human organ transplant bank will be covered. Such charges, including complications from the donor procedure for up to six weeks from the date of procurement, are covered. Services for treatment of a condition that is not directly related to, or a direct result of, the transplant are not covered. Our payment for unrelated donor searches for bone marrow/stem cell transplants will not exceed $30,000 per transplant.

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

Specified Transplants

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

Transplant Travel Expense

Certain travel expenses incurred in connection with an approved,
specified transplant (heart, liver, lung, combination heart-lung, kidney,
pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and
similar procedures) performed at a designated CME that is 75 miles or
more from the recipient’s or donor’s place of residence are covered,
provided the expenses are authorized by us in advance. Our maximum
payment will not exceed $10,000 per transplant for the following travel
expenses incurred by the recipient and one companion* or the donor:

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

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

The Calendar Year Deductible will not apply and no co-payments will be
required for transplant travel expenses authorized in advance by us. We
will provide benefits for lodging and ground transportation, up to the
current limits set forth in the Internal Revenue Code.
Expense incurred for the following is not covered: interim visits to a medical care facility while waiting for the actual transplant procedure; travel expenses for a companion and/or caregiver for a transplant donor; return visits for a transplant donor for treatment of a condition found during the evaluation; rental cars, buses, taxis or shuttle services; and mileage within the city in which the medical transplant facility is located.

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

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

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

**Bariatric Travel Expense.** Certain travel expenses incurred in connection with an approved, specified bariatric surgery, performed at a designated *CME* that is fifty (50) miles or more from the *insured person’s* place of residence, are covered, provided the expenses are authorized by us in advance. The fifty (50) mile radius around the *CME* will be determined by the **bariatric CME coverage area** (See **DEFINITIONS**). Our maximum payment will not exceed **$3,000** per surgery for the following travel expenses incurred by the *insured person* and/or one companion:

- Transportation for the *insured person* and/or one companion to and from the *CME*.
- Lodging, limited to one room, double occupancy.
- Other reasonable expenses. Tobacco, alcohol, drug and meal expenses are excluded from coverage.

Customer service will confirm if the “Bariatric Travel Expense” benefit is available in connection with access to the selected bariatric *CME*. Details regarding reimbursement can be obtained by calling the customer service number on your I.D. card. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.
Mental or Nervous Disorders or Substance Abuse. Covered services shown below for the medically necessary treatment of mental or nervous disorders or substance abuse, or to prevent the deterioration of chronic conditions.

1. Inpatient hospital services as stated in the "Hospital" provision of this section, services from a residential treatment center, and visits to a day treatment center.

2. Physician visits during a covered inpatient stay.

3. Physician visits for outpatient psychotherapy or psychological testing for the treatment of mental or nervous disorders or substance abuse.

4. 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 Services. Outpatient services, supplies, and office visits provided in connection with preventive care services as shown below. The calendar year deductible will not apply to these services or supplies when they are provided by a participating provider. No co-payment will apply to these services or supplies when they are provided by a participating provider.

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

2. Immunizations prescribed by a examining physician.

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

4. Health screenings as ordered by the examining physician for the following: breast cancer, cervical cancer, including human papillomavirus (HPV), prostate cancer, colorectal cancer, and other
medically accepted cancer screening tests, blood lead levels, high blood pressure, type 2 diabetes mellitus, cholesterol, and obesity.

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

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

7. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
   a. Women’s contraceptives, sterilization procedures, and counseling. This includes generic and single source brand drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUD)s, and implants are also covered.
   b. Breast feeding support, supplies, and counseling. One breast pump will be covered per calendar year under this benefit.
   c. Gestational diabetes screening.

This list of preventive care services is not exhaustive. Preventive tests and screenings with a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF), or those supported by the Health Resources and Services Administration (HRSA) will be covered with no copayment and will not apply to the calendar year deductible.

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

You may call Customer Service using the number on your ID card for additional information about these services. You may also view the federal government’s web sites:

http://www.healthcare.gov/center/regulations/prevention.html
http://www.ahrq.gov/clinic/uspsffix.htm
http://www.cdc.gov/vaccines/recs/acip/

Breast Cancer. Services and supplies provided in connection with the screening for, diagnosis of, and treatment for breast cancer whether due to illness or injury, including:
1. Diagnostic mammogram examinations in connection with the treatment of a diagnosed illness or injury. Routine mammograms will be covered initially under the Preventive Care Services benefit.

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

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

4. Breast prostheses following a mastectomy (see “Prosthetic Devices”).

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

**Cancer Clinical Trials.** Coverage is provided for services and supplies for routine patient care costs, as defined below, in connection with phase I, phase II, phase III and phase IV cancer clinical trials if all of the following conditions are met:

1. The treatment provided in a clinical trial must either:
   a. Involve a drug that is exempt under federal regulations from a new drug application, or
   b. Be approved by (i) one of the National Institutes of Health, (ii) the federal Food and Drug Administration in the form of an investigational new drug application, (iii) the United States Department of Defense, or (iv) the United States Veteran’s Administration.

2. You must be diagnosed with cancer to be eligible for participation in these clinical trials.

3. Participation in such clinical trials must be recommended by your physician after determining participation has a meaningful potential to benefit the insured person.

4. For the purpose of this provision, a clinical trial must have a therapeutic intent. Clinical trials to just test toxicity are not included in this coverage.

Routine patient care costs means the costs associated with the provision of services, including drugs, items, devices and services which would otherwise be covered under the plan, including health care services which are:

1. Typically provided absent a clinical trial.
2. Required solely for the provision of the investigational drug, item, device or service.

3. Clinically appropriate monitoring of the investigational item or service.

4. Prevention of complications arising from the provision of the investigational drug, item, device, or service.

5. Reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

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

1. Drugs or devices not approved by the federal Food and Drug Administration that are associated with the clinical trial.

2. Services other than health care services, such as travel, housing, companion expenses and other nonclinical expenses that you may require as a result of the treatment provided for the purposes of the clinical trial.

3. Any item or service provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient.

4. Health care services that, except for the fact they are provided in a clinical trial, are otherwise specifically excluded from the plan.

5. Health care services customarily provided by the research sponsors free of charge to insured persons enrolled in the trial.

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

Disagreements regarding the coverage or medical necessity of possible clinical trial services may be subject to INDEPENDENT MEDICAL REVIEW OF GRIEVANCES INVOLVING A DISPUTED HEALTH CARE SERVICE.

**Physical Therapy, Physical Medicine and Occupational Therapy.**

The following services provided by a physician under a treatment plan:

1. Physical therapy and physical medicine provided on an outpatient basis for the treatment of illness or injury including the therapeutic use of heat, cold, exercise, electricity, ultra violet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care which are customarily provided by chiropractors, physical therapists and osteopaths.)
2. Occupational therapy provided on an outpatient basis when the ability to perform daily life tasks has been lost or reduced by, or has not been developed due to, illness or injury including programs which are designed to rehabilitate mentally, physically or emotionally handicapped persons. Occupational therapy programs are designed to maximize or improve a patient's upper extremity function, perceptual motor skills and ability to function in daily living activities.

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

For the services of a non-participating provider only, our maximum payment is limited to $25 for each visit.

Up to 24 visits in a year for all covered services are payable.

If we apply covered charges toward the Calendar Year Deductible and do not provide payment, that visit will be included in the visit maximum (24 visits) for that year.

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

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

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

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

**Outpatient Speech Therapy.**
**Acupuncture.** The services of a *physician* for acupuncture treatment to treat a disease, illness or injury, including a patient history visit, physical examination, treatment planning and treatment evaluation, electroacupuncture, cupping and moxibustion. We will pay for up to 12 visits during a *calendar year*, and for up to a maximum of $30 for all covered services rendered during each visit.

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

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

1. The following equipment and supplies:
   a. Blood glucose monitors, including monitors designed to assist the visually impaired, and blood glucose testing strips.
   b. Insulin pumps.
   c. Pen delivery systems for insulin administration (non-disposable).
   d. Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin.
   e. Podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes-related complications.

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

2. Diabetes education program which:
   a. Is designed to teach an *insured person* who is a patient and covered members of the patient’s family about the disease process and the daily management of diabetic therapy;
   b. Includes self-management training, education, and medical nutrition therapy to enable the *insured person* to properly use the equipment, supplies, and medications necessary to manage the disease; and
   c. Is supervised by a *physician*.

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

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3. The following items are covered under your prescription drug benefits:
   
   
   b. Insulin syringes, disposable pen delivery systems for insulin administration.
   
   c. Testing strips, lancets, and alcohol swabs.
   
   These items must be obtained either from a retail pharmacy or through the home delivery program (see YOUR PRESCRIPTION DRUG BENEFITS).

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

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

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

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

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

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

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

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

If the request is not for urgently needed drugs, after we get the request from your physician:

- Based on your medical condition, as medically necessary, we will review it and decide if we will approve benefits within 5-business days. We will tell you and your physician what we have decided in writing - by fax to your doctor, and by mail, to you.

- If more information is needed to make a decision, we will tell your physician in writing within 5-business days after we get the request what information is missing and why we cannot make a decision. If, for reasons beyond our control, we cannot tell your physician what information is missing within 5-business days, we will tell your physician that there is a problem as soon as we know that we cannot respond within 5-business days. In any event, we will tell you and your physician that there is a problem by telephone, and in writing by facsimile, to your physician, and in writing to you by mail.

- As soon as we can, based on your medical condition, as medically necessary, within 5-business days after we have all the information we need to decide if we will approve benefits, we will tell you and your physician what we have decided in writing - by fax to your physician and by mail to you.
If you have any questions regarding whether a specialty pharmacy drug requires prior authorization, please call us at 1-800-700-2541 (or TTY/TDD 1-800-905-9821).

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

MEDICAL CARE THAT IS NOT COVERED

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

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

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

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

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

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 maximum allowed amounts or any Medical Benefit Maximum.

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

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

Government Treatment. Any services 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.

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

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.

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

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

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use. Smoking cessation drugs, except as specifically stated under YOUR PRESCRIPTION DRUG BENEFITS section of this booklet.

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

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

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

This exclusion does not apply to the following:

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

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

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice or home infusion therapy provider as specifically stated in the "Home Health Care", "Hospice Care", "Home Infusion Therapy", or "Physical Therapy, Physical Medicine And Occupational Therapy" provisions of MEDICAL CARE THAT IS COVERED. This exclusion also does not apply to the medically necessary treatment of severe mental disorders, or to the medically necessary treatment of pervasive developmental disorder or autism, to the extent stated in the section BENEFITS FOR PERVERSIVE DEVELOPMENTAL DISORDER OR AUTISM.

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

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

Varicose Vein Treatment. Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.

Scalp hair prostheses. Scalp hair prostheses, including wigs or any form of hair replacement, except as specifically stated in the "Prosthetic Devices" provision.

Commercial Weight Loss Programs. Weight loss programs not approved by us, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this plan.
This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

This exclusion does not apply to medically necessary treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as stated in the “Bariatric Surgery” provision of MEDICAL CARE THAT IS COVERED.

**Sex Transformation.** Procedures or treatments to change characteristics of the body to those of the opposite sex.

**Sterilization Reversal.** Reversal of sterilization.

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

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

**Orthopedic Supplies.** Orthopedic shoes (other than shoes joined to braces) or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications as specifically stated in the “Prosthetic Devices” provision of MEDICAL CARE THAT IS COVERED.

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

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

**Chronic Pain.** Treatment of chronic pain, except as specifically provided under the “Hospice Care” or “Home Infusion Therapy” provisions of MEDICAL CARE THAT IS COVERED.

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

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

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

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

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

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

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

**Routine Exams or Tests.** Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specifically stated in the "Preventive Care Services" provision of **MEDICAL CARE THAT IS COVERED**.
Acupuncture. Acupuncture treatment except as specifically stated in the “Acupuncture” provision of MEDICAL CARE THAT IS COVERED. Acupressure, or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

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

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

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specifically stated in the “Infusion Therapy” or “Home Infusion Therapy,” “Specialty Drugs,” and “Prescription Drug for Abortion” provisions of MEDICAL CARE THAT IS COVERED or under YOUR PRESCRIPTION DRUG BENEFITS section of this booklet. Non-prescription, over-the-counter patent or proprietary drugs or medicines. Cosmetics, health or beauty aids.

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

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

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

Private Duty Nursing. Private duty nursing services.

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.

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

BENEFITS FOR PERVERSIVE 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.

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.

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

DEFINITIONS

Pervasive Developmental Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, includes Autistic Disorder, Rett’s Disorder, Childhood Disintegrative Disorder, Asperger’s Disorder, and Pervasive Developmental Disorder Not Otherwise Specified.

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

Intensive Behavioral Intervention means any form of Applied Behavioral Analysis that is comprehensive, designed to address all domains of functioning, and provided in multiple settings for no more than 40 hours per week, across all settings, depending on the individual’s needs and progress. Interventions can be delivered in a one-to-one ratio or small group format, as appropriate.

Qualified Autism Service Provider is either of the following:

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

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

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

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

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

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

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

- Has adequate education, training, and experience, as certified by a Qualified Autism Service Provider.

**BEHAVIORAL HEALTH TREATMENT SERVICES COVERED**

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

- The treatment must be prescribed by a licensed physician and surgeon (an M.D. or D.O.) or developed by a licensed clinical 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.

**PRE-EXISTING CONDITION EXCLUSION**

No payment will be made for services or supplies for the treatment of a pre-existing condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period prior to your coverage under this plan. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were subject to a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy nor to an insured person who is under age 19.

This exclusion may last up to six months from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period (see "Eligibility Date" under the section HOW COVERAGE BEGINS AND ENDS). However, you can reduce the length of this exclusion period by the number of days of your prior creditable coverage. Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a significant break in coverage. The maximum allowable break in coverage is 180 days if your prior coverage was provided through an employer and ended because your employment (or the person's employment through whom you had this coverage) ended, the availability of coverage through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated. For prior coverage that was not provided through an employer, such as individual coverage or coverage through a government program such as Medicaid, the maximum allowable break in coverage is 63 days. Please see "Creditable Coverage" in the DEFINITIONS section for a complete list of the types of coverage for which credit is given.

To reduce the six-month exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you
have. There is no time limit within which you must provide a certificate in order to receive credit for your prior coverage. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or carrier. There are also other ways that you can show you have **creditable coverage**. Please contact us if you need help demonstrating **creditable coverage**. All questions about the **pre-existing condition** exclusion and **creditable coverage** should be directed to the customer service telephone number listed on your identification card.

**REIMBURSEMENT FOR ACTS OF THIRD PARTIES**

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

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

   - If we paid the provider other than on a capitated basis, our lien will not be more than amount we paid for those services.
   - If we paid the provider on a capitated basis, our lien will not be more than 80% of the usual and customary charges for those services in the geographic area in which they were given.
   - If you hired an attorney to gain your recovery from the third party, our lien will not be for more than one-third of the money due you under any final judgment, compromise, or settlement agreement.
   - If you did not hire an attorney, our lien will not be for more than one-half of the money due you under any final judgment, compromise or settlement agreement.
   - If a final judgment includes a special finding by a judge, jury, or arbitrator that you were partially at fault, our lien will be reduced by the same comparative fault percentage by which your recovery was reduced.
   - Our lien is subject to a pro rata reduction equal to your reasonable attorney’s fees and costs in line with the common fund doctrine.
2. You must advise us in writing, within 60 days of filing a claim against the third party and take necessary action, furnish such information and assistance, and execute such papers as we may require to facilitate enforcement of our rights. You must not take action which may prejudice our rights or interests under your plan. Failure to give us such notice or to cooperate with us, or actions that prejudice our rights or interests will be a material breach of this plan and will result in your being personally responsible for reimbursing us.

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

YOUR PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG COVERED EXPENSE

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

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

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

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

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

You will always be responsible for expense incurred which is not covered under this plan.
PRESCRIPTION DRUG CO-PAYMENTS

After the pharmacy benefits manager determines prescription drug covered expense, they will subtract your Medical and Prescription Drug Deductible from the total amount they consider prescription drug covered expense. After that deductible has been satisfied, they will subtract your Prescription Drug Co-Payment for each prescription during the remainder of the year.

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

The Medical and Prescription Drug Deductible and Prescription Drug Co-Payments are set forth in the SUMMARY OF BENEFITS.

HOW TO USE YOUR PRESCRIPTION DRUG BENEFITS

When You Go to a Participating Pharmacy. To identify you as an insured person covered for prescription drug benefits, you will be issued an identification card. You must present this card to participating pharmacies when you have a prescription filled.

Once you have met your deductible, and provided you have properly identified yourself as an insured person, a participating pharmacy will only charge your Co-Payment.

For information on how to locate a participating pharmacy in your area, call 1-888-224-4911.

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

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

Participating pharmacies usually have claims forms, but, if the participating pharmacy does not have claim forms, claim forms and
customer service are available by calling 1-888-224-4911. Mail your claim, with the appropriate portion completed by the pharmacist, to the pharmacy benefits manager within 90 days of the date of purchase. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed.

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

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

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

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

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

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

The prescription must state the drug name, dosage, directions for use, quantity, the physician’s name and phone number, the patient’s name and address, and be signed by a physician. You must submit it with the appropriate payment for the amount of the purchase, and a properly completed order form. Once you have met any applicable deductible, you will only have to pay the cost of your Co-Payment.
Your first home delivery prescription must also include a completed Patient Profile questionnaire. The Patient Profile questionnaire can be obtained by calling the toll-free number shown on your ID card. You need only enclose the prescription or refill notice, and the appropriate payment for any subsequent home delivery prescriptions, or call the toll-free number. Co-payments can be made by check, money order or credit card.

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

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

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

You or your physician may order your specialty drug by calling 1-800-700-2541. When you call Anthem Blue Cross Life and Health – Specialty Drug Program, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your specialty drug to you. (If you order your specialty drug by telephone, you will need to use a credit card or debit card to pay for it.) You may also submit your specialty drug prescription with the appropriate payment for the amount of the purchase (you can pay by check, money order, credit card or debit card), and a properly completed order form to Anthem Blue Cross Life and Health Insurance Company – Specialty Drug. Once you have met your deductible, if any, you will only have to pay the cost of your Co-Payment.

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

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

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

PRESCRIPTION DRUG FORMULARY

We use a prescription drug formulary to help your physician make prescribing decisions. The presence of a drug on the plan’s prescription drug formulary list does not guarantee that you will be prescribed that drug by your physician. This list of outpatient prescription drugs is developed by a committee of physicians and pharmacists to determine which medications are sound, therapeutic and cost effective choices. These medications, which include both generic and brand name drugs, are listed in the prescription drug formulary. The committee updates the formulary quarterly to ensure that the list includes drugs that are safe and effective. Note: The formulary drugs may change from time to time.

Some drugs may require prior authorization. If you have a question regarding whether a particular drug is on our formulary drug list or requires prior authorization please call us at 1-800-700-2541 (or TTY/TDD 1-800-905-9821).

Prior Authorization. Certain drugs require written prior authorization of benefits in order for you to receive benefits. Prior authorization criteria will be based on medical policy and the Pharmacy and Therapeutics Process established guidelines. You may need to try a drug other than the one originally prescribed if we determine that it should be clinically effective for you. However, if we determine through prior authorization that the drug originally prescribed is medically necessary, you will be provided the drug originally requested at the applicable co-payment. (If, when you first become an insured person, you are already being treated for a medical condition by a drug that has been appropriately prescribed and is considered safe and effective for your medical condition, and you underwent a prior authorization process under the prior plan which required you to take different drugs, we will not require you to try a drug other than the one you are currently taking.) If approved, drugs requiring prior authorization for benefits will be provided to you after you make the required co-payment.

In order for you to get a drug that requires prior authorization, your physician must make a written request to us for you to get it using an Outpatient Prescription Drug Prior Authorization of Benefits form. The form can be facsimiled or mailed to us. If your physician needs a copy of
the form, he or she may call us at 1-800-700-2541 (or TTY/TDD 1-800-905-9821) to request one. The form is also available on-line at www.anthem.com/ca.

If the request is for urgently needed drugs, after we get the Outpatient Prescription Drug Prior Authorization of Benefits form:

- We will review it and decide if we will approve benefits within 72-hours. (As soon as we can, based on your medical condition, as medically necessary, we may take less than 72-hours to decide if we will approve benefits.) We will tell you and your physician what we have decided in writing - by fax to your physician and by mail to you.

- If more information is needed to make a decision, or we cannot make a decision for any reason, we will tell your physician, within 24-hours after we get the form, what information is missing and why we cannot make a decision. If, for reasons beyond our control, we cannot tell your physician what information is missing within 24-hours, we will tell your physician that there is a problem as soon as we know that we cannot respond within 24-hours. In either event, we will tell you and your physician that there is a problem – always in writing by facsimile and, when appropriate, by telephone to your physician and in writing by mail to you.

- As soon as we can, based on your medical condition, as medically necessary, but, not more than 48-hours after we have all the information we need to decide if we will approve benefits, we will tell you and your physician what we have decided in writing - by fax to the physician and by mail to you.

If the request is not for urgently needed drugs, after we get the Outpatient Prescription Drug Prior Authorization of Benefits form:

- Based on your medical condition, as medically necessary, we will review it and decide if we will approve benefits within 5-business days or a shorter period as applicable by state or federal law. We will tell you and your physician what we have decided in writing - by fax to your physician, and by mail, to you.

- If more information is needed to make a decision, we will tell your physician in writing within 5-business days or a shorter period as applicable by state or federal law after we get the request what information is missing, and why we cannot make a decision. If, for reasons beyond our control, we cannot tell your physician what information is missing within 5-business days, we will tell your physician that there is a problem as soon as we know that we cannot respond within 5-business days. In any event, we will tell you and your physician that there is a problem in writing by facsimile, and
when appropriate, by telephone to your *physician*, and in writing to you by mail.

- As soon as we can, based on your medical condition, as *medically necessary*, within 5-business days or a shorter period as applicable by state or federal law, and after we have all the information we need to decide if we will approve benefits, we will tell you and your *physician* what we have decided in writing - by fax to your *physician* and by mail to you.

While we are reviewing the Outpatient Prescription Drug Prior Authorization of Benefits form, a 72-hour emergency supply of medication may be dispensed to you if your *physician* or pharmacist determines that it is appropriate and *medically necessary*. You may have to pay the applicable co-payment shown in SUMMARY OF BENEFITS: PRESCRIPTION DRUG BENEFITS: PRESCRIPTION DRUG CO-PAYMENTS for the 72-hour supply of your *drug*. If we approve the request for the *drug* after you have received a 72-hour supply, you will receive the remainder of the 30-day supply of the *drug* with no additional copayment.

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

If we deny a request for prior authorization of a *drug* that is not part of our *formulary drug* list, you or your prescribing *physician* may appeal our decision by calling us at 1-888-224-4911. If you are dissatisfied with the resolution of your inquiry and want to file a grievance, you may write us at Anthem Blue Cross Life and Health Insurance Company, 21555 Oxnard Street, Woodland Hills, CA 91367, and follow the formal grievance process.

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

- Your coverage under this *plan* ends;
- The *policy* with the *group* terminates;
- You reach a benefit maximum that applies to *prescription drugs*, if the *plan* includes such a maximum;
- Your *prescription drug* benefits under the *plan* change so that *prescription drugs* are no longer covered or are covered in a different way.
A revocation or modification of a prior authorization of benefits for *prescription drugs* applies only to unfilled portions or remaining refills of the *prescription*, if any, and not to *drugs* you have already received.

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

**PRESCRIPTION DRUG CONDITIONS OF SERVICE**

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

1. It must be prescribed by a licensed prescriber and be dispensed within one year of being prescribed, subject to federal and state laws. This requirement will not apply to seasonal flu and pneumonia vaccinations provided at a *participating pharmacy*.

2. It must be approved for general use by the *Food and Drug Administration* (FDA).

3. It must be for the direct care and treatment of your illness, injury or condition. Dietary supplements, health aids or drugs for cosmetic purposes are not included. However: (1) formulas prescribed by a *physician* for the treatment of phenylketonuria are covered; and (2) seasonal flu and pneumonia vaccinations provided at a *participating pharmacy* are covered.

4. It must be dispensed from a licensed retail *pharmacy*, through our home delivery program or through our specialty drug program.

5. *If it is an approved compound medication*, be dispensed by a *participating pharmacy*. Call 1-800-700-2541 (or TTY/TDD 1-800-905-9821) to find out where to take your prescription for an approved *compound medication* to be filled. (You can also find a participating *pharmacy* at www.anthem.com/ca.) *Some compound medications must be approved before you can get them* (See PRESCRIPTION DRUG FORMULARY: PRIOR AUTHORIZATION). You will have to pay the full cost of the *compound medications* you get from a *pharmacy* that is not a *participating pharmacy*.

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

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

a. The first two month’s supply of a specified specialty drug which is available through a participating retail pharmacy;

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

c. An insured person who is unable to pay for delivery of their medication (i.e., no credit card); or

d. An insured person for whom, according to the Coordination of Benefit rules, this plan is not the primary plan.

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

Urgent or emergency need of a specialty drug subject to the specialty drug program. If you are out of a specialty drug which must be obtained through the specialty drug program, we will authorize an override of the specialty drug program requirement for 72-hours, or until the next business day following a holiday or weekend, to allow you to get an emergency supply of medication if your doctor decides that it is appropriate and medically necessary. You may have to pay the applicable co-payment shown SUMMARY OF
BENEFITS: PRESCRIPTION DRUG BENEFITS: PRESCRIPTION DRUG CO-
PAYMENTS for the 72-hour supply of your drug.

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

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

8. For a retail pharmacy or specialty drug program, the prescription must not exceed a 30-day supply.

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

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

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

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

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

1. Outpatient drugs and medications which the law restricts to sale by prescription. Formulas prescribed by a physician for the treatment of phenylketonuria.

2. Insulin.

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

4. Prescription contraceptives; including oral contraceptives, diaphragms, and patches. Contraceptives may be covered as preventive care services. In order to be covered as preventive care, the contraceptives must be generic drugs or single source brand name drugs that you get from a Retail Pharmacy or through the home delivery program.

5. Injectable drugs which are self-administered by the subcutaneous route (under the skin) by the patient or family member. Drugs with Food and Drug Administration (FDA) labeling for self-administration.

6. All compound prescription drugs which contain at least one covered prescription ingredient.

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

8. Inhaler spacers and peak flow meters for the treatment of pediatric asthma.

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

10. Smoking cessation products requiring a physician’s prescription.
PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED

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

1. Immunizing agents, biological sera, blood, blood products or blood plasma. While not covered under this prescription drug benefit, these items are covered under the "Preventive Care Services" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this plan that apply to those benefits. This exclusion will not apply to seasonal flu and pneumonia vaccinations, or to those listed as covered by the PreventiveRx program, if included, provided at a participating pharmacy.

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

3. Drugs and medications used to induce spontaneous and non-spontaneous abortions. While not covered under this prescription drug benefit, FDA approved medications that may only be dispensed by or under direct supervision of a physician, such as drugs and medications used to induce non-spontaneous abortions, are covered as specifically stated in the “Prescription Drug for Abortion” provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this plan that apply to the benefit.

4. Drugs and medications dispensed or administered in an outpatient setting; including, but not limited to, outpatient hospital facilities and physicians’ offices. While not covered under this prescription drug benefit, these services are covered as specified under the “Hospital,” “Home Health Care,” “Hospice Care,” and “Home Infusion Therapy” provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this plan that apply to those benefits.
5. Professional charges in connection with administering, injecting or dispensing of drugs. While not covered under this prescription drug benefit, these services are covered as specified under the "Professional Services" and "Home Infusion Therapy" provisions (see Table of Contents), subject to all terms of this plan that apply to those benefits.

6. Drugs and medications which may be obtained without a physician’s written prescription, except insulin or niacin for cholesterol lowering.

7. Drugs and medications dispensed by or while you are confined in a hospital, skilled nursing facility, rest home, sanitorium, convalescent hospital, or similar facility. While not covered under this prescription drug benefit, such drugs are covered as specified under the "Hospital", "Skilled Nursing Facility", and "Hospice Care", provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this plan that apply to those benefits. While you are confined in a rest home, sanitarium, convalescent hospital or similar facility, drugs and medications supplied and administered by your physician are covered as specified under the “Professional Services” provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this plan that apply to the benefit. Other drugs that may be prescribed by your physician while you are confined in a rest home, sanitarium, convalescent hospital or similar facility, may be purchased at a pharmacy by the member, or a friend, relative or care giver on your behalf, and are covered under this prescription drug benefit.

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

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

10. Oxygen. While not covered under this prescription drug benefit, oxygen is covered as specified under the "Hospital", "Skilled Nursing Facility", "Home Health Care" and "Hospice Care" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this plan that apply to those benefits.
11. Cosmetics and health or beauty aids. However, health aids that are medically necessary and meet the requirements for durable medical equipment as specified under the “Durable Medical Equipment” provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), are covered, subject to all terms of this plan that apply to that benefit.

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

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

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

15. Over-the-counter smoking cessation drugs. This does not apply to medically necessary drugs that you can only get with a prescription under state and federal law.

16. Drugs used primarily for cosmetic purposes (e.g., Retin-A for wrinkles). However, this will not apply to the use of this type of drug for medically necessary treatment of a medical condition other than one that is cosmetic.

17. Drugs used primarily for the purpose of treating infertility, unless medically necessary for another covered condition.

18. Anorexiants and drugs used for weight loss except when used to treat morbid obesity (e.g., diet pills and appetite suppressants).

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

20. Allergy desensitization products or allergy serum. While not covered under this prescription drug benefit, such drugs are covered as specified under the “Hospital”, “Skilled Nursing Facility”, and “Professional Services” provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this plan that apply to those benefits.
21. Infusion drugs, except drugs that are self-administered subcutaneously. While not covered under this prescription drug benefit, infusion drugs are covered as specified under the “Professional Services” and “Home Infusion Therapy” provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this plan that apply to those benefits.

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

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

24. Compound medications obtained from other than a participating pharmacy. You will have to pay the full cost of the compound medications you get from a non-participating pharmacy.

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

If you order a specialty drug through the home delivery program, it will be forwarded to the specialty pharmacy program for processing and will be processed according to specialty pharmacy program rules.

COORDINATION OF BENEFITS

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

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

Allowable Expense is any necessary, reasonable and customary item of expense which is at least partially covered by at least one Other 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.

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 trusted plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.
4. Medicare. This does not include Medicare when, by law, its benefits are secondary to those of any private insurance program or other non-governmental program.

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

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

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

EFFECT ON BENEFITS

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

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

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

ORDER OF BENEFITS DETERMINATION

The following rules 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 and the plan which covers you as a retired employee would pay last.

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

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

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

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

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

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

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

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

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

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

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

OUR RIGHTS UNDER THIS PROVISION

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

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

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

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

**BENEFITS FOR MEDICARE ELIGIBLE INSURED PERSONS**

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

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

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

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

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

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

1. Medicare must provide benefits first to any services covered both by Medicare and under this *plan*.

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

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

**UTILIZATION REVIEW PROGRAM**

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

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

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

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

This plan includes the processes of pre-service, care coordination, and retrospective reviews to determine when services should be covered. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service where care is provided. This plan requires that covered services be medically necessary for benefits to be provided.

Certain services require pre-service review of benefits in order for benefits to be provided. Participating providers will initiate the review on your behalf. A non-participating provider may or may not initiate the review for you. In both cases, it is your responsibility to initiate the process and ask your physician to request pre-service review. You may also call us directly. Pre-service review criteria are based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. We may determine that a service that was initially prescribed or requested is...
not *medically necessary* if you have not previously tried alternative treatments that are more cost effective.

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

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

**UTILIZATION REVIEW REQUIREMENTS**

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

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

- Scheduled, non-emergency inpatient *hospital stays* and *residential treatment center* admissions.
  
  **Exceptions:** Pre-service review is not required for inpatient *hospital stays* for the following services:
  
  - Maternity care of 48 hours or less following a normal delivery or 96 hours or less following a cesarean section, and
  - Mastectomy and lymph node dissection.

- Specific non-emergency outpatient services, including diagnostic treatment and other services.

- Specific outpatient surgeries performed in an outpatient facility or a doctor’s office.

- *Facility-based care* for the treatment of *mental or nervous disorders* and substance abuse.

- Transplant services.

- Air ambulance in a non-medical *emergency*.

- Specific durable medical equipment.
• Home infusion therapy.

• Home health care.

• Admissions to a skilled nursing facility.

• Bariatric surgical services performed at a Centers of Medical Excellence (CME) facility.

• Advanced imaging procedures, including but not limited to: Magnetic Resonance Imaging (MRI), Computerized Tomography (CT scan), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography, and Nuclear Cardiac Imaging. You may call the toll-free customer service telephone number on your identification card to find out if an imaging procedure requires pre-service review.

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

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

Retrospective review is performed to review services that have already been provided. This applies in cases when pre-service or care coordination review was not completed, or in order to evaluate and audit medical documentation subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified.

EFFECT ON BENEFITS

In order for the full benefits of this plan to be payable, the following criteria must be met:

1. The appropriate utilization reviews must be performed in accordance with this plan.

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

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

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

Facility-based care for the treatment of mental or nervous disorders and substance abuse.

Transplant services as follows:

a. For kidney, bone, skin or cornea transplants if the physicians on the surgical team and the facility in which the transplant is to take place are approved for the transplant requested.

b. For transplantation of heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney or bone marrow/stem cell and similar procedures if the providers of the related preoperative and postoperative services are approved and the transplant will be performed at a Centers of Medical Excellence (CME) facility.

Air ambulance in a non-medical emergency.

Specific durable medical equipment.

Services of a home infusion therapy provider if the attending physician has submitted both a prescription and a plan of treatment before services are rendered.

Home health care services if:

a. The services can be safely provided in your home, as certified by your attending physician;

b. Your attending physician manages and directs your medical care at home; and

c. Your attending physician has established a definitive treatment plan which must be consistent with your medical needs and lists the services to be provided by the home health agency.

Services provided in a skilled nursing facility if you require daily skilled nursing or rehabilitation, as certified by your attending physician.

Bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss if:

a. The services are to be performed for the treatment of morbid obesity.
b. The physicians on the surgical team and the facility in which the surgical procedure is to take place are approved for the surgical procedure requested; and

c. The bariatric surgical procedure will be performed at a CME facility.

- Advanced imaging procedures, including, but not limited to: Magnetic Resonance Imaging (MRI), Computerized Tomography (CT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography and Nuclear Cardiac Imaging.

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

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

3. Services that are not reviewed prior to or during service delivery will be reviewed retrospectively when the bill is submitted for benefit payment. If that review results in the determination that part or all of the services were not medically necessary and appropriate, benefits will not be provided for those services. Remaining benefits will be subject to previously noted reductions that apply when the required reviews are not obtained.

**HOW TO OBTAIN UTILIZATION REVIEWS**

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

**Pre-service Reviews**

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

2. You must tell your physician that this plan requires pre-service review. Physicians who are participating providers will initiate the review on your behalf. A non-participating provider may initiate the review for you, or you may call us directly. The toll-free number for pre-service review is printed on your identification card.
3. If you do not receive the reviewed service within 60 days of the certification, or if the nature of the service changes, a new pre-service review must be obtained.

4. We will determine if services are medially necessary and appropriate. For inpatient hospital and residential treatment center stays, we will, if appropriate, specify a specific length of stay for services. For facility-based care for the treatment of mental or nervous disorders and substance abuse we will, if appropriate, specify the type and level of services, as well as their duration. You, your physician and the provider of the service will receive a written confirmation showing this information.

Care Coordination Reviews

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

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

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

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

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

1. Retrospective review is performed when we are not notified of the service you received, and are therefore unable to perform the appropriate review prior to your discharge from the hospital or completion of outpatient treatment. It is also performed when pre-service or care coordination review has been done, but services continue longer than originally certified.

   It may also be performed for the evaluation and audit of medical documentation after services have been provided, whether or not pre-service or care coordination review was performed.

2. Such services which have been retroactively determined to not be medically necessary and appropriate will be retrospectively denied certification.

THE MEDICAL NECESSITY REVIEW PROCESS

We work with you and your health care providers to cover medically necessary and appropriate care and services. While the types of services requiring review and the timing of the reviews may vary, we are committed to ensuring that reviews are performed in a timely and professional manner. The following information explains our review process.

1. A decision on the medical necessity of a pre-service request will be made no later than five business days from receipt of the information reasonably necessary to make the decision, and based on the nature of your medical condition.

   When your medical condition is such that you face an imminent and serious threat to your health, including the potential loss of life, limb, or other major bodily function and the normal five day timeframe described above would be detrimental to your life or health or could jeopardize your ability to regain maximum function, a decision on the medical necessity of a pre-service request will be made no later than 72 hours after receipt of the information reasonably necessary to make the decision (or within any shorter period of time required by applicable federal law, rule, or regulation).

2. A decision on the medical necessity of a care coordination request will be made no later than one business day from receipt of the information reasonably necessary to make the decision, and based on the nature of your medical condition. However, care will not be discontinued until your physician has been notified and a plan of care that is appropriate for your needs has been agreed upon.
3. A decision on the medical necessity of a retrospective review will be made and communicated in writing no later than 30 days from receipt of the information necessary to make the decision to you and your physician.

4. If we do not have the information we need, we will make every attempt to obtain that information from you or your physician. If we are unsuccessful, and a delay is anticipated, we will notify you and your physician of the delay and what we need to make a decision. We will also inform you of when a decision can be expected following receipt of the needed information.

5. All pre-service, care coordination and retrospective reviews for medical necessity are screened by clinically experienced, licensed personnel (called “Review Coordinators”) using pre-established criteria and our medical policy. These criteria and policies are developed and approved by practicing providers not employed by us, and are evaluated at least annually and updated as standards of practice or technology change. Requests satisfying these criteria are certified as medically necessary. Review Coordinators are able to approve most requests.

6. For pre-service and care coordination requests, written confirmation including the specific service determined to be medically necessary will be sent to you and your provider no later than two business days after the decision, and your provider will be initially notified by telephone within 24 hours of the decision for pre-service and care coordination reviews.

7. If the request fails to satisfy these criteria or medical policy, the request is referred to a Peer Clinical Reviewer. Peer Clinical Reviewers are health professionals clinically competent to evaluate the specific clinical aspects of the request and render an opinion specific to the medical condition, procedure and/or treatment under review. Peer Clinical Reviewers are licensed in California with the same license category as the requesting provider. When the Peer Clinical Reviewer is unable to certify the service, the requesting physician is contacted by telephone for a discussion of the case. In many cases, services can be certified after this discussion. If the Peer Clinical Reviewer is still unable to certify the service, your provider will be given the option of having the request reviewed by a different Peer Clinical Reviewer.
8. Only the Peer Clinical Reviewer may determine that the proposed services are not *medically necessary* and appropriate. Your *physician* will be notified by telephone within 24 hours of a decision not to certify and will be informed at that time of how to request reconsideration. Written notice will be sent to you and the requesting provider within two business days of the decision. This written notice will include:

- an explanation of the reason for the decision,
- reference of the criteria used in the decision to modify or not certify the request,
- the name and phone number of the Peer Clinical Reviewer making the decision to modify or not certify the request,
- how to request reconsideration if you or your provider disagree with the decision.

9. Reviewers may be plan employees or an independent third party we choose at our sole and absolute discretion.

10. You or your *physician* may request copies of specific criteria and/or medical policy by writing to the address shown on your plan identification card. We disclose our medical necessity review procedures to health care providers through provider manuals and newsletters.

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

- The information submitted with the claim differs from that given by phone;
- The service is excluded from coverage; or
- You are not eligible for coverage when the service is actually provided.

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

- Your coverage under this *plan* ends;
- The *policy* with the *group* terminates;
• You reach a benefit maximum that applies to the services in question;

• Your benefits under the plan change so that the services in question are no longer covered or are covered in a different way.

PERSONAL CASE MANAGEMENT

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

HOW PERSONAL CASE MANAGEMENT WORKS

You may be identified for possible personal case management through the plan’s utilization review procedures, by the attending physician, hospital staff, or our claims reports. You or your family may also call us.

Benefits for personal case management will be considered only when all of the following criteria are met:

1. You require extensive long-term treatment;

2. We anticipate that such treatment utilizing services or supplies covered under this plan will result in considerable cost;

3. Our cost-benefit analysis determines that the benefits payable under this plan for the alternative plan of treatment can be provided at a lower overall cost than the benefits you would otherwise receive under this plan while maintaining the same standards of care; and

4. You (or your legal guardian) and your physician agree, in a letter of agreement, with our recommended substitution of benefits and with the specific terms and conditions under which alternative benefits are to be provided.

Alternative Treatment Plan. If we determine that your needs could be met more efficiently, an alternative treatment plan may be recommended. This may include providing benefits not otherwise covered under this plan. A case manager will review the medical records and discuss your treatment with the attending physician, you and your family.
We make treatment recommendations only; any decision regarding treatment belongs to you and your physician. The group will, in no way, compromise your freedom to make such decisions.

EFFECT ON BENEFITS

1. Benefits are provided for an alternative treatment plan on a case-by-case basis only. We have absolute discretion in deciding whether or not to authorize services in lieu of benefits for any insured person, which alternatives may be offered and the terms of the offer.

2. Any authorization of services in lieu of benefits in a particular case in no way commits us to do so in another case or for another insured person.

3. The personal case management program does not prevent us from strictly applying the expressed benefits, exclusions and limitations of this plan at any other time or for any other insured person.

Note: We reserve the right to use the services of one or more third parties in the performance of the services outlined in the letter of agreement. No other assignment of any rights or delegation of any duties by either party is valid without the prior written consent of the other party.

DISAGREEMENTS WITH MEDICAL MANAGEMENT DECISIONS

1. If you or your physician disagree with a decision, or question how it was reached, you or your physician may request reconsideration. Requests for reconsideration (either by telephone or in writing) must be directed to the reviewer making the determination. The address and the telephone number of the reviewer are included on your written notice of determination. Written requests must include medical information that supports the medical necessity of the services.

2. If you, your representative, or your physician acting on your behalf find the reconsidered decision still unsatisfactory, a request for an appeal of a reconsidered decision may be submitted in writing to us.

3. If the appeal decision is still unsatisfactory, your remedy may be binding arbitration. (See BINDING ARBITRATION.)
EXCEPTIONS TO THE UTILIZATION REVIEW PROGRAM

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

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

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

QUALITY ASSURANCE

Utilization review programs are monitored, evaluated, and improved on an ongoing basis to ensure consistency of application of screening criteria and medical policy, consistency and reliability of decisions by reviewers, and compliance with policy and procedure including but not limited to timeframes for decision making, notification and written confirmation. Our Board of Directors is responsible for medical necessity review processes through its oversight committees including the Strategic Planning Committee, Quality Management Committee, and Physician Relations Committee. Oversight includes approval of policies and procedures, review and approval of self-audit tools, procedures, and results. Monthly process audits measure the performance of reviewers and Peer Clinical Reviewers against approved written policies, procedures, and timeframes. Quarterly reports of audit results and, when needed, corrective action plans are reviewed and approved through the committee structure.
HOW COVERAGE BEGINS AND ENDS

HOW COVERAGE BEGINS

ELIGIBLE STATUS

1. **Insured Employees.** You are in an eligible status if you are a benefited *full-time employee* or a *retired employee*. A *full-time employee* is one who works at least 20 hours a week and 1,040 hours annually in the conduct of the business of the group.

   A *retired employee* retired on or before December 31, 2005 who: (i) is retired from active full-time employment, (ii) has completed 15 years of service in the conduct of the business of the group prior to retirement, (ii) is at least 55 years of age on the date of retirement, and (iii) was covered under a group sponsored plan immediately prior to retirement.

   A *retired employee* retired on or after January 1, 2006 who: (i) is retired from active full-time employment, (ii) has completed 15 years of service in the conduct of the business of the group prior to retirement, (ii) is at least 60 years of age on the date of retirement, and (iii) was covered under a group sponsored plan immediately prior to retirement.

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

Definition of Family Member

1. **Spouse** is the *employee’s spouse* under a legally valid marriage. Spouse does not include any person who is: (a) covered as an *insured employee*; or (b) in active service in the armed forces.

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

3. **Child** is the *employee’s, spouse’s or domestic partner’s natural child, stepchild, legally adopted child, or a child for whom the 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 *employee* under another plan or health insurer, or has six or
more months of other creditable coverage, (ii) is chiefly dependent on the 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 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 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 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 employee’s, the spouse’s or domestic partner’s right to control the health care of the child.

d. A child for whom the 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.

ELIGIBILITY DATE

1. For Employees: You become eligible for coverage on the first day of the month following your date of hire. (This is your "waiting" period.)

2. For Family Members: You become eligible for coverage on the later of: (a) the date the employee becomes eligible for coverage; or (b) the date you meet the family member definition.
Exceptions to the Waiting Period:

1. If, after you have completed the waiting period, you cease to be eligible due to termination of employment, and you return to an eligible status within six months after the date your employment terminated, you will become eligible on the first day of the month following the date you return.

2. If you were covered under the prior plan, the time you spent under the prior plan will be used to satisfy, or partially satisfy, your waiting period under this plan.

ENROLLMENT

To enroll as an employee, or to enroll family members, the 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 31 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

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

1. Timely Enrollment. If you enroll for coverage before, on, or within 31 days after your eligibility date, then your coverage will begin as follows: (a) for employees, on your eligibility date; and (b) for family members, on the later of (i) the date the 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 fail to enroll within 31 days after your eligibility date, you must wait until the group’s next Open Enrollment Period to enroll.

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

For late enrollees and disenrollees: You may enroll earlier than the group’s next Open Enrollment Period if you meet any of the conditions listed under SPECIAL ENROLLMENT PERIODS.
Important Note for Newborn and Newly-Adopted Children. If the insured employee (or spouse or domestic partner, if the spouse or domestic partner is enrolled) is already covered: (1) any child born to the employee, spouse or domestic partner will be enrolled from the moment of birth; and (2) any child being adopted by the 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 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 employee’s, spouse’s or domestic partner’s right to control the health care of the child may be used); or (b) the 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 coverage to continue beyond this 31-day period, the 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 31 days after the date your coverage ends or the date employer contributions toward coverage under the other plan terminate.

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

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

2. A court has ordered coverage be provided for a spouse, domestic partner or dependent child under your employee health plan and an application is filed within 31 days from the date the court order is issued.

3. We do not have a written statement from the group stating that prior to declining coverage or disenrolling, you received and signed acknowledgment of a written notice specifying that if you do not enroll for coverage within 31 days after your eligibility date, or if you disenroll, and later file an enrollment application, your coverage may not begin until the first day of the month following the end of the group’s next open enrollment period.

4. You have a change in family status through either marriage or domestic partnership, or the birth, adoption, or placement for adoption of a child:
   a. If you are enrolling following marriage or domestic partnership, you and your new spouse or domestic partner must enroll within
31 days of the date of marriage or domestic partnership. Your new spouse or domestic partner’s children may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above.

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

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

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

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

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

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

**OPEN ENROLLMENT PERIOD**

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

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

### HOW COVERAGE ENDS

Your coverage ends, without notice from us, as provided below:

1. If the *policy* terminates, your coverage ends at the same time. The *policy* may be cancelled 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 *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 is not paid.

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

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

**Exceptions to Item 6:**

a. **Leave of Absence.** If you are an *insured employee* and the *group* pays premium to us on your behalf, your coverage may continue for up to six months during a temporary leave of absence approved by the *group*. This time period may be extended if required by law.

b. **Handicapped Children.** If a *child* reaches the age limit shown in the "Eligible Status" provision of this section, the *child* will continue to qualify as a *family member* if he or she is (i) covered under this *plan*, (ii) chiefly dependent on the *insured 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 insured 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 insured employee must send proof of the child’s physical or mental condition within 60-days of the date the insured 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 insured 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 employee must give or send to the group written notice of the termination. Coverage for a former spouse or domestic partners, and their dependent children, if any, ends according to the “Eligible Status” provisions. If Anthem Blue Cross Life and Health suffers a loss because of the 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 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 employee notifies the group in writing to cancel coverage for a former spouse or domestic partner and the children of the spouse or domestic partner, if any, immediately upon termination of the 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, CALCOBRA CONTINUATION OF COVERAGE, EXTENSION OF BENEFITS and HIPAA COVERAGE AND CONVERSION.

**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.

DEFINITIONS

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

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

Qualified Beneficiary means: (a) a person enrolled for this COBRA continuation coverage who, on the day before the Qualifying Event, was covered under this policy as either an insured employee or insured family member; and (b) a child who is born to or placed for adoption with the insured employee during the COBRA continuation period. Qualified Beneficiary does not include: (a) any person who was not enrolled during the Initial Enrollment Period, including any family members acquired during the COBRA continuation period, with the exception of newborns and adoptees as specified above; or (b) a domestic partner, or a child of...
a *domestic partner*, if they are eligible under HOW COVERAGE BEGINS AND ENDS.

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

1. **For Insured Employees and Insured Family Members:**
   a. The *employee’s* termination of employment, for any reason other than gross misconduct; or
   b. A reduction in the *employee’s* work hours.

2. **For Retired Employees and their Insured Family Members.**
   Cancellation or a substantial reduction of retiree benefits under the *plan* due to the *group’s* filing for Chapter 11 bankruptcy, provided:
   a. The *policy* expressly includes coverage for retirees; and
   b. Such cancellation or reduction of benefits occurs within one year before or after the *group’s* filing for bankruptcy.

3. **For Insured Family Members:**
   a. The death of the *insured employee;*
   b. The *spouse’s* divorce or legal separation from the *employee;*
   c. The end of a *child’s* status as a dependent *child*, as defined by the *policy;* or
   d. The *employee’s* entitlement to Medicare.

**ELIGIBILITY FOR COBRA CONTINUATION**

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

**TERMS OF COBRA CONTINUATION**

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

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

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

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

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

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

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

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

Besides applying to the insured employee, the employee’s premium rate will also apply to:

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

2. 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

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

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

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

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

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

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

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

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

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

4. The date the policy terminates;

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

6. The date, following the election of COBRA, the insured person first becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the insured person, in which case this COBRA continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied; or

7. The date, following the election of COBRA, the insured person first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.
*For an insured person whose COBRA continuation coverage began under a prior plan, this term will be dated from the time of the Qualifying Event under that prior plan. Additional note: If your COBRA continuation under this plan began on or after January 1, 2003 and ends in accordance with item 1, you may further elect to continue coverage for medical benefits only under CalCOBRA for the balance of 36 months (COBRA and CalCOBRA combined). All COBRA eligibility must be exhausted before you are eligible to further continue coverage under CalCOBRA. Please see CalCOBRA CONTINUATION OF COVERAGE in this booklet for more information.

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

If your COBRA continuation under this plan ends in accordance with items 1, 2 or 3, you may be eligible for medical conversion coverage. If your COBRA continuation under this plan ends in accordance with items 1, 2, 3, or 4 you may be eligible for HIPAA coverage. The group will provide notice of these options within 180 days prior to your COBRA termination date. Please see HIPAA COVERAGE AND CONVERSION in this booklet for more information.

EXTENSION OF CONTINUATION DURING TOTAL DISABILITY

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

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

1. Satisfy the legal requirements for being totally and permanently disabled under the Social Security Act; and
2. Be determined and certified to be so disabled by the Social Security Administration.

Notice. The insured person must furnish the group with proof of the Social Security Administration's determination of disability during the first 18 months of the COBRA continuation period and no later than 60 days after the later of the following events:
1. The date of the Social Security Administration’s determination of the disability;
2. The date on which the original Qualifying Event occurs;
3. The date on which the Qualified Beneficiary loses coverage; or
4. The date on which the Qualified Beneficiary is informed of the obligation to provide the disability notice.

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

1. If the disabled insured person continues coverage during this extension, this rate shall be 150% of the applicable rate for the length of time the disabled insured person remains covered, depending upon the number of covered dependents. If the disabled insured person does not continue coverage during this extension, this charge shall remain at 102% of the applicable rate.

2. The cost for extended continuation coverage must be remitted to us by the group each month during the period of extended continuation coverage. We must receive timely payment of the premium each month from the group in order to maintain the extended continuation coverage in force.

3. The group may require that you pay the entire cost of the extended continuation coverage.

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

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

1. The end of the month following a period of 30 days after the Social Security Administration’s final determination that you are no longer totally disabled;
2. The end of 29 months from the Qualifying Event*;
3. The date the policy terminates;
4. The end of the period for which premiums are last paid;
5. The date, following the election of COBRA, the insured person first becomes covered under the other group health plan, unless the other group health plan contains an exclusion or limitation to a pre-existing condition of the insured person, in which case this COBRA extension will end at the end of the period for which the pre-existing condition exclusion or limitation applied; or

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

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

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

CALCOBRA CONTINUATION OF COVERAGE

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

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

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

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

TERMS OF CALCOBRA CONTINUATION

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

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

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

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

1. 110% of the applicable *group* rate if your coverage under federal COBRA ended after 18 months; or
2. 150% of the applicable *group* rate if your coverage under federal COBRA ended after 29 months.

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

**Payment Dates.** The first payment is due along with your enrollment form within 45 days after you elect continuation coverage. You must make this payment by first-class mail or other reliable means of delivery, in an amount sufficient to pay any required premium and premium due. Failure to submit the correct amount within this 45-day period will disqualify you from receiving continuation coverage under CalCOBRA. Succeeding premium payments are due on the first day of each following month.
If premium payments are not received when due, your coverage will be cancelled. We will cancel your coverage only upon sending you written notice of cancellation at least 30 days prior to cancelling your coverage (or any longer period of time required by applicable federal law, rule, or regulation). If you make payment in full within this time period, your coverage will not be cancelled. If you do not make the required payment in full within this time period, your coverage will be cancelled as of 12:00 midnight on the thirtieth day after the date on which the notice of cancellation is sent (or any longer period of time required by applicable federal law, rule, or regulation) and will not be reinstated. Any payment we receive after this time period runs out will be refunded to you within 20 business days. Note: You are still responsible for any unpaid premium payments that you owe to us, including premium payments that apply during any grace period.

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

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

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

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

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

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

1. The date that is 36 months after the date of your qualifying event under federal COBRA*;
2. The date the policy terminates;
3. The date the group no longer provides coverage to the class of employees to which you belong;

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

5. The date you become covered under any other health plan, unless the other health plan contains an exclusion or limitation relating to a pre-existing condition that you have. In this case, this continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied;

6. The date you become entitled to Medicare; or

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

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

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

If your CalCOBRA continuation under this plan ends in accordance with items 1, 2, or 3, you may be eligible for HIPAA coverage or medical conversion coverage. You will receive notice of these options within 180 days prior to your CalCOBRA termination date. Please see HIPAA COVERAGE AND CONVERSION in this booklet for more information.

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.

**HIPAA COVERAGE AND CONVERSION**

If your coverage for medical benefits under this plan ends, you may be eligible to enroll for coverage with any carrier or health plan that offers individual medical coverage. HIPAA coverage and conversion coverage are available upon request if you meet the requirements stated below. Both HIPAA coverage and conversion are available for medical benefits only. Please note that the benefits and cost of these plans will differ from your employer’s plan.

**HIPAA Coverage**

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides an option for individual coverage when coverage under the employer’s group plan ends. To be eligible for HIPAA coverage, you must meet all of the following requirements:

1. You must have a minimum of 18 months of continuous health coverage, most recently under an employer-sponsored health plan, and have had coverage within the last 63 days.
2. Your most recent coverage was not terminated due to nonpayment of premiums or fraud.
3. If continuation of coverage under the employer plan was available under COBRA, CalCOBRA, or a similar state program, such coverage must have been elected and exhausted.
4. You must not be eligible for Medicare, Medicaid, or any group medical coverage and cannot have other medical coverage.
You must apply for HIPAA coverage within 63 days of the date your coverage under the employer's plan ends. Any carrier or health plan that offers individual medical coverage must make HIPAA coverage available to qualified persons without regard to health status. If you decide to enroll in HIPAA coverage, you will no longer qualify for conversion coverage.

Conversion Coverage

To apply for a conversion plan, you must submit an application to us and make the first premium payment within 63 days of the date your coverage under the employer's plan ends. Under certain circumstances you are not eligible for a conversion plan. They are:

1. You are not eligible if your coverage under this plan ends because the policy terminates and is replaced by another group plan within 15 days.

2. You are not eligible if your coverage under this plan ends because premium is not paid when due because you (or the insured employee who enrolled you as a dependent) did not contribute your part, if any.

3. You are not eligible for a conversion plan if you are eligible for health coverage under another group plan when your coverage ends.

4. You are not eligible for a conversion plan if you are eligible for Medicare coverage when your coverage under this plan ends, whether or not you have actually enrolled in Medicare.

5. You are not eligible for a conversion plan if you are covered under an individual health plan.

6. You are not eligible for a conversion plan if you were not covered for medical benefits under the plan for three consecutive months immediately prior to the termination of your coverage.

If you decide to enroll in a conversion plan, you will no longer qualify for HIPAA coverage.

**Important:** The intention of conversion coverage is not to replace the coverage you have under this plan, but to make available to you a specified amount of coverage for medical benefits until you can find a replacement. The conversion plan provides lesser benefits than this plan and the provisions and rates differ.
When coverage under your employer’s group plan ends, you will receive more information about how to apply for HIPAA coverage or conversion, including a postcard for requesting an application and a telephone number to call if you have any questions.

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.

Out of Area Services. We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs”. Whenever you obtain healthcare services outside of our service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard® Program and may include negotiated National Account arrangements available between us and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside our service area, you may obtain care from healthcare providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, you may obtain care from non-participating healthcare providers. Our payment practices in both instances are described below.

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services outside our service area and the claim is processed through the BlueCard® Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to us.
Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

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

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

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

Terms of Coverage

1. In order for you to be entitled to benefits under the 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.

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.

Availability of Care. If there is an epidemic or public disaster and you cannot obtain care for covered services, we refund the unearned part of the premium charge paid for you. A written request for that refund and satisfactory proof of the need for care must be sent to us within 31 days. This payment fulfills our obligation under this plan.

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

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

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

Notice of Claim. You, or someone on your behalf, must give us written notice of a claim within 20 days after you incur covered 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.
Proof of Loss. You or the provider of service must send us properly and fully completed claim forms within 90 days of the date you receive the service or supply for which a claim is made. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed. Except in the absence of legal capacity, we are not liable for the benefits of the plan if you do not file claims within the required time period. We will not be liable for benefits if we do not receive written proof of loss on time.

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

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

Payment to Providers. We will pay the benefits of this plan directly to contracting hospitals, participating providers, CME and medical transportation providers. Also, we will 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 will 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.

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

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

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

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

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

No claim for covered charges in connection with a pre-existing condition will be reduced or denied after you have been covered for six consecutive months under the policy, unless the disease, illness, injury or physical condition was specifically excluded from coverage by name or description. Also, if you were covered under creditable coverage, the time spent under the creditable coverage will be used to satisfy, or reduce, the six consecutive month period.

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.

Certificate of Creditable Coverage. Certificates of creditable coverage are issued automatically when your coverage under this plan ends. We will also provide a certificate of creditable coverage in response to your request, or to a request made on your behalf, at any time while you are
covered under this plan and up to 24 months after your coverage under this plan ends. The certificate of creditable coverage documents your coverage under this plan. To request a certificate of creditable coverage, please call the customer service telephone number listed on your ID card.

**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 customer service at the telephone number listed on your ID card to request continuity of care or to obtain a copy of the written policy. Eligibility is based on 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.

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 investigatory, 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:
    - Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized standards;
    - Medical literature meeting the criteria of the National 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 customer service telephone number listed on your ID card.

**BINDING ARBITRATION**

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this plan or the policy, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

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

The insured person and Anthem Blue Cross Life and Health agree to be bound by these arbitration provisions and acknowledge that they are giving up their right to trial by jury for both medical malpractice claims and any other disputes.

The insured person and Anthem Blue Cross Life and Health agree to give up the right to participate in class arbitrations against each other. Even if applicable law permits class actions or class arbitrations, the insured person waives any right to pursue, on a class basis, any such
controversy or claim against Anthem Blue Cross Life and Health and Anthem Blue Cross Life and Health waives any right to pursue on a class basis any such controversy or claim against the insured person.

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 person making written demand on Anthem Blue Cross Life and Health. 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 person and Anthem Blue Cross Life and Health, or by order of the court, if the insured person and Anthem Blue Cross Life and Health cannot agree.

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

Please send all Binding Arbitration demands in writing to Anthem Blue Cross Life and Health Insurance Company, P.O. Box 4310, Woodland Hills, CA 91365-4310 marked to the attention of the Customer Service Department listed on your identification card.

DEFINITIONS

The meanings of key terms used in this 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, are referred to a **non-participating provider**, but only when:

- There is no **participating provider** who practices in the appropriate specialty, which provides the required services, or which has the necessary facilities within a 30-mile radius of your residence or within the county in which your residence is located, whichever is less; and
- You are referred in writing to the **non-participating provider** by the **physician** who is a **participating provider**; and
- We have authorized the referral before services are rendered.

Benefits for **medically necessary** and appropriate **authorized referral** services received from a **non-participating provider** will be payable as shown in the Exceptions under the SUMMARY OF BENEFITS: CO-PAYMENTS.

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

Such authorized referrals are not available to bariatric surgical services. These services are only covered when performed at a designated bariatric **CME**.

**Bariatric CME Coverage Area** is the area within the 50-mile radius surrounding a designated bariatric **CME**.

**Brand name prescription drug (brand name drug)** is a **prescription drug** that has been patented and is only produced by one manufacturer.

**Centers of Medical Excellence (CME)** are health care providers designated by us as a selected facility for specified medical services. A provider participating in a CME network has an agreement in effect with us at the time services are rendered or is available through our affiliate companies or our relationship with the Blue Cross and Blue Shield Association. CME agree to accept the **maximum allowed amount** as payment in full for covered services. A **participating provider** in the Prudent Buyer Plan network is not necessarily a **CME**.

**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, of which at least one of the components is commercially available as a prescription product. Compound medications do not include:
1. Duplicates of existing products and supplies that are mass-produced by a manufacturer for consumers; or

2. Products lacking a National Drug Code (NDC) number.

**Contracting hospital** is a hospital which has a Standard Hospital Contract in effect with Anthem Blue Cross, an affiliate of Anthem Blue Cross Life and Health, to provide care to persons covered by Anthem Blue Cross or any of its affiliates. A list of contracting hospitals will be sent on request.

**Creditable coverage** is any individual or group plan that provides medical, hospital and surgical coverage, including continuation or conversion coverage, coverage under Medicare or Medicaid, TRICARE, the Federal Employees Health Benefits Program, programs of the Indian Health Service or of a tribal organization, a state health benefits risk pool, coverage through the Peace Corps, the State Children's Health Insurance Program, or a public health plan established or maintained by a state, the United States government, or a foreign country. Creditable coverage does not include accident only, credit, coverage for on-site medical clinics, disability income, coverage only for a specified disease or condition, hospital indemnity or other fixed indemnity insurance, Medicare supplement, long-term care insurance, dental, vision, workers’ compensation insurance, automobile insurance, no-fault insurance, or any medical coverage designed to supplement other private or governmental plans. Creditable coverage is used to reduce the length of the pre-existing condition exclusion period under this plan and/or to set up eligibility rules for children who cannot get a self-sustaining job due to a physical or mental condition.

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).

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).
Custodial care is care provided primarily to meet your personal needs. This includes help in walking, bathing or dressing. It also includes: preparing food or special diets; feeding by utensil, tube or gastrostomy; suctioning and administration of medicine which is usually self-administered or any other care which does not require continuing services of medical personnel.

If medically necessary, benefits will be provided for feeding (by tube or gastrostomy) and suctioning.

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

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

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

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

Emergency is a sudden, serious, and unexpected acute illness, injury, or condition (including without limitation sudden and unexpected severe pain), or a psychiatric emergency medical condition, which the 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.

Facility-based care is care provided in a hospital, psychiatric health facility, residential treatment center or day treatment center for the treatment of mental or nervous disorders or substance abuse.

Formulary drug is a drug listed on the prescription drug formulary.

Full-time employee meets the plan’s eligibility requirements for full-time employees as outlined under HOW COVERAGE BEGINS AND ENDS.
Generic prescription drug (generic drug) is a pharmaceutical equivalent of one or more brand name drugs and must be approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength, and effectiveness as the brand name drug.

Group refers to the business entity to which we have issued this policy. The name of the group is THE CSU CHICO RESEARCH FOUNDATION.

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 or nervous disorder or substance abuse), and (2) residential treatment centers.

Infertility is: (1) the presence of a condition recognized by a physician as a cause of infertility; or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.
**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**. An insured person may enroll under only one health plan provided by Anthem Blue Cross Life and Health, or any of its affiliates, which is sponsored by the **group**.

**Investigative** procedures or medications are those that have progressed to limited use on humans, but which are not widely accepted as proven and effective 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. Provided for the diagnosis or direct care and treatment of the medical condition;
3. Within standards of good medical practice within the organized medical community;
4. Not primarily for your convenience, or for the convenience of your **physician** or another provider;
5. 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
6. 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; and

c. For hospital stays, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received by you as an outpatient or in a less intensified medical setting.

Mental or nervous disorders, for the purposes of this plan, are conditions that affect thinking and the ability to figure things out, perception, mood and behavior. A mental or nervous disorder is recognized primarily by symptoms or signs that appear as distortions of normal thinking, distortions of the way things are perceived (e.g., seeing or hearing things that are not there), moodiness, sudden and/or extreme changes in mood, depression, and/or unusual behavior such as depressed behavior or highly agitated or manic behavior. Mental or nervous disorders include severe mental disorders as defined in this plan (see definition of "severe mental disorders").

Any condition meeting this definition is a mental or nervous disorder no matter what the cause of the condition may be.

Multi-source brand name drugs are drugs with at least one generic substitute.

Non-contracting hospital is a hospital which does not have a Standard Hospital Contract in effect with Anthem Blue Cross, Anthem Blue Cross Life and Health’s parent company, at the time services are rendered.

Non-participating pharmacy is a pharmacy which does not have a contract in effect with the pharmacy benefits manager at the time services are rendered. In most cases, you will be responsible for a larger portion of your pharmaceutical bill when you go to a non-participating pharmacy.

Non-participating provider is one of the following providers which does NOT have a Prudent Buyer Plan Participating Provider Agreement in effect with us at the time services are rendered:

- A hospital
- A physician

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• An ambulatory surgical center
• A home health agency
• A facility which provides diagnostic imaging services
• A durable medical equipment outlet
• A skilled nursing facility
• A clinical laboratory
• A home infusion therapy provider
• An urgent care center
• A retail health clinic
• A hospice
• A licensed ambulance company
• A licensed qualified autism service provider

They are not participating providers. Remember that the maximum allowed amount may only represent a portion of the amount which a non-participating provider charges for services. See YOUR MEDICAL BENEFITS: MAXIMUM ALLOWED AMOUNT.

Other health care provider is one of the following providers:

• A certified registered nurse anesthetist
• A blood bank

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

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

Participating provider is one of the following providers or other licensed health care professionals who have a Prudent Buyer Plan Participating Provider Agreement in effect with us at the time services are rendered:

• A hospital
• A physician
• An ambulatory surgical center
• A home health agency
• A facility which provides diagnostic imaging services
• A durable medical equipment outlet
• A skilled nursing facility
• A clinical laboratory
• A home infusion therapy provider
• An urgent care center
• A retail health clinic
• A hospice
• A licensed ambulance company
• A licensed qualified autism service provider

Participating providers agree to accept the maximum allowed amount as payment for covered services. A directory of participating providers is available upon request.

Pharmacy means a licensed retail pharmacy.

Pharmacy and Therapeutics Process is a process in which health care professionals including nurses, pharmacists, and physicians determine the clinical appropriateness of drugs and promote access to quality medications. The process also reviews drugs to determine the most cost effective use of benefits and advise on programs to help improve care. Our programs include, but are not limited to, drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and drug profiling initiatives.

Pharmacy Benefits Manager (PBM) is the entity with which Anthem has contracted with to administer its prescription drug benefits. The PBM is an independent contractor and not affiliated with Anthem.

Physician means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or

2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license and such license is required to render that service, and is providing a service for which benefits are specified in this booklet:
   • A dentist (D.D.S. or D.M.D.)
   • An optometrist (O.D.)
   • A dispensing optician
   • A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
   • A licensed clinical psychologist
A licensed educational psychologist for the provision of behavioral health treatment services for the treatment of pervasive developmental disorder or autism only

- A chiropractor (D.C.)
- An acupuncturist (A.C.)
- A licensed clinical social worker (L.C.S.W.)
- A marriage and family therapist (M.F.T.)
- A licensed professional clinical counselor (L.P.C.C.)*
- A physical therapist (P.T. or R.P.T.)*
- A speech pathologist*
- An audiologist*
- An occupational therapist (O.T.R.)*
- A respiratory care practitioner (R.C.P.)*
- A nurse practitioner
- A psychiatric mental health nurse (R.N.)*
- A nurse midwife**
- A registered dietitian (R.D.)* for the provision of diabetic medical nutrition therapy only

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

**If there is no nurse midwife who is a participating provider in your area, you may call the Customer Service telephone number on your ID card for a referral to an OB/GYN.

Plan is the set of benefits described in this booklet and in the amendments to this booklet (if any). This plan is subject to the terms and conditions of the 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.

Pre-existing condition means an illness, injury or condition which existed during the six-month period immediately prior to either (a) your effective date or (b) the first day of any waiting period required by the group, whichever is earlier. A condition is considered to have existed when you: (1) sought or received medical advice for that condition; (2) received medical care or treatment for that condition; or (3) received medical supplies, drugs or medicines for that condition.
**Prescription** means a written order or refill notice issued by a licensed prescriber.

**Prescription drug tiers** are used to classify drugs for the purpose of setting their co-payment. Anthem will decide which drugs should be in each tier based on clinical decisions made by the Pharmacy and Therapeutics Process. Anthem retains the right at its discretion to determine coverage for dosage formulation in terms of covered dosage administration methods (for example, by mouth, injection, topical or inhaled) and may cover one form of administration and may exclude or place other forms of administration in another tier (if it is medically necessary for you to get a drug in an administrative form that is excluded will you need to get written prior authorization (see PRESCRIPTION DRUG FORMULARY: PRIOR AUTHORIZATION above) to get that that administrative form of the drug), This is an explanation of what drugs each tier includes:

- **Tier 1 Drugs** are those that have the lowest co-payment. This tier includes low cost preferred drugs that may be generic, single source brand name drugs or multi-source brand name drugs.

- **Tier 2 Drugs** are those that have higher copayments than Tier 1 Drugs, but, lower than Tier 3 Drugs. This tier includes preferred drugs that may be generic, single source brand name drugs or multi-source brand name drugs.

- **Tier 3 Drugs** are those that have the higher copayments than Tier 2 Drugs, but, lower than Tier 4 Drugs. This tier includes non-preferred drugs that may be generic, single source brand name drugs or multi-source brand name drugs.

- **Tier 4 Drugs** are those that have the higher copayments than Tier 3 Drugs. This tier includes non-preferred drugs that may be generic, single source brand name drugs or multi-source brand name drugs.

**Prescription drug covered expense** is the expense you incur for a covered prescription drug, but not more than the prescription drug maximum allowed amount. Expense is incurred on the date you receive the service or supply.

**Prescription drug maximum allowed amount** is the maximum amount allowed for any drug. The amount is determined by using prescription drug cost information provided to us by the pharmacy benefits manager. The amount is subject to change. You may determine the prescription drug maximum allowed amount of a particular drug by calling 1-800-700-2541 (or TTY/TDD 1-800-905-9821).
Prescription drug formulary (formulary) is a list which we have developed of outpatient prescription drugs which may be cost-effective, therapeutic choices. Any participating pharmacy can assist you in purchasing drugs listed on the formulary. You may also get information about covered formulary drugs by calling 1-888-224-4911 or going to our internet website anthem.com/ca.

Preventive Care Services include routine examinations, screenings, tests, education, and immunizations administered with the intent of preventing future disease, illness, or injury. Services are considered preventive if you have no current symptoms or prior history of a medical condition associated with that screening or service. These services shall meet requirements as determined by federal and state law. Sources for determining which services are recommended include the following:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force (USPSTF);
2. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.

Please call us at the customer service number listed on your ID card for additional information about services that are covered by this plan as preventive care services. You may also refer to the following websites that are maintained by the U.S. Department of Health & Human Services.

http://www.healthcare.gov/center/regulations/prevention.html
http://www.ahrq.gov/clinic/uspstfix.htm
http://www.cdc.gov/vaccines/recs/acip/

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 or nervous disorder* that manifests itself by acute symptoms of sufficient severity that the patient is either (1) an immediate danger to himself or herself or to others, or (2) immediately unable to provide for or utilize food, shelter, or clothing due to the *mental or nervous disorder*.

**Psychiatric health facility** is an acute 24-hour facility as defined in California Health and Safety Code 1250.2. It must be:

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

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

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

**Residential treatment center** is an inpatient treatment facility where the patient resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation as the result of a *mental or nervous disorder* or substance abuse. The facility must be licensed to provide psychiatric treatment of *mental or nervous disorders* or rehabilitative treatment of substance abuse according to state and local laws.

**Retail Health Clinic** - A facility that provides limited basic medical care services to *insured persons* on a "walk-in" basis. These clinics normally operate in major pharmacies or retail stores.
Severe mental disorders include the following psychiatric diagnoses specified in California Insurance Code section 10144.5: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, and bulimia.

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

1. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community and is at risk of being removed from the home or has already been removed from the home or the mental disorder has been present for more than six months or is likely to continue for more than one year without treatment.

2. The child is psychotic, suicidal, or potentially violent.

3. The child meets special education eligibility requirements under California law (Government Code Section 7570).

Single source brand name drugs are drugs with no generic substitute.

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

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

Specialty drugs are typically high-cost, injectable, infused, oral or inhaled medications that generally require close supervision and monitoring of their effect on the patient by a medical professional. Certain specified specialty drugs may require special handling, such as temperature controlled packaging and overnight delivery, and therefore, certain specified specialty drugs will be required to be obtained through the specialty pharmacy program, unless you qualify for an exception.

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

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

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**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.

**Transplant Centers of Medical Excellence maximum allowed amount (CME maximum allowed amount)** is the fee *CME* agree to accept as payment for covered services. It is usually lower than their normal charge. CME maximum allowed amounts are determined by Centers of Medical Excellence Agreements.

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

**Urgent care center** is a physician’s office or a similar facility which meets established ambulatory care criteria and provides medical care outside of a hospital emergency department, usually on an unscheduled, walk-in basis. Urgent care centers are staffed by medical doctors, nurse practitioners and physician assistants primarily for the purpose of treating patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room.

To find an urgent care center, please call us at the customer service number listed on your ID card or you can also search online using the “Provider Finder” function on our website at [www.anthem.com/ca](http://www.anthem.com/ca). Please call the urgent care center directly for hours of operation and to verify that the center can help with the specific care that is needed.

**We (us, our)** refers to Anthem Blue Cross Life and Health Insurance Company or Anthem Blue Cross (an affiliate of Anthem Blue Cross Life and Health).

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

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

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**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 certain rights and responsibilities to help make sure that you get the most from your plan and access to the best care possible. That includes certain things about your care, how your personal information is shared and how you work with us and your doctors. It's kind of like a “Bill of Rights”. It helps you know what you can expect from your overall health care experience and become a smarter health care consumer.

You have the right to:

- Speak freely and privately with your doctors and other health professionals about all health care options and treatment needed for your condition, no matter what the cost or whether it's covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect, dignity, and the right to privacy.
- Privacy, when it comes to your personal health information, as long as it follows state and Federal laws, and our privacy rules.
- Get information about our company and services, and our network of doctors and other health care providers.
- Get more information about your rights and responsibilities and give us your thoughts and ideas about them.
- Give us your thoughts and ideas about any of the rules of your health care plan and in the way your plan works.
- Make a complaint or file an appeal about:
  - Your health care plan
  - Any care you get
  - Any covered service or benefit ruling that your health care plan makes
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future; and the right to have your doctor tell you how that may affect your health now and in the future
- Participate in matters that deal with the company policies and operations.
- Get all of the most up-to-date information about the cause of your illness, your treatment and what may result from that illness or treatment from a doctor or other health care professional. When it seems that you will not be able to understand certain information, that information will be given to someone else that you choose.
- Get help at any time, by contacting your local insurance department.

You have the responsibility to:
Choose any primary care physician (doctor), also called a PCP, who is in our network if your health care plan says that you have to have a PCP.

Treat all doctors, health care professionals and staff with courtesy and respect.

Keep all scheduled appointments with your health care providers and call their office if you have a delay or need to cancel.

Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.

To the extent possible, understand your health problems and work with your doctors or other health care professionals to make a treatment plan that you all agree on.

Follow the care plan that you have agreed on with your doctors or health care professionals.

Tell your doctors or other health care professionals if you don’t understand any care you’re getting or what they want you to do as part of your care plan.

Follow all health care plan rules and policies.

Let our Customer Service department know if you have any changes to your name, address or family members covered under your plan.

Give us, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health care plans and insurance benefits you have in addition to your coverage with us.

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

**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](http://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.

To request a written or oral translation, please contact customer service by calling the phone number on your ID card to update your language preference to receive future translated documents or to request interpretation assistance.

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

STATEMENT OF RIGHTS UNDER THE NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

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

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.
In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, please call us at the customer service telephone number listed on your ID card.

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

This plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). If you have any questions about this coverage, please call us at the customer service telephone number listed on your ID card.