CITY OF MERCED

January 1, 2018

LOW OPTION PLAN

Prudent Buyer EPO Benefit Booklet

SPD175075-21 0318 PBE 100-20/100 (FC96)

Dear Plan Member:

This Benefit Booklet provides a complete explanation of your benefits, limitations and other plan provisions which apply to you.

Subscribers and covered dependents ("members") are referred to in this booklet as "you" and "your". The *plan administrator* is referred to as "we", "us" and "our".

All italicized words have specific definitions. These definitions can be found either in the specific section or in the DEFINITIONS section of this booklet.

Please read this Benefit Booklet ("*benefit booklet*") carefully so that you understand all the benefits your *plan* offers. Keep this Benefit Booklet handy in case you have any questions about your coverage.

Important: This is not an insured benefit plan. The benefits described in this Benefit Booklet or any rider or amendments hereto are funded by the *plan administrator* who is responsible for their payment. Anthem Blue Cross Life and Health Insurance Company provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association (BCA).

COMPLAINT NOTICE

All complaints and disputes relating to coverage under this *plan* must be resolved in accordance with the *plan's* grievance procedures. Grievances may be made by telephone (please call the number described on your Identification Card) or in writing (write to Anthem Blue Cross Life and Health Insurance Company, 21555 Oxnard Street, Woodland Hills, CA 91367 marked to the attention of the Member Services Department named on your identification card). If you wish, the Claims Administrator will provide a Complaint Form which you may use to explain the matter.

All grievances received under the *plan* will be acknowledged in writing, together with a description of how the *plan* proposes to resolve the grievance. Grievances that cannot be resolved by this procedure shall be submitted to arbitration.

Claims Administered by:

ANTHEM BLUE CROSS

on behalf of

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

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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. IF YOU HAVE SPECIAL HEALTH CARE NEEDS, YOU SHOULD CAREFULLY READ THOSE SECTIONS THAT APPLY TO THOSE NEEDS. THE MEANINGS OF WORDS AND PHRASES IN ITALICS ARE DESCRIBED IN THE SECTION OF THIS BOOKLET ENTITLED DEFINITIONS.

Participating Providers in California. The *claims administrator* has established a network of various types of "Participating Providers". These providers are called "participating" because they have agreed to participate in their preferred provider organization program (PPO), which is called the Prudent Buyer Plan. *Participating providers* have agreed to a rate they will accept as reimbursement for covered services. See the definition of "Participating Providers" in the DEFINITIONS section for a complete list of the types of providers which may be *participating providers*.

All care must be provided, or coordinated by, a *participating provider physician*.

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

How to Access Primary and Specialty Care Services

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

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

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

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

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

A directory of Participating Providers is available upon request. 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 the Member Services number listed on your ID card and request for a directory to be sent to you. You may also search for a *participating provider* using the "Find a Doctor" function on the website at **www.anthem.com/ca**. The listings include the credentials of *participating providers* such as specialty designations and board certification.

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

Participating Providers Outside of California

If you are outside of the California service areas, please call the toll-free BlueCard Provider Access number on your ID card to find a *participating provider* in the area you are in. A directory of PPO Providers for outside of California is available upon request.

Non-Participating Providers. *Non-participating providers* are providers which have not agreed to participate in the Prudent Buyer Plan network. They have not agreed to the reimbursement rates and other provisions of a Prudent Buyer Plan contract. **Benefits are provided for them under the plan only if you have an *authorized referral,* for an *emergency* or for *urgent care.***

In addition, if you are a new *member* who enrolled in this *plan* as a result of the *plan administrator* changing health plans, and you are receiving services for an acute, serious, or chronic *mental or nervous disorder* from a *non-participating provider*, you may be able to continue your course of treatment with *the non-participating provider* for a reasonable period of time prior to transferring to another provider who participates in the Prudent Buyer Plan network. To request this continued care or to get a copy of the *claims administrator's* written policy for this continued care, please call the Member Services telephone number listed on your ID card.

The *claims administrator* has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity.

Members seeking services from *non-participating providers* could be balance billed by the *non-participating provider* for those services that are determined to be not payable as a result of these review processes and meets the criteria set forth in any applicable state regulations adopted pursuant to state law. A claim may also be determined to be not payable due to a provider's failure to submit medical records with the claims that are under review in these processes.

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

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* 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 the Member Services telephone number listed on your ID card to ensure that you can obtain the health care services that you need.

Centers of Medical Excellence. The *claims administrator* is 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—BlueCross BlueShield Global Core

Prior to travel outside the United States, call the Member Services telephone number listed on your ID card to find out if your plan has BlueCross BlueShield Global Core benefits. Your coverage outside the United States is limited and the *claims administrator* recommends:

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

- Always carry your current ID card.

- In an emergency, seek medical treatment immediately.

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

Payment Information

- **Participating BlueCross BlueShield Global Core hospitals.** In most cases, you should not have to pay upfront for inpatient care at participating BlueCross BlueShield Global Core *hospitals* except for the out-of-pocket costs you normally pay (non-covered services, deductible, co-payments, and co-insurance). 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 BlueCross BlueShield Global Core *hospital*. Then you can complete a BlueCross BlueShield Global Core claim form and send it with the original bill(s) to the BlueCross BlueShield Global Core Service Center (the address is on the form).

Claim Filing

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

Additional Information About BlueCross BlueShield Global Core Claims.

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

Claim Forms

- International claim forms are available from the *claims administrator*, from the BlueCross BlueShield Global Core Service Center, or online at:

  www.bcbsglobalcore.com

  The address for submitting claims is on the form.

TIMELY ACCESS TO CARE

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

- **Urgent Care appointments for services that do not require prior authorization:** within forty-eight (48) hours of the request for an appointment;
- **Urgent Care appointments for services that require prior authorization:** within ninety-six (96) hours of the request for an appointment;
- **Non-Urgent appointments for primary care:** within ten (10) business days of the request for an appointment;
- **Non-Urgent appointments with specialists:** within fifteen (15) business days of the request for an appointment;
- **Appointments for ancillary services (diagnosis or treatment of an injury, illness or other health condition) that are not urgent care:** within fifteen (15) business days of the request for an appointment.

For Mental Health Conditions and Substance Abuse care:

- **Urgent Care appointments for services that do not require prior authorization:** within forty-eight (48) hours of the request for an appointment;
- **Urgent Care appointments for services that require prior authorization:** within ninety-six (96) hours of the request for an appointment;
- **Non-Urgent appointments with mental health and substance abuse providers who are not psychiatrists:** within ten (10) business days of the request for an appointment;
- **Non-Urgent appointments with mental health and substance abuse providers who are psychiatrists:** within fifteen (15) business days of the request for an appointment. Due to accreditation standards, the date will be ten (10) business days for the initial appointment only.

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

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

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

SUMMARY OF BENEFITS

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

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

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

For your convenience, this summary provides a brief outline of your benefits. You need to refer to the entire *benefit booklet* for more complete information about the benefits, conditions, limitations and exclusions of your *plan*.

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

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

Also, the *plan* may not impose deductibles, co-payments, co-insurance, and out of pocket expenses on mental health and substance abuse benefits that are more restrictive than deductibles, co-payments, co-insurance and out of pocket expenses applicable to other medical and surgical benefits.

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

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*.

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

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

The benefits of this *plan* may be subject to the SUBROGATION AND REIMBURSEMENT section.

MEDICAL BENEFITS

DEDUCTIBLES

Calendar Year Deductibles

- Member Deductible..... **$100**
- Family Deductible **$300**

Additional Deductible

- Emergency Room Deductible..... **$200**

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

– The Calendar Year Deductible will not apply to the Preventive Care Services benefit.

– The Calendar Year Deductible will not apply to office visits to a *physician*.

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

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

– The Calendar Year Deductible will not apply to services and supplies provided under the Pregnancy and Maternity Care benefit.

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

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

CO-PAYMENTS

Co-Payment.* After you have met any applicable deductible, you will be responsible for the following copayments:

- *Participating Providers*..... **No charge**
- *Other Health Care Providers* ..... **No charge**
- *Non-Participating Providers (*Only with an *authorized referral.)* ..... **No charge**

Note: 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:**

– Your Co-Payment for inpatient services will be **$100** per day for the first three days of your inpatient *stay*. This Co-Payment will not apply for inpatient services provided under the Pregnancy and Maternity Care benefit.

– Your Co-Payment for outpatient surgery or services at an *ambulatory surgical center* will be **$100** per occurrence.

– Your Co-Payment for services provided by a *home health agency* will be **$20** per visit.

– Your Co-Payment for *physician* visits will be:

  a. **$20** for office visits, including internet based consultations. This Co-Payment will not apply to office visits for services provided under the Pregnancy and Maternity Care benefit.

  b. **$25** for home visits.

  Note: These Co-Payments will not apply toward the satisfaction of any deductible. This exception applies only to the charge for the visit itself. It does not apply to any other charges made during that visit, such as testing procedures, surgery, etc. Also, the office visit Co-Payment will not apply if the visits are for pregnancy or maternity care.

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

– Your Co-Payment for chiropractic services will be **$5**.

– Your Co-Payment for each injectable drug for birth control will be **$25**.

– Your Co-Payment for ambulance services covered under the Ambulance benefit will be **$50**.

– Your Co-Payment for routine newborn circumcision provided by a *physician* in an office setting will be **$20**. No Co-Payment will be required if the routine newborn circumcision is provided in an outpatient facility.

– Your Co-Payment for an elective abortion will be **$100** per event.

– Your Co-Payment for tubal ligation will be **$100**. This Co-Payment will not apply if it is in conjunction with *preventive care service*s or delivery or abdominal surgery.

– Your Co-Payment for a vasectomy will be **$75**.

– Your Co-Payment for the diagnosis and testing of *infertility* will be **50%** of the *maximum allowed amount*.

– Your Co-Payment for the following services will be **20%** of the *maximum allowed amount*:

  a. rental or purchase of durable medical equipment; and

  b. prosthetic or orthotic devices covered under the Prosthetic or Orthotic Devices benefit.

  NOTE: All flat dollar Co-Payments are waived for members with Medicare as Primary Payor.

Out-of-Pocket Amount*. After you have made the following total out-of-pocket payments for covered services and supplies 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 *member* **$1,600**
- Per family **$3,300****

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

  ***Exceptions:**

  – 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

The *plan* 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*

Chiropractic Services

- For covered outpatient services .....**30 visits**
  per *calendar year*

Transplant Travel Expense

- For the Recipient and One Companion per Transplant Episode (limited to 6 trips per episode)
  - For transportation to the *CME*.....**$250**
    per trip for each person
    for round trip coach airfare
  - For hotel accommodations.....**$100**
    per day, for up to 21 days per trip,
    limited to one room,
    double occupancy
  - For expenses such as meals **$25**
    per day for each person,
    for up to 21 days per trip
- For the Donor per Transplant Episode (limited to one trip per episode)
  - For transportation to the *CME*.....**$250**
    for round trip coach airfare
  - For hotel accommodations.....**$100**
    per day, for up to 7 days
  - For expenses such as meals **$25**
    per day, for up to 7 days

Lifetime Maximum

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

YOUR MEDICAL BENEFITS

MAXIMUM ALLOWED AMOUNT

General

This section describes the term "*maximum allowed amount"* as used in this *benefit booklet*, 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 providers, non-participating providers,* or *other health care providers*. It is the payment towards the service 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* or *other health care provider*, you may be billed by the provider for the difference between their charges and the *maximum allowed amount.* In many situations, this difference could be significant.

When you receive covered services, the *claims administrator* will, to the extent applicable, apply claim processing rules to the claim submitted. The *claims administrator* uses 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 the *claims administrator* determines 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 an *other health care provider*. Services provided by *non-participating providers* will only be covered for *emergency services*, urgent care, or with an authorized referral.

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 the *claims administrator* to accept as reimbursement for the covered services. Because *participating providers* have agreed to accept the *maximum allowed amount* as payment in full for those covered services, they should

not send you a bill or collect for amounts above the *maximum allowed amount.* However, you may receive a bill or be asked to pay all or a portion of the *maximum allowed amount* to the extent you have not met your Deductible or have a Co-Payment. Please call the Member Services telephone number on your ID card for help in finding a *participating provider* or visit www.anthem.com/ca.

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

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

Non-Participating Providers (Only with an *authorized referral*, in an *emergency*, or for *urgent care*) and Other Health Care Providers.*

Providers who are not in the 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 *claims administrator's* applicable *non-participating* or *other health care provider* rate or fee schedule for this plan, an amount negotiated by the *claims administrator* or a third party vendor which has been agreed to by the *non-participating provider* or *other health care provider,* an amount derived from the total charges billed by the *non-participating provider* or *other health care provider,* or 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, the *claims administrator* will update such information, which is unadjusted for geographic locality, no less than annually.

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

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

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

***Exceptions:**

– **Clinical Trials.** The *maximum allowed amount* for services and supplies provided in connection with 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 the *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*.

MEMBER COST SHARE

For certain covered services, and depending on your plan design, you may be required to pay all or a part of the *maximum allowed amount* as your cost share amount (Deductibles or Copayments). Please see the SUMMARY OF BENEFITS section for your cost share responsibilities and limitations, or call the Member Services telephone number on your ID card to learn how this *plan's* benefits or cost share amounts may vary by the type of provider you use.

The *plan* 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, non-participating provider,* or *other health care 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.

Authorized Referrals

In some circumstances the *claims administrator* may authorize you to receive services provided by *non-participating provider.* In such circumstance, you or your *physician* must contact the *claims administrator* in advance of obtaining the covered service you receive from a *non-participating provider*. It is your responsibility to ensure that the *claims administrator* has been contacted. If the *claims administrator* authorizes you to receive services provided by a *non-participating provider,* you may still be liable for the difference between the *maximum allowed amount* and the *non-participating provider's* charge. If you receive prior authorization for a *non-participating provider* due to network adequacy issues, you will not be responsible for the difference between the *non-participating provider's* charge and the *maximum allowed amount*. Please call the Member Services telephone number on your ID card for *authorized referral* information or to request authorization.

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

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

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

DEDUCTIBLES

Each deductible under this *plan* is separate and distinct from the other. Only the covered charges that make up the *maximum allowed amount* will apply toward the satisfaction of any deductible except as specifically indicated in this booklet.

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

Additional Deductible

Emergency Room Deductible

Each time you visit an emergency room for treatment you will be responsible for paying the Emergency Room Deductible. But this deductible will not apply if you are admitted as a *hospital* inpatient from the emergency room immediately following emergency room treatment. Note: You will no longer be responsible for paying the Emergency Room Deductible once your Out-of-Pocket Amount is reached.

CO-PAYMENTS

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

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

OUT-OF-POCKET AMOUNTS

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

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

- Charges which are not covered under this plan.
- Charges which exceed the *maximum allowed amount*.

MEDICAL BENEFIT MAXIMUMS

The *plan* does not make benefit payments for any *member* in excess of any of the Medical Benefit Maximums.

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

CREDITING PRIOR PLAN COVERAGE

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

If the *plan administrator* moves from one of the *claims administrator's* plans to another, (for example, changes its coverage from HMO to PPO), and you were covered by the other product immediately before enrolling in this product with no break in coverage, then you may get credit for any accrued Calendar Year Deductible and Out of Pocket Amounts, if applicable and approved by the *claims administrator*. Any maximums, when applicable, will be carried over and charged against the Medical Benefit Maximums under this *plan*.

If the *plan administrator* offers more than one of the *claims administrator's* products, and you change from one product to another with no break in coverage, you will get credit for any accrued Calendar Year Deductible and, if applicable, Out of Pocket Amounts and any maximums will be carried over and charged against Medical Benefit Maximums under this *plan*.

If the *plan administrator* offers coverage through other products or carriers in addition to the *claims administrator's*, and you change products or carriers to enroll in this product with no break in coverage, you will get credit for any accrued Calendar Year Deductible, Out of Pocket Amount, and any Medical Benefit Maximums under this *plan*.

This Section Does Not Apply To You If:

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

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 *participating provider physician* or a *non-participating provider physician* with an *authorized referral*.

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, the *plan* will provide benefits for the following services and supplies:

Hospital

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

2. Services in *special care units*.

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

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

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

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.

When available in your area, benefits are also available for *intensive in-home behavioral health services*. These do not require confinement to the home. These services are described in the BENEFITS FOR MENTAL HEALTH CONDITIONS OR SUBSTANCE ABUSE section below.

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

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

Hospice Care. The services and supplies listed below are covered when provided by a *hospice* for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care is care that controls pain and relieves symptoms but is not intended to cure the illness. You must be suffering from a terminal illness for which the prognosis of life expectancy is one year or less, as certified by your *physician* and submitted to the *claims administrator*. 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 your death. Bereavement services are available to surviving members of the immediate family for a period of one year after your 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 the *claims administrator* every 30 days.

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

1. Medication, ancillary medical supplies and supply delivery, (not to exceed a 14-day supply); 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;

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.

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

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.

Online Visits. When available in your area, covered services will include medical consultations using the internet via webcam, chat, or voice. Online visits 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 or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (a) improve function; or (b) create a normal appearance, to the extent possible. This includes surgery performed to restore and achieve symmetry following a *medically necessary* mastectomy. This also 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. Ambulance services are covered when you are transported by a state licensed vehicle that is designed, equipped, and used to transport the sick and injured and is staffed by Emergency Medical Technicians (EMTs), paramedics, or other licensed or certified medical professionals. Ambulance services are covered when one or more of the following criteria are met:

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

Non-emergency ambulance services are subject to medical necessity reviews. *Emergency* ground ambulance services do not require pre-service review. Pre-service review is required for air ambulance in a non-medical *emergency*. When using an air ambulance in a non-emergency situation, the *claims administrator* reserves the right to select the air ambulance provider. If you do not use the air ambulance the *claims administrator* selects in a non-emergency situation, no coverage will be provided.

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

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

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

- A *physician's* office or clinic;

- A morgue or funeral home.

If provided through the 911 emergency response system*, ambulance services are covered if you reasonably believed that a medical *emergency* existed even if you are not transported to a *hospital*.

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

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

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

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

Diagnostic Services. Coverage is provided for outpatient diagnostic imaging, laboratory services and genetic tests. Genetic tests 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.

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

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

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

The following renal dialysis services are covered:

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

Prosthetic or Orthotic 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. The *plan* will pay for other *medically necessary prosthetic devices,* including:
    a. Surgical implants;
    b. Artificial limbs or eyes; and
    c. Benefits are available for certain types of orthotics (braces, boots, splints). Covered services include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

Durable Medical Equipment. Rental or purchase of dialysis equipment; dialysis supplies. Therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications. Rental or purchase of other medical equipment and supplies which are:

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

The *claims administrator* will determine whether the item satisfies the conditions above.

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

1. Nebulizers, including face masks and tubing.

2. Inhaler spacers and peak flow meters.

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

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.). The *claims administrator* will make the final determination as to whether the dental treatment could have been safely rendered in another setting due to the nature of the procedure or your medical condition. *Hospital stays* for the purpose of administering general anesthesia are not considered necessary and are not covered except as specified in #2, below.

2. **General Anesthesia.** General anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a *hospital* or a*mbulatory surgical center*. This applies only if (a) the *member* is less than seven years old, (b) the *member* is developmentally disabled, or (c) the *member's* health is compromised and general anesthesia is *medically necessary*. Charges for the dental procedure itself, including professional fees of a dentist, may not be 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 *accidental injury* and/or restore function lost as a direct result of the *accidental injury*. Damage to natural teeth due to chewing or biting is not *accidental injury* unless the chewing or biting results from a medical or mental condition.

Pregnancy and Maternity Care

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

   a. Prenatal, postnatal and postpartum care. Prenatal care also includes participation in the California Prenatal Screening Program, which is a statewide prenatal testing program administered by the State Department of Public Health;

   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.

2. Medical *hospital* benefits for routine nursery care of a newborn *child,* (for additional information, please see the "Important Note for Newborn and Newly-Adopted Children" under HOW COVERAGE BEGINS AND ENDS). Routine nursery care of a newborn child includes screening of a newborn for genetic diseases, congenital conditions, and other health conditions provided through a program established by law or regulation.

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

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

1. The recipient; or

2. The donor.

Benefits for an organ donor are as follows:

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

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

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

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 pre-service review, or which are provided at a facility other than a transplant center approved by the *claims administrator*. See UTILIZATION REVIEW PROGRAM for details.

To maximize your benefits, you should call the Transplant Department as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation or work-up for a transplant. The *claims administrator* will help you maximize your benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, *Centers of Medical Excellence (CME)* rules, or exclusions apply. Call the Member Services phone number on the back of your ID card and ask for the transplant coordinator.

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

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

Specified Transplants

You must obtain the *claims administrator's* 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 covered.** 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. The following travel expenses in connection with an authorized, specified transplant (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures) performed at a *CME* only when the recipient or donor's home is more than 250 miles from the *CME*, provided the expenses are approved by the *claims administrator* in advance:

1. For the recipient and a companion, per transplant episode, up to six trips per episode:
    a. Round trip coach airfare to the *CME*, not to exceed **$250** per person per trip.
    b. Hotel accommodations, not to exceed **$100** per day for up to 21 days per trip, limited to one room, double occupancy.
    c. Other expenses, such as meals, not to exceed **$25** per day for each person, for up to 21 days per trip.
2. For the donor, per transplant episode, limited to one trip:
    a. Round trip coach airfare to the *CME*, not to exceed **$250**.
    b. Hotel accommodations, not to exceed **$100** per day for up to 7 days.
    c. Other expenses, such as meals, not to exceed **$25** per day, for up to 7 days.

Bariatric Surgery. Services and supplies in connection with *medically necessary* surgery for weight loss, only for morbid obesity and only when performed at an approved *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.**

Preventive Care Services. Preventive care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA) and applicable state law. This means for *preventive care services,* 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.

Certain benefits for *members* who have current symptoms or a diagnosed health problem may be covered under a different benefit instead of this benefit, if the coverage does not fall within the state or ACA-recommended *preventive care services*.

1. A *physician's* services for routine physical examinations.
2. Immunizations prescribed by the examining *physician.*
3. Radiology and laboratory services and tests ordered by the examining *physician* in connection with a routine physical examination, excluding any such tests related to an illness or injury. Those radiology and laboratory services and tests related to an illness or injury will be covered as any other medical service available under the terms and conditions of the provision “Diagnostic Services”.
4. Health screenings as ordered by the examining *physician* for the following: breast cancer, including BRCA testing if appropriate (in conjunction with genetic counseling and evaluation), cervical cancer, including human papillomavirus (HPV), prostate cancer, colorectal cancer, and other medically accepted cancer screening tests, blood lead levels, high blood pressure, type 2 diabetes mellitus, cholesterol, obesity, and screening for iron deficiency anemia in pregnant women.
5. Human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.
6. Counseling and risk factor reduction intervention services for sexually transmitted infections, human immunodeficiency virus (HIV), contraception, tobacco use and tobacco use-related diseases.
7. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:

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

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

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

   Note: For FDA-approved, *self-administered hormonal contraceptives*, up to a 12-month supply is covered when dispensed or furnished at one time by a provider or pharmacist, or at a location licensed or otherwise authorized to dispense *drugs* or supplies.

b. Breast feeding support, supplies, and counseling. One breast pump will be covered per pregnancy under this benefit.
c. Gestational diabetes screening.
d. Preventive prenatal care.

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

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

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

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

https://www.healthcare.gov/what-are-my-preventive-care-benefits

http://www.ahrq.gov

http://www.cdc.gov/vaccines/acip/index.html

Osteoporosis. Coverage for services related to diagnosis, treatment, and appropriate management of osteoporosis including, but not limited to, all Food and Drug Administration approved technologies, including bone mass measurement technologies as deemed *medically necessary*.

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

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

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

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

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

5. Breast prostheses following a mastectomy (see “Prosthetic or Orthotic Devices”).

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

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

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

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

1. Federally funded trials approved or funded by one or more of the following:
    a. The National Institutes of Health,
    b. The Centers for Disease Control and Prevention,
    c. The Agency for Health Care Research and Quality,
    d. The Centers for Medicare and Medicaid Services,
    e. A cooperative group or center of any of the four entities listed above or the Department of Defense or the Department of Veterans Affairs,
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants, or
    g. Any of the following departments if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines (1) to be comparable to the system of peer review of investigations and studies used by the National Institutes of Health, and (2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
        i. The Department of Veterans Affairs,
        ii. The Department of Defense, or
        iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration.
3. Studies or investigations done for drug trials that are exempt from the investigational new drug application.

Participation in the clinical trial must be recommended by your *physician* after determining participation has a meaningful potential to benefit you. All requests for clinical trials services, including requests that are not part of approved clinical trials, will be reviewed according to the *plan*'s Clinical Coverage Guidelines, related policies and procedures.

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

1. The investigational item, device, or service itself.
2. Any item or service provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.
3. Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
4. Any item, device, or service that is paid for by the sponsor of the trial or is customarily provided by the sponsor free of charge for any enrollee in the trial.

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

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 physical therapists and osteopaths. It does not include massage therapy services at spas or health clubs.)
2. Occupational therapy provided on an outpatient basis when the ability to perform daily life tasks has been lost or reduced by, 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.

Chiropractic Services. Chiropractic service for manual manipulation of the spine to correct subluxation demonstrated by *physician*-read x-ray. The *plan* will provide up to a maximum of 30 visits in a *calendar year* for all covered services.

Injectable Drugs and Implants for Birth Control. Injectable drugs and implants for birth control administered in a *physician's* office if *medically necessary*.

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

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.

Contraceptive supplies prescribed by a *physician* for reasons other than contraceptive purposes for *medically necessary* treatment such as decreasing the risk of ovarian cancer, eliminating symptoms of menopause or for contraception that is necessary to preserve life or health may also be covered.

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.

Note: For FDA-approved, *self-administered hormonal contraceptives*, up to a 12-month supply is covered when dispensed or furnished at one time

by a provider or pharmacist, or at a location licensed or otherwise authorized to dispense *drugs* or supplies.

Sterilization Services. Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered.

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

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

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

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

    These covered equipment and supplies are covered under your *plan's* benefits for durable medical equipment (see "Durable Medical Equipment").

2. Diabetes education program which:

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

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

    c. Is supervised by a *physician*.

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

3. The following items are covered as medical supplies:

    a. Insulin syringes, disposable pen delivery systems for insulin administration. Charges for insulin and other prescriptive medications are not covered.

    b. Testing strips, lancets, and alcohol swabs.

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

Jaw Joint Disorders. The *plan* will pay for splint therapy or surgical treatment for disorders or conditions directly affecting the upper or lower jawbone or the joints linking the jawbones and the skull (the temporomandibular joints), including the complex of muscles, nerves and other tissues related to those joints.

Phenylketonuria (PKU). Benefits for the testing and treatment of phenylketonuria (PKU) are paid on the same basis as any other medical condition. Coverage for treatment of PKU shall include those formulas and special food products that are part of a diet prescribed by a licensed *physician* and managed by a health care professional in consultation with a *physician* who specializes in the treatment of metabolic disease and who participates in or is authorized by the *claims administrator*. The diet must be deemed *medically necessary* to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

The cost of the necessary formulas and special food products is covered only as it exceeds the cost of a normal diet. “Formula” means an enteral product or products for use at home. The formula must be prescribed by a *physician* or nurse practitioner, or ordered by a registered dietician upon referral by a health care provider authorized to prescribe dietary treatments, and is *medically necessary* for the treatment of PKU. Formulas and special food products used in the treatment of PKU that are obtained from a *pharmacy* are covered as prescription drugs (see “Prescription Drugs and Medications”). Formulas and special food products that are not obtained from a *pharmacy* are covered under this benefit.

“Special food product” means a food product that is all of the following:

- Prescribed by a *physician* or nurse practitioner for the treatment of PKU, and
- Consistent with the recommendations and best practices of qualified *physicians* with expertise in the treatment and care of PKU, and
- Used in place of normal food products, such as grocery store foods, used by the general population.

Note: It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving.

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

Designated Pharmacy Provider. The *claims administrator* may establish one or more *designated pharmacy provider* programs which provide specific pharmacy services (including shipment of *prescription drugs*) to *members*. A *participating provider* is not necessarily a *designated pharmacy provider*. To be a *designated pharmacy provider*, the *participating provider* must have signed a *designated pharmacy provider* agreement with the *plan*. You or your *physician* can contact Member Services to learn which *pharmacy* or *pharmacies* are part of a *designated pharmacy provider* program.

For *prescription drugs* that are shipped to you or your *physician* and administered in your *physician's* office, you and your *physician* are required to order from a *designated pharmacy provider*. A patient care coordinator will work with you and your *physician* to obtain precertification and to assist shipment to your *physician's* office.

The *claims administrator* may also require you to use a *designated pharmacy provider* to obtain *prescription drugs* for treatment of certain clinical conditions such as hemophilia. The *claims administrator* reserves the right to modify the list of *prescription drugs* as well as the setting and/or level of care in which the care is provided to you. The *claims administrator* may, from time to time, change with or without advance notice, the *designated pharmacy provider* for a *drug*. Such change can help provide cost effective, value based and/or quality services.

If you are required to use a *designated pharmacy provider* and you choose not to obtain your *prescription drug* from a *designated pharmacy provider*, coverage will be the same as for a *non-participating provider*.

You can get the list of the *prescription drugs* covered under this section by calling Member Services at the phone number on the back of your ID Card.

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 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 it's determined that it should be clinically effective for you. However, if it's determines 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, the *claims administrator* will not require you to try a drug other than the one you are currently taking.

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

If the request is not for urgently needed drugs, after the *claims administrator* gets the request from your *physician*:

- Based on your medical condition, as *medically necessary*, the *claims administrator* will review it and decide if they will approve benefits within 5-business days. The *claims administrator* will tell you and your *physician* what has been decided in writing - by fax to your doctor, and by mail, to you.

- If more information is needed to make a decision, the *claims administrator* will tell your *physician* in writing within 5-business days after they get the request what information is missing and why a decision cannot be made. If, for reasons beyond the *claims administrator's* control, they cannot tell your *physician* what information is missing within 5-business days, the *claims administrator* will tell your *physician* that there is a problem as soon as they know that they cannot respond within 5-business days. In any event, the *claims administrator* will tell you and your *physician* that there is a problem by telephone, and in writing by facsimile, to your As soon as the *claims administrator* can, based on your medical condition, as *medically necessary*, within 5-business days after they have all the information they need to decide if they will approve benefits, the *claims administrator* will tell you and your *physician* what has been decided in writing - by fax to your *physician* and by mail to you.

- As soon as the *claims administrator* can, based on your medical condition, as *medically necessary*, within 5-business days after they have all the information they need to decide if they will approve benefits, the *claims administrator* will tell you and your *physician* what has been 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 1-800-700-2541 (or TTY/TDD 1-800-905-9821).

If a request for prior authorization of a specialty pharmacy drug is denied, you or your prescribing *physician* may appeal the decision by calling 1-800-700-2541 (or TTY/TDD 1-800-905-9821).

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.)

Non-Participating Providers. Services or supplies that are provided by a *non-participating provider* without an *authorized referral*, except *emergency services* or *urgent care*.

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.

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

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

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

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

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

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

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

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

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. The *plan* 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.

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

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

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

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

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

5. Two-thirds of its patients must have conditions directly related to the *hospital's* research.

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

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

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

Orthodontia. Braces and other orthodontic appliances or services.

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

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

This exclusion does not apply to the following:

- Services which 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.

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

Hearing Aids or Tests. Hearing aids and routine hearing tests. Routine hearing tests, except as specifically provided as part of a routine exam under the "Preventive Care Services" section provision of MEDICAL CARE THAT IS COVERED.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, except as specifically provided under the “Preventive Care Services” provision of MEDICAL CARE THAT IS COVERED. Eyeglasses or contact lenses, except as specifically stated in the "Prosthetic or Orthotic 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 PERVASIVE 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 PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.

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

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

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

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

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

Sterilization Reversal. Reversal of an elective sterilization.

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

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

Foot Orthotics. Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes.

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.

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

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

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

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

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

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

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

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

Routine Physicals and Immunizations. Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the "Preventive Care Services" provision of MEDICAL CARE THAT IS COVERED.

Acupuncture. Acupuncture treatment, acupressure, or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

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

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

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

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

- **Drugs Contrary to Approved Medical and Professional Standards.** *Drugs* given to you or prescribed in a way that is against approved medical and professional standards of practice.
- **Drugs Over Quantity or Age Limits.** *Drugs* which are over any quantity or age limits set by the *plan* or us.
- **Drugs Over the Quantity Prescribed or Refills After One Year.** *Drugs* in amounts over the quantity prescribed or for any refill given more than one year after the date of the original *prescription*.
- **Drugs Prescribed by Providers Lacking Qualifications, Registrations and/or Certifications.** *Prescription drugs* prescribed by a provider that does not have the necessary qualifications, registrations and/or certifications as determined by us.
- **Drugs That Do Not Need a Prescription.** *Drugs* that do not need a *prescription* by federal law (including *drugs* that need a *prescription* by state law, but not by federal law), except for injectable insulin. This exclusion does not apply to over-the-counter *drugs* that we must cover under state law, or federal law when recommended by the U.S. Preventive Services Task Force, and prescribed by a *physician*.
- **Lost or Stolen Drugs.** Refills of lost or stolen *drugs*.

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 PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.

Chiropractic services. Chiropractic services except for manual manipulation for subluxation of the spine as specifically stated in “Chiropractic Services” provision of MEDICAL CARE THAT IS COVERED.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specifically stated in the "Home Infusion Therapy" and "Prescription Drug for Abortion" provisions of MEDICAL CARE THAT IS COVERED. Non-prescription, over-the-counter patent or proprietary drugs or medicines. Cosmetics, health or beauty aids. However, health aids that are *medically necessary* and meet the requirements for durable medical equipment as specified under the "Durable Medical Equipment" provision of MEDICAL CARE THAT IS COVERED, are covered, subject to all terms of this *plan* that apply to that benefit

Outpatient drugs that are not covered under this *plan* may be covered through MEDCO HEALTH, the supplemental coverage provided by the *plan administrator*. Please see your employer for details or call 1-800-711-0917 for assistance.

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specifically stated in "Injectable Drugs and Implants for Birth Control" provision in MEDICAL CARE THAT IS COVERED.

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

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 the *claims administrator*.

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

BENEFITS FOR MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE

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

Services for the treatment of *mental health conditions* and substance abuse covered under this *plan* are subject to the same deductibles, co-payments and co-insurance that apply to services provided for other covered medical conditions and *prescription drugs*.

DEFINITIONS

The meanings of key terms used in this section are shown in italics. Please see the DEFINITIONS section for detailed explanations of any italicized words used in the section.

SUMMARY OF BENEFITS

DEDUCTIBLES

Please see the SUMMARY OF BENEFITS section for your cost share responsibilities. The amounts listed and any exceptions, if applicable, also apply to services provided for the treatment of *mental health conditions* and substance abuse.

CO-PAYMENTS

***Mental Health Conditions* and Substance Abuse Co-Payments.** You are responsible for the following percentages of the *maximum allowed amount:*

Inpatient Services

- *Participating Providers*..... **No charge**
- *Non-Participating Providers*..... **No charge ****

Outpatient Office Visit Services

- *Participating Providers*.....**$20***
  **This Co-Payment will not apply toward the satisfaction of any deductible*.
- *Non-Participating Providers*..... **No charge****

Other Outpatient Items and Services

- *Participating Providers*..... **No charge**
- *Non-Participating Providers*..... **No charge****

******Only with an authorized referral

OUT-OF-POCKET AMOUNTS

Please see the SUMMARY OF BENEFITS section for your plan's out-of-pocket amounts. The amounts listed and any exceptions, if applicable, also apply to services provided for the treatment of *mental health conditions* and substance abuse.

BENEFIT MAXIMUMS

For all other services covered under this benefit, please see the Medical Benefit Maximums in the SUMMARY OF BENEFITS section for any benefit maximums that apply to your *plan*. The amounts listed and any

exceptions, if applicable, also apply to services provided for the treatment of *mental health conditions* and substance abuse.

MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE THAT ARE COVERED

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

- **Inpatient Services**: Inpatient *hospital* services and services from a *residential treatment center* (including crisis residential treatment) , for inpatient services and supplies, and *physician* visits during a covered inpatient *stay*.
- **Outpatient Office Visits** for the following:
  - Online visits,
  - *intensive in-home behavioral health services*, when available in your area,
  - Individual and group mental health evaluation and treatment,
  - Nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa,
  - Drug therapy monitoring,
  - Individual and group chemical dependency counseling,
  - Medical treatment for withdrawal symptoms,
  - Methadone maintenance treatment,
  - Behavioral health treatment for pervasive Developmental Disorder or autism delivered in an office setting.
- **Other Outpatient Items and Services**:
  - *Partial hospitalization programs*, including *intensive outpatient programs* and visits to a *day treatment center*.
  - Psychological testing,
  - Multidisciplinary treatment in an intensive outpatient psychiatric treatment program,
  - Behavioral health treatment for Pervasive Developmental Disorder or autism delivered at home.

- **Behavioral health treatment for pervasive developmental disorder or autism**. Inpatient services, office visits, and other outpatient items and services are covered under this section. See the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM for a description of the services that are covered. **Note:** You must obtain pre-service review for all 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).

- Diagnosis and all *medically necessary* treatment of *severe mental disorder* of a person of any age and serious emotional disturbances of a child.

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

MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE THAT ARE NOT COVERED

Please see the exclusions or limitations listed under MEDICAL CARE THAT IS NOT COVERED for a list of services not covered under your plan. Services that are not covered, if applicable, also apply to services provided for the treatment of *mental health conditions* and substance abuse.

BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM

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

Behavioral health treatment services covered under this *plan* are subject to the same deductibles, co-payments and co-insurance that apply to services provided for other covered medical conditions. Services provided by Qualified Autism Service Providers, Qualified Autism Service Professionals, and Qualified Autism Service Paraprofessionals (see the "Definitions" below) will be covered under *plan* benefits that apply for outpatient office visits or other outpatient items and services. Services provided in a facility, such as the outpatient department of a *hospital*, will be covered under *plan* benefits that apply to such facilities. See also the section BENEFITS FOR MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE.

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

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

DEFINITIONS

Pervasive Developmental Disorder or autism means one or more of disorders defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

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

Intensive Behavioral Intervention means any form of Applied Behavioral Analysis that is comprehensive, designed to address all domains of functioning, and provided in multiple settings, 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.

The *claims administrator's* network of *participating providers* is limited to licensed Qualified Autism Service Providers who contract with the *claims administrator* or a Blue Cross and/or Blue Shield Plan and who may supervise and employ Qualified Autism Service Professionals or Qualified

Autism Service Paraprofessionals who provide and administer Behavioral Health Treatment.

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

- Provides behavioral health treatment,
- Is employed and supervised by a Qualified Autism Service Provider,
- Provides treatment according to a treatment plan developed and approved by the Qualified Autism Service Provider,
- Is a behavioral service provider approved as a vendor by a California regional center to provide services as an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program as defined in state regulation or who meets equivalent criteria in the state in which he or she practices if not providing services in California, and
- Has training and experience in providing services for Pervasive Developmental Disorder or autism pursuant to applicable state law.

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

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

BEHAVIORAL HEALTH TREATMENT SERVICES COVERED

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

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

SUBROGATION AND REIMBURSEMENT

These provisions apply when the *plan* pays benefits as a result of injuries or illnesses you sustained and you have a right to a Recovery or have received a Recovery from any source. A "Recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, worker's compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements characterize the money you receive as a Recovery, it shall be subject to these provisions.

Subrogation

The *plan* has the right to recover payments it makes on your behalf from any party responsible for compensating you for your illnesses or injuries. The following apply:

- The *plan* has first priority from any Recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- You and your legal representative must do whatever is necessary to enable the *plan* to exercise the *plan*'s rights and do nothing to prejudice those rights.
- In the event that you or your legal representative fail to do whatever is necessary to enable the *plan* to exercise its subrogation rights, the *plan* shall be entitled to deduct the amount the *plan* paid from any future benefits under the *plan*.
- The *plan* has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the *plan*.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the *plan*'s subrogation claim and any claim held by you, the *plan*'s subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- The *plan* is not responsible for any attorney fees, attorney liens, other expenses or costs you incur. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the *plan*.

Reimbursement

If you obtain a Recovery and the *plan* has not been repaid for the benefits the *plan* paid on your behalf, the *plan* shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following provisions will apply:

- You must reimburse the *plan* from any Recovery to the extent of benefits the *plan* paid on your behalf regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.

- Notwithstanding any allocation or designation of your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the *plan* shall have a right of full recovery, in first priority, against any Recovery. Further, the *plan*'s rights will not be reduced due to your negligence.

- You and your legal representative must hold in trust for the *plan* the proceeds of the gross Recovery (*i.e.*, the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the *plan* immediately upon your receipt of the Recovery. You and your legal representative acknowledge that the portion of the Recovery to which the *plan's* equitable lien applies is a *plan* asset

- Any Recovery you obtain must not be dissipated or disbursed until such time as the p*lan* has been repaid in accordance with these provisions.

- You must reimburse the *plan*, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the *plan*.

- If you fail to repay the *plan*, the *plan* shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the *plan* has paid or the amount of your Recovery whichever is less, from any future benefit under the *plan* if:

    1. The amount the *plan* paid on your behalf is not repaid or otherwise recovered by the *plan*; or

    2. You fail to cooperate.

- In the event that you fail to disclose the amount of your settlement to the *plan*, the *plan* shall be entitled to deduct the amount of the *plan*'s lien from any future benefit under the *plan*.

- The *plan* shall also be entitled to recover any of the unsatisfied portion of the amount the *plan* has paid or the amount of your Recovery,

whichever is less, directly from the Providers to whom the *plan* has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the *plan* will not have any obligation to pay the Provider or reimburse you.

- The *plan* is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or make you whole.

Your Duties

- You must promptly notify the *plan* of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved and any other information requested by the *plan*.

- You must cooperate with the *plan* in the investigation, settlement and protection of the *plan's* rights. In the event that you or your legal representative fail to do whatever is necessary to enable the *plan* to exercise its subrogation or reimbursement rights, the *plan* shall be entitled to deduct the amount the *plan* paid from any future benefits under the *plan*.

- You must not do anything to prejudice the *plan*'s rights.

- You must send the *plan* copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.

- You must promptly notify the *plan* if you retain an attorney or if a lawsuit is filed on your behalf.

- You must immediately notify the *plan* if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

The *plan administrator* has sole discretion to interpret the terms of the Subrogation and Reimbursement provision of this *plan* in its entirety and reserves the right to make changes as it deems necessary.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, that Recovery shall be subject to this provision.

The *plan* is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

The *plan* shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal injury protection policy regardless of any election made by you to the contrary. The *plan* shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

COORDINATION OF BENEFITS

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

DEFINITIONS

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

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

The following are not Allowable Expense:

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

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

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

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

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

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

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage;

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

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

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

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

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

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

ORDER OF BENEFITS DETERMINATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

OUR RIGHTS UNDER THIS PROVISION

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

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

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

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

BENEFITS FOR MEDICARE ELIGIBLE MEMBERS

For Active Employees and Dependents. If you are a *subscriber* or a *dependent* of a *subscriber*, and entitled to Medicare, you will receive the full benefits of this *plan*, except as listed below:

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

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

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

For Retired Employees and Their Spouses. If you are a *retired employee* or the *spouse* of a *retired employee* and you are eligible for Medicare Part A because you made the required number of quarterly contributions to the Social Security System, your benefits under this *plan* will be subject to the section entitled COORDINATION OF BENEFITS and the provision "Coordinating Benefits With Medicare", below.

Coordinating Benefits With Medicare. The *plan* 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.

The *claims administrator* will not apply any charges paid by Medicare for services covered under this *plan* toward your *plan* deductible, if any, and office co-payments. Your *plan* deductibles, if any, and any office visit co-payments are waived if Medicare is the primary payor.

UTILIZATION REVIEW PROGRAM

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

When level of care, setting or place of service is part of the review, services that can be safely given to you in a lower level of care or lower cost setting / place of care, will not be *medically necessary* if they are given in a higher level of care, or higher cost setting / place of care.

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

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

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

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

TYPES OF REVIEWS

- **Pre-service Review –** A review of a service, treatment or admission for a coverage determination which is done before the service or treatment begins or admission date.

  - **Precertification** – A required pre-service review for a benefit coverage determination for a service or treatment. Certain services require precertification in order for you to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of medical necessity or is *experimental* / *investigative* as those terms are defined in this booklet.

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

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

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

- **Continued Stay / Concurrent Review –** A utilization review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment.

  - Both pre-service and continued stay / concurrent reviews may be considered urgent when, in the view of the treating provider or any *physician* with knowledge of your medical condition, without such care or treatment, your life or health or your ability to regain maximum function could be seriously threatened or you could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.

- **Post-service Review –** A review of a service, treatment or admission for a benefit coverage that is conducted after the service has been provided. Post-service reviews are performed when a service, treatment or admission did not need a precertification, or when a needed precertification was not obtained. Post-service reviews are done for a service, treatment or admission in which the *plan* has a related clinical coverage guideline and are typically initiated by the *claims administrator*.

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

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

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

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

  - Specific non-emergency outpatient services, including diagnostic treatment and other services.
  - Specific outpatient surgeries performed in an outpatient facility or a doctor's office.
  - Transplant services, including transplant travel expense. The following criteria must be met for certain transplants, as follows:

    - For 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.
    - 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)* or a *Blue Distinction Centers for Specialty Care* (*BDCSC*) facility.

  - Air ambulance in a non-medical *emergency*.
  - Visits for physical therapy, physical medicine and occupational therapy beyond those described under the "Physical Therapy,

Physical Medicine and Occupational Therapy" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED. A specified number of additional visits may be authorized. While there is no limit on the number of covered visits for *medically necessary* physical therapy, physical medicine, and occupational therapy, additional visits in excess of the stated number of visits must be authorized in advance.

- Visits for *chiropractic services* beyond those described under the "Physical Therapy, Physical Medicine and Occupational Therapy" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED. A specified number of additional visits may be authorized. While there is no limit on the number of covered visits for *medically necessary* physical therapy, physical medicine, occupational therapy, and *chiropractic services* additional visits in excess of the stated number of visits must be authorized in advance.

- Specific durable medical equipment.

- Infusion therapy or home infusion therapy, if the attending *physician* has submitted both a prescription and a plan of treatment before services are rendered.

- Home health care. The following criteria must be met:

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

  - Your attending *physician* manages and directs your medical care at home; and

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

- Admissions to a *skilled nursing facility* if you require daily skilled nursing or rehabilitation, as certified by your attending *physician*.

- Bariatric surgical services, such as gastric bypass and other surgical procedures for weight loss, including bariatric travel expense, if:

  - The services are to be performed for the treatment of morbid obesity;

- ♦ The *physicians* on the surgical team and the facility in which the surgical procedure is to take place are approved for the surgical procedure requested; and
- ♦ The bariatric surgical procedure will be performed at a *BDCSC* facility.

- 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 Member Services telephone number on your identification card to find out if an imaging procedure requires pre-service review.
- *Prescription drugs* that require prior authorization as described under the "Prescription Drugs Obtained from or Administered by a Medical Provider" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.
- Partial hospitalization, intensive outpatient programs, transcranial magnetic stimulation (TMS).

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

WHO IS RESPONSIBLE FOR PRECERTIFICATION?

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

Provider Network Status	Responsibility to Get Precertification	Comments
Participating Providers	Provider	• The provider must get precertification when required.
Non-Participating Providers	*Member*	• *Member* must get precertification when required. (Call Member Services.) • *Member* may be financially responsible for charges or costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be *medically necessary*.
Blue Card Provider	*Member* **(Except for Inpatient Admissions)**	• *Member* must get precertification when required. (Call Member Services.) • *Member* may be financially responsible for charges or costs related to the service and/or setting in whole or in part if the service and or setting is found to not be *medically necessary*. • **Blue Card Providers must obtain precertification for all Inpatient Admissions.**

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

HOW DECISIONS ARE MADE

The *claims administrator* uses clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make medical necessity decisions. This includes decisions about *prescription drugs* as detailed in the section "Prescription Drugs Obtained From Or Administered By a Medical Provider." Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. The *claims administrator* reserves the right to review and update these clinical coverage guidelines from time to time.

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

If you are not satisfied with the *plan's* decision under this section of your benefits, you may call the Member Services phone number on the back of your Identification Card to find out what rights may be available to you.

DECISION AND NOTICE REQUIREMENTS

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

Request Category	**Timeframe Requirement for Decision**
Urgent Pre-Service Review	72 hours from the receipt of the request
Non-Urgent Pre-Service Review	5 business days from the receipt of the request

Continued Stay / Concurrent Review when hospitalized at the time of the request and no previous authorization exists	72 hours from the receipt of the request
Urgent Continued Stay / Concurrent Review when request is received at least 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Urgent Continued Stay / Concurrent Review when request is received less than 24 hours before the end of the previous authorization	72 hours from the receipt of the request
Non-Urgent Continued Stay / Concurrent Review	5 business days from the receipt of the request
Post-Service Review	30 calendar days from the receipt of the request

If more information is needed to make a decision, the *claims administrator* will tell the requesting *physician* of the specific information needed to finish the review. If the *plan* does not get the specific information it needs by the required timeframe identified in the written notice, the *claims administrator* will make a decision based upon the information received.

The *claims administrator* will notify you and your *physician* of the *plan's* decision as required by **[**state and federal**]** law. Notice may be given by one or more of the following methods: verbal, written and/or electronic.

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

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

- Your coverage under this *plan* ends;
- The *agreement* with the *plan administrator* terminates;
- You reach a benefit maximum that applies to the service in question;

- Your benefits under the *plan* change so that the service is no longer covered or is covered in a different way.

HEALTH PLAN INDIVIDUAL CASE MANAGEMENT

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

HOW HEALTH PLAN INDIVIDUAL CASE MANAGEMENT WORKS

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

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

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

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

A decision will be made case-by-case, if in the *claims administrator's* discretion, the alternate or extended benefit is in the best interest for you and the *plan* and you or your authorized representative agree to the alternate or extended benefit in writing.

Alternative Treatment Plan. In certain cases of severe or chronic illness or injury, the *plan* may provide benefits for alternate care that is not listed as a covered service. The *claims administrator* may also extend services beyond the benefit maximums of this *plan*. A decision will be made case-

by-case, if in the *claims administrator's* discretion the alternate or extended benefit is in the best interest for you and the *plan* and you or your authorized representative agree to the alternate and extended benefit in writing. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to you or to any other member. The *claims administrator* reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, the *claims administrator* will notify you or your authorized representative in writing.

EXCEPTIONS TO THE UTILIZATION REVIEW PROGRAM

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

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

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

You may determine whether a health care provider participates in certain programs or a provider arrangement by checking the *claims administrator's* online provider directory on the website at www.anthemcom/ca or by calling the Member Services telephone number listed on your ID card.

HOW COVERAGE BEGINS AND ENDS

HOW COVERAGE BEGINS

ELIGIBLE STATUS

1. **Subscribers.** You are in an eligible status if you are a regular *full-time employee* or a *retired employee*. For specific information about your employer's eligibility rules for coverage, please contact your Human Resources or Benefits Department. A *retired employee* is eligible to receive health plan benefits as part of the *participating employer*'s pension plan, and was covered under the *participating employer's* sponsored plan immediately prior to retirement.

2. **Dependents.** The following are eligible to enroll as *dependents:* (a) The *subscriber's spouse;* and (b) A *child*.

Definition of Dependent

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

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

    a. The child is under 26 years of age.

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

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

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

ELIGIBILITY DATE

1. For *subscribers,* you become eligible for coverage in accordance with rules established by your employer. For specific information about your employer's eligibility rules for coverage, please contact your Human Resources or Benefits Department.

2. For *dependents,* you become eligible for coverage on the later of: (a) the date the *subscriber* becomes eligible for coverage; or, (b) the date you meet the *dependent* definition.

   If, after you become covered under this *plan*, you cease to be eligible due to termination of employment, and you return to an eligible status based on your employer's eligibility rules, you will become eligible to re-enroll for coverage on the first day of the month following the date you return.

ENROLLMENT

To enroll as a *subscriber,* or to enroll *dependents,* the *subscriber* must properly file an application. An application is considered properly filed, only if it is personally signed, dated, and given to the *plan administrator* within 31 days from your eligibility date. 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 required monthly contributions. 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 *subscribers,* on your eligibility date; and (b) for *dependents,* on the later of (i) the date the *subscriber's* coverage begins, or (ii) the first day of the month after the *dependent* becomes eligible. If you become eligible before the *plan* takes effect, coverage begins on the effective date of the *plan,* provided the enrollment application is on time and in order.

2. **Late Enrollment:** If you enroll more than 31 days after your eligibility date, you must wait until the 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 next Open Enrollment period (see OPEN ENROLLMENT PERIOD).

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

Important Note for Newborn and Newly-Adopted Children. If the *subscriber* (or *spouse,* if the *spouse* is enrolled) is already covered:(1) any *child* born to the *subscriber* or *spouse* will be covered from the moment of birth; and (2) any *child* being adopted by the *subscriber* or *spouse* will be covered from the date on which either: (a) the adoptive ***child's*** birth parent, or other appropriate legal authority, signs a written document granting the *subscriber* or *spouse* the right to control the health care of the *child* (in the absence of a written document, other evidence of the *subscriber's* or *spouse's* right to control the health care of the *child* may be used)*;* or (b) the *subscriber* or *spouse* assumed a legal obligation for full or partial financial responsibility for the *child* in anticipation of the ***child's*** adoption. The written document referred to above includes, but is not limited to, a health facility minor release report, a medical authorization form, or relinquishment form.

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

Special Enrollment Periods

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

1. You have met all of the following requirements:

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

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

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

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

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

   i. If the other health plan was another employer group health plan or health insurance coverage, including coverage under a COBRA continuation, coverage ended because you lost eligibility under the other plan, your coverage under a COBRA continuation was exhausted, or employer contributions toward coverage under the other plan terminated. You must properly file an application with the *plan administrator* 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 *plan administrator* within 60 days after the date your coverage ended.

2. A court has ordered coverage be provided for a *spouse* 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. The *plan administrator* does not have a written statement from the *participating employer* 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 next open enrollment period.

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

    a. If you are enrolling following marriage, you and your new *spouse* must enroll within 31 days of the date of marriage. Your new *spouse'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), 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 *plan administrator* within 60 days after the date you are determined to be eligible for this assistance.

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

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

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

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

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

OPEN ENROLLMENT PERIOD

There is an open enrollment period once each *year*. During that time, an individual who meets the eligibility requirements as a *subscriber* under this *plan* may enroll. A *subscriber* may also enroll any eligible *dependents* at that time. Persons eligible to enroll as *dependents* may enroll only under the *subscriber'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 as provided below:

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

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

3. Coverage for *dependents* ends when *subscriber's* coverage ends.

4. Coverage ends at the end of the period for which the required monthly contribution has been paid on your behalf when the required monthly contribution for the next period is not paid.

5. If you voluntarily cancel coverage at any time, coverage ends on the due date for the required monthly contribution coinciding with or following the date of voluntary cancellation which you provide 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 due date for the required monthly contribution coinciding with or following the date you cease to meet such requirements.

   Exceptions to item 6:

   a. **Leave of Absence.** If you are a *subscriber* and the required monthly contributions are paid, your coverage may continue for up to six months during an approved temporary leave of absence by the *participating employer*. This time period may be extended if required by law.

   b. **Handicapped Children:** If a *child* reaches the age limits shown in the "Eligible Status" provision of this section, the *child* will continue to qualify as a *dependent* if he or she is (i) covered under this *plan,* (ii) still financially dependent on the *subscriber* or *spouse,* and (iii) incapable of self-sustaining employment due to a physical handicap or mental retardation. A *physician* must certify this disability in writing. We must receive the certification, at no expense to us, within 31 days of the date the *child* otherwise becomes ineligible. When a period of two years has passed, we may request proof of continuing dependency and disability, but not more often than once each year. This exception will last until the *child* is no longer handicapped or dependent on the *subscriber* or *spouse* for financial support. A *child* is considered financially dependent if he or she qualifies as a dependent for federal income tax purposes.

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

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 *plan* is subject to the federal law which governs this provision (Title X of P. L. 99-272), you may be entitled to continuation of coverage. Check with your *plan administrator* for details.

DEFINITIONS

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

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

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

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

1. **For Subscribers and Dependents:**

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

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

2. **For Retired Employees and their Dependents.** Cancellation or a substantial reduction of retiree benefits under the *plan* due to the *participating employer’s* filing for Chapter 11 bankruptcy, provided that:

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

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

3. **For Dependents:**

   a. The death of the *subscriber;*

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

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

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

ELIGIBILITY FOR COBRA CONTINUATION

A *subscriber* or *dependent* 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 *plan administrator*, the *participating employer* or its designated administrator (Anthem Blue Cross Life and Health is not the administrator) will notify either the *subscriber* or *dependent* of the right to continue coverage under COBRA, as provided below:

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

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

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

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

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

Notice of continued coverage, along with the initial required monthly contribution, must be delivered to us within 45 days after you elect COBRA continuation coverage.

Additional Dependents. A *spouse* or *child* acquired during the COBRA continuation period is eligible to be enrolled as a *dependent*. The standard enrollment provisions of the *plan* apply to enrollees during the COBRA continuation period.

Cost of Coverage. You may be required to pay the entire cost of your COBRA continuation coverage. This cost, called the "required monthly contribution", must be remitted to the *plan administrator* each month during the COBRA continuation period.

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

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

2. A *child* if neither the *subscriber* nor the *spouse* has enrolled for this COBRA continuation coverage (if more than one *child* is so enrolled, the required monthly contribution 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, a *subscriber* or *dependent,* who is a Qualified Beneficiary, may be entitled to an extended COBRA continuation period. This period will in no event continue beyond 36 months from the date of the first qualifying event.

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

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

For *dependents* properly enrolled during the COBRA continuation, coverage begins according to the enrollment provisions of the *plan*.

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

1. The end of 18 months from the Qualifying Event, if the Qualifying Event was termination of employment or reduction in work hours;*
2. The end of 36 months from the Qualifying Event, if the Qualifying Event was the death of the *subscriber,* divorce or legal separation, or the end of dependent *child* status;*
3. The end of 36 months from the date the *subscriber* became entitled to Medicare, if the Qualifying Event was the *subscriber's* entitlement to Medicare. If entitlement to Medicare does not result in coverage terminating and Qualifying Event 1 occurs within 18 months after Medicare entitlement, coverage for Qualified Beneficiaries other than the *subscriber* will end 36 months from the date the *subscriber* became entitled to Medicare;
4. The date the *plan* terminates;
5. The end of the period for which required monthly contributions are last paid;
6. The date, following the election of COBRA, the *member* first becomes covered under any other group health plan; or
7. The date, following the election of COBRA, the *member* first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

*For a *member* whose COBRA continuation coverage began under a *prior plan,* this term will be dated from the time of the Qualifying Event under that *prior plan*.

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

Other Coverage Options Besides COBRA Continuation Coverage. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a *spouse's* plan) through the conditions listed under the SPECIAL ENROLLMENT PERIODS provision. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

EXTENSION OF CONTINUATION DURING TOTAL DISABILITY

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

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

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

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

Notice. The *member* must furnish the *plan administrator* 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 cost for the extended continuation coverage must be remitted to us. This cost (called the "required monthly contribution") shall be subject to the following conditions:

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

2. The cost for extended continuation coverage must be remitted to us each month during the period of extended continuation coverage. We must receive timely payment of the required monthly contribution in order to maintain the extended continuation coverage in force.

3. You may be required to 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 required monthly contribution shall then be **150%** of the applicable rate for the 19th through 36th months if the disabled *member* remains covered. The charge will be **102%** of the applicable rate for any periods of time the disabled *member* is not covered following the 18th month.

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

1. The end of the month following a period of 30 days after the Social Security Administration's final determination that you are no longer totally disabled;
2. The end of 29 months from the Qualifying Event;
3. The date the *plan* terminates;
4. The end of the period for which required monthly contributions are last paid;
5. The date, following the election of COBRA, the *member* first becomes covered under any other group health plan; or
6. The date, following the election of COBRA, the *member* first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

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

EXTENSION OF BENEFITS

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

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

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

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

    a. You are no longer totally disabled.

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

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

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

GENERAL PROVISIONS

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

Independent Contractors. The *claims administrator's* 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 the *claims administrator's* agents nor is the *claims administrator*, or any of the employees of the *claims administrator*, an employee or agent of any *hospital,* medical group or medical care provider of any type.

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

Inter-Plan Arrangements

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

When you receive care outside of the Anthem Blue Cross Service Area, you will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some providers ("non-participating providers") do not contract with the Host Blue. See below for an explanation of how both kinds of providers are paid.

Inter-Plan Arrangements Eligibility – Claim Types

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

A. BlueCard® Program

Under the BlueCard® Program, when you receive covered services within the geographic area served by a Host Blue, the *claims administrator* will still fulfill the plan's contractual obligations. But, the Host Blue is responsible for: (a) contracting with its providers; and (b) handling its interactions with those providers.

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

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

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

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

B. Negotiated (non–BlueCard Program) Arrangements

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

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

C. Special Cases: Value-Based Programs

BlueCard® Program

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

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

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

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

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

E. Non-participating Providers Outside Our Service Area

1. Allowed Amounts and Member Liability Calculation

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

2. **Exceptions**

In certain situations, the *claims administrator* may use other pricing methods, such as billed charges or the pricing we would use if the healthcare services had been obtained within the Anthem Blue Cross Service Area, or a special negotiated price to determine the amount we will pay for services provided by non-participating

providers. In these situations, you may be liable for the difference between the amount that the non-participating provider bills and the payment we make for the covered services as set forth in this paragraph.

F. BlueCross BlueShield Global Core® Program

If you plan to travel outside the United States, call Member Services for information about your BlueCross BlueShield Global Core benefits. Benefits for services received outside of the United States may be different from services received in the United States.

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

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

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

How Claims are Paid with BlueCross BlueShield Global Core

In most cases, when you arrange inpatient hospital care with BlueCross BlueShield Global Core, claims will be filed for you. The only amounts that you may need to pay up front are any co-payment or deductible amounts that may apply.

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

- *Physician* services;
- Inpatient hospital care not arranged through BlueCross BlueShield Global Core; and
- Outpatient services.

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

When you need BlueCross BlueShield Global Core claim forms you can get international claims forms in the following ways:

- Call the BlueCross BlueShield Global Core Service Center at the numbers above; or
- Online at www.bcbsglobalcore.com

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

Terms of Coverage

1. In order for you to be entitled to benefits under the *plan,* both the *plan* and your coverage under the *plan* 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 *plan* is subject to amendment, modification or termination according to the provisions of the *plan* without your consent or concurrence.

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

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

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

Continuity of Care. If the *claims administrator* terminates its contractual relationship with a *participating provider* and you are undergoing a course of treatment from that provider at the time the contract is terminated, you may be able to continue to receive services from that provider (but only if such provider agrees to continue to comply with the same contractual requirements that applied prior to termination). To qualify, you must have an acute or a serious chronic condition, a high risk pregnancy, or a pregnancy in the second or third trimester. You may request this continuity of care by calling the Member Services telephone number listed on your ID card. If approved, services may be received for a limited period of time, but no longer than 90 days, unless you cannot be safely transferred to a

participating provider. Coverage is provided according to the terms and conditions of this *plan* applicable to *participating providers*.

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 the *claims administrator*, be subject to a reduced negotiated rate in the event the participating *physician* fails to make routine referrals to *participating providers*, except as otherwise allowed (such as for *emergency services*). *Hospitals* and other health care facilities may be paid either a fixed fee or on a discounted fee-for-service basis.

Other forms of payment arrangement are Payment Innovation Programs. These programs may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner. The programs may vary in methodology and subject area of focus and may be modified by the *plan administrator* from time to time, but they will be generally designed to tie a certain portion of a *participating provider's* total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, *participating providers* may be required to make payment to the *plan* under the program as a consequence of failing to meet these pre-defined standards. The programs are not intended to affect the *member's* access to health care. The program payments are not made as payment for specific covered services provided to the *member*, but instead, are based on the *participating provider's* achievement of these pre-defined standards. The *member* is not responsible for any co-payment amounts related to payments made by the *plan* or to the *plan* under the programs and the member does not share in any payments made by *participating providers* to the *plan* under the programs.

Availability of Care. If there is an epidemic or public disaster and you cannot obtain care for covered services, we refund the unearned part of the required monthly contribution paid. 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 the *claims administrator* determines to be *medically necessary*. The services must be ordered by the attending *physician* for the direct care and treatment of a covered condition. They must be standard medical practice where received for the condition being treated and must be legal in the United States. The process used to authorize or deny health care services under this *plan* is available to you upon request.

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

Benefits Not Transferable. Only the *member* is entitled to receive benefits under this *plan*. The right to benefits cannot be transferred.

Notice of Claim. You or the provider of service must send the *claims administrator* 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. The *plan administrator* is not liable for the benefits of the *plan* if you do not file claims within the required time period. The *plan administrator* will not be liable for benefits if the *claims administrator* does 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.

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

Payment to Providers. The benefits of this *plan* will be paid directly to *participating providers*, *CME* and medical transportation providers. Also, other providers of service will be paid directly when you assign benefits in writing. If you are a MediCal member and you assign benefits in writing to the State Department of Health Services, the benefits of this *plan* will be paid to the State Department of Health Services. These payments will fulfill the *plan's* obligation to you for those covered services.

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

Right of Recovery. Whenever payment has been made in error, the *claims administrator* will have the right to make appropriate adjustment to claims, recover such payment from you or, if applicable, the provider, in accordance with applicable laws and regulations. In the event the *claims administrator* recovers a payment made in error from the provider, except in cases of fraud or misrepresentation on the part of the provider, the

claims administrator will only recover such payment from the provider within 365 days of the date the payment was made on a claim submitted by the provider. The *claims administrator* reserves the right to deduct or offset any amounts paid in error from any pending or future claim.

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

The *claims administrator* has oversight responsibility for compliance with provider and vendor and subcontractor contracts. The *claims administrator* 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.

The *claims administrator* has 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. The *claims administrator* will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. The *claims administrator* may not provide you with notice of overpayments made by the *plan* or you if the recovery method makes providing such notice administratively burdensome.

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. If you bring a civil action under Section 502(a) of ERISA, you must bring it within one year of the grievance or appeal decision.

Plan Administrator - COBRA. In no event will the *claims administrator* be *plan administrator* for the purposes of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA). The term "*plan administrator*" refers to CSAC Excess Insurance Authority or to a person or entity other than the *claims administrator*, engaged by CSAC Excess Insurance Authority to perform or assist in performing administrative tasks in connection with the *plan*. In providing notices and otherwise performing under the CONTINUATION OF COVERAGE section of this *benefit booklet*, the *plan administrator* is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as your agent.

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

Prepayment Fees. The *participating employer* may require that you contribute all or part of the costs of these required monthly contributions. Please consult the *participating employer* for details.

Liability to Pay Providers. In the event that the *plan* does not pay a provider who has provided benefits to you, you will be required to pay that provider any amounts not paid to them by the *plan*.

Renewal Provisions. The *plan* is subject to renewal at certain intervals. The required monthly contribution or other terms of the *plan* may be changed from time to time.

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

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

Value-Added Programs. The *claims administrator* may offer health or fitness related programs to its *members*, through which they may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not covered services under the *plan* but are in addition to *plan* benefits. As such, program features are not guaranteed under this health *plan* contract and could be discontinued at any time. The *claims administrator* does not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Voluntary Clinical Quality Programs. The *claims administrator* may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from covered services under your plan. These programs are not guaranteed and could be discontinued at any time. The *claims administrator* will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards or retailer coupons, which we encourage you to use for health and wellness related activities or items. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may also be offered a home visit appointment to collect such specimens and complete biometric screenings. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit or the home visit. If you have any questions about whether receipt of a gift card or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

Voluntary Wellness Incentive Programs. The claims administrator may offer health or fitness related program options for purchase by the plan administrator to help you achieve your best health. These programs are not covered services under your plan, but are separate components, which are not guaranteed under this plan and could be discontinued at any time. If the plan administrator has selected one of these options to make available to all employees, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options the plan administrator may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact the Member Services number on your ID card and the claims administrator will work with you (and, if you wish, your physician) to find a wellness program with the same reward that is right for you in light of your health status. If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.

New Program Incentives. The *plan administrator* may offer incentives from time to time at their discretion in order to introduce you to new programs and services available under this *plan*. The purpose of these incentives include, but is not limited to, making you aware of cost effective benefit options or services, helping you achieve your best health, and encouraging you to update member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards and health-related merchandise. Acceptance of these incentives is voluntary as long as the *plan* offers the incentives program. The *plan administrator* may discontinue an incentive for a particular new service or program at any time. If you have any questions about whether receipt of an incentive or retailer coupon results in taxable income to you, please consult your tax advisor.

Protecting your privacy

Where to find our Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law governing the privacy of individually identifiable health information. We are required by HIPAA to notify you of the availability of our Notice of Privacy Practices. The notice describes our privacy practices, legal duties and your rights concerning your Protected Health Information. We must follow the privacy practices described in the notice while it is in effect (it will remain in effect unless and until we publish and issue a new notice).

We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy Rule:
For payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan.

For health care operations: We use and share PHI for health care operations.

For treatment activities: We do not provide treatment. This is the role of a health care provider, such as your doctor or a hospital. Examples of ways we use your information for payment, treatment and health care operations:

- We keep information about your premium and deductible payments.
- We may give information to a doctor's office to confirm your benefits.
- We may share explanation of benefits (EOB) with the subscriber of your plan for payment purposes.
- We may share PHI with your health care provider so that the provider may treat you.
- We may use PHI to review the quality of care and services you get.
- We may use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.
- We may also use and share PHI directly or indirectly with or through health information exchanges for payment, health care operations and treatment. If you do not want your PHI to be shared for payment, health care operations, or treatment purposes in health information exchanges, please visit anthem.com/health-insurance/about-us/privacy for more information.

We, including our affiliates or vendors, may call or text any telephone numbers provided by you using an automated telephone dialing system and/or a prerecorded message. Without limitation, these calls may concern treatment options, other health-related benefits and services, enrollment, payment, or billing.

You may obtain a copy of our Notice of Privacy Practices on our website at https://www.anthem.com/ca/health-insurance/about-us/privacy or you may contact Member Services using the contact information on your identification card.

COMPLAINTS AND APPEALS

The agent for service of legal process is CSAC Excess Insurance Authority (*plan administrator*). The plan administrator has delegated to Anthem Blue Cross Life and Health (the *claims administrator*) authority to determine claims for benefits under the *plan* as well as authority to determine appeals of any adverse benefit determinations under the *plan*. The *claims administrator* shall administer complaints and appeals according to the *claims administrator's* complaint and appeals policy. All claims with respect to which legal action is taken against the proceeds, such as suit, attachment or restraining order shall be referred to the *plan administrator*.

For claim appeals information, please refer to the Complaint Notice on the inside back cover of this booklet, and the Your Right To Appeals and Binding Arbitration sections.

BINDING ARBITRATION

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

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

The *member* and the *plan administrator* agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The *member* and the *plan administrator* agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class actions or class arbitrations, the *member* waives any right to pursue, on a class basis, any such controversy or claim against the *plan administrator* and the *plan administrator* waives any right to pursue on a class basis any such controversy or claim against the *member*.

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

The arbitration is begun by the *member* making written demand on the *plan administrator*. 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 mutual agreement of the *member* and the *plan administrator*, or by order of the court, if the *member* and the *plan administrator* 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, the *plan administrator* will assume all or a portion of the costs of the arbitration.

DEFINITIONS

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

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

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

Authorized referral occurs when you, because of your medical needs, require the services of a specialist who is a *non-participating provider*, but only when:

1. there is no *participating provider* who practices in the appropriate specialty, or there is no *contracting hospital* which provides the required services or has the necessary facilities; and

2. that meets the adequacy and accessibility requirements of state or federal law

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 bariatric *CME*.

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

Benefit booklet is this written description of the benefits provided under the *plan*.

Centers of Medical Excellence (CME) are health care providers designated by the *claims administrator* as a selected facility for specified medical services. A provider participating in a CME network has an agreement in effect with the *claims administrator* at the time services are rendered or is available through their affiliate companies or their 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.

Chiropractic services means *medically necessary* care by means of adjustment of the spine (to correct a subluxation) performed by a legally licensed chiropractor pursuant to the terms of their license. (Subluxation is a term used in the chiropractic field to describe what happens when one of the vertebrae in your spine moves out of position.

Claims administrator refers to Anthem Blue Cross Life and Health Insurance Company. On behalf of Anthem Blue Cross Life and Health Insurance Company, Anthem Blue Cross shall perform all administrative services in connection with the processing of claims under the *plan.*

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

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

If your prior coverage was through an employer, you will receive credit for that coverage if it ended because your employment ended, the availability of medical coverage offered through employment or sponsored by the employer terminated, or the employer's contribution toward medical coverage terminated, and any lapse between the date that coverage ended and the date you become eligible under this *plan* is no more than 180 days (not including any waiting period imposed under this *plan* by the employer).

If your prior coverage was not through an employer, you will receive credit for that coverage if any lapse between the date that coverage ended and the date you become eligible under this *plan* is no more than 63 days (not including any waiting period imposed under this *plan* by the employer).

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

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

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

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

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

Designated pharmacy provider is a *participating pharmacy* that has executed a Designated Pharmacy Provider Agreement with the *plan* or a *participating provider* that is designated to provide *prescription drugs*, including *specialty drugs*, to treat certain conditions.

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

Emergency or Emergency Medical Condition means a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity including severe pain such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient's health or the health of another person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency includes being in active labor when there is inadequate time for a safe transfer to another *hospital* prior to delivery, or when such a transfer would pose a threat to the health and safety of the *member* or unborn child.

An *emergency medical condition* includes a *psychiatric emergency medical condition*, which is a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following: a) an immediate danger to himself or herself or to others, or b) immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

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

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

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

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

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

Hospice is an agency or organization providing a specialized form of interdisciplinary health care that provides palliative care (pain control and symptom relief) and alleviates the physical, emotional, social, and spiritual discomforts of a terminally ill person, as well as providing supportive care to the primary caregiver and the patient's family. A hospice must be: currently licensed as a hospice pursuant to Health and Safety Code section 1747 or a licensed *home health agency* with federal Medicare certification pursuant to Health and Safety Code sections 1726 and 1747.1. A list of hospices meeting these criteria is available upon request.

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

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

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

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

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

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

Maximum allowed amount is the maximum amount of reimbursement the *claims administrator* 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 the *claims administrator* determines to be:

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease
3. Provided for the diagnosis or direct care and treatment of the medical condition;
4. Within standards of good medical practice within the organized medical community;

5. Not primarily for your convenience, or for the convenience of your *physician* or another provider;

6. Not more costly than an equivalent service or sequence of services that is medically appropriate and is likely to produce equivalent therapeutic or diagnostic results in regard to the diagnosis or treatment of the patient's illness, injury, or condition; and

7. The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:

    a. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and

    b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; 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.

Member is the *subscriber* or *dependent*.

Mental health conditions include conditions that constitute *severe mental disorders* and serious emotional disturbances of a child, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), as well as any mental health condition identified as a "mental disorder" in the DSM, Fourth Edition Text Revision (DSM IV). Substance abuse means drug or alcohol abuse or dependence.

Non-participating provider is one of the following providers which does NOT have a Prudent Buyer Plan Participating Provider Agreement in effect with the *claims administrator* 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 licensed ambulance company
- A *home infusion therapy provider*
- 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
- A *hospice*

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

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

Participating employer. A participating employer is a California county government. Specific qualifications of a participating employer are stipulated in the *participation agreement*.

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 the *claims administrator* 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 licensed ambulance company
- A *home infusion therapy provider*
- 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.

Participation agreement is the agreement between the *plan administrator* and the *participating employer* providing for participation of specified *subscribers* in this *plan.*

Physician means:

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

2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license and such license is required to render that service, and is providing a service for which benefits are specified in this booklet:

    - A dentist (D.D.S. or D.M.D.)
    - An optometrist (O.D.)
    - A dispensing optician
    - A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
    - A licensed clinical psychologist
    - A licensed educational psychologist or other provider permitted by California law to provide behavioral health treatment services for the treatment of pervasive developmental disorder or autism only
    - A chiropractor (D.C.)
    - An acupuncturist (A.C.)
    - A licensed clinical social worker (L.C.S.W.)
    - A marriage and family therapist (M.F.T.)
    - A licensed professional clinical counselor (L.P.C.C.)*
    - A physical therapist (P.T. or R.P.T.)*
    - A speech pathologist*
    - An audiologist*
    - An occupational therapist (O.T.R.)*
    - A respiratory care practitioner (R.C.P.)*
    - A nurse midwife**
    - A nurse practitioner
    - A physician assistant

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

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

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

Plan is the set of benefits described in this *benefit booklet* and in the amendments to this *benefit booklet*, if any. These benefits are subject to the terms and conditions of the *plan.* If changes are made to the plan, an amendment or revised *benefit booklet* will be issued to each *subscriber* affected by the change.

Plan administrator refers to CSAC Excess Insurance Authority, the entity which is responsible for the administration of the *plan.*

Prior plan is a plan sponsored by us 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.

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

https://www.healthcare.gov/what-are-my-preventive-care-benefits

http://www.ahrq.gov

http://www.cdc.gov/vaccines/acip/index.html

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 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 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.

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 of a *mental health condition* or substance abuse. The facility must be licensed to provide psychiatric treatment of *mental health condition* or substance abuse according to state and local laws and requires a minimum of one *physician* visit per week in the facility. The facility must be fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

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

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

Self-Administered Hormonal Contraceptives are products with the following routes of administration:

- Oral;
- Transdermal;
- Vaginal;
- Depot Injection.

Severe mental disorders include severe mental illness as specified in California Health and Safety Code section 1374.72: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, and bulimia.

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

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

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

3. The child meets special education eligibility requirements under California law (Education Code Section 56320).

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

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

Specialist is a *physician* who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has added training in a specific area of health care.

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

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

Subscriber is the person who, by meeting the *plan's* eligibility requirements for employees, is allowed to choose membership under this *plan* for himself or herself and his or her eligible *dependents*. Such requirements are outlined in HOW COVERAGE BEGINS AND ENDS.

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

Totally disabled subscriber is a *subscriber* who, because of illness or injury, is unable to work for income in any job for which he/she is qualified or for which he/she becomes qualified by training or experience, and who is in fact unemployed.

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

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

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 the Member Services number listed on your ID card or you can also search online using the "Find a Doctor" function on the website at www.anthem.com/ca. Please call the *urgent care center* directly for hours of operation and to verify that the center can help with the specific care that is needed.

We (us, our) refers to the *plan administrator*.

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

You (your) refers to the *subscriber* and *dependents* who are enrolled for benefits under this *plan*.

YOUR RIGHT TO APPEALS

For purposes of these Appeal provisions, "claim for benefits" means a request for benefits under the *plan*. The term includes both pre-service and post-service claims.

- A pre-service claim is a claim for benefits under the *plan* for which you have not received the benefit or for which you may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the *plan* for which you have received the service.

If your claim is denied or if your coverage is rescinded:

- you will be provided with a written notice of the denial or rescission; and
- you are entitled to a full and fair review of the denial or rescission.

The procedure the *claims administrator* will follow will satisfy following the minimum requirements for a full and fair review under applicable federal regulations.

Notice of Adverse Benefit Determination

If your claim is denied, the *claims administrator's* notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific *plan* provision(s) on which the *claims administrator*'s determination is based;
- a description of any additional material or information needed to perfect your claim;
- an ex*plan*ation of why the additional material or information is needed;
- a description of the *plan*'*s* review procedures and the time limits that apply to them, including a statement of your right to bring a civil action under ERISA (if applicable) if you appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision;

- information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision; and

- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you.

For claims involving urgent/concurrent care:

- the *claims administrator*'s notice will also include a description of the applicable urgent/concurrent review process; and

- the *claims administrator* may notify you or your authorized representative within 72 hours orally and then furnish a written notification.

Appeals

You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. The c*laims administrator*'s review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

- The *claims administrator* shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. The time frame allowed for the *claims administrator* to complete its review is dependent upon the type of review involved (e.g. pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care, you may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including the *claims administrator*'s decision, can be sent between the *claims administrator* and you by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact the *claims administrator* at the phone number listed on your ID card and provide at least the following information:

- the identity of the claimant;

- the date (s) of the medical service;
- the specific medical condition or symptom;
- the provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals should be submitted in writing by the Member or the Member's authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the appeal (e.g. urgent care). You or your authorized representative must submit a request for review to:

Anthem Blue Cross Life and Health Insurance Company
ATTN: Appeals
P.O. Box 4310, Woodland Hills, CA 91365-4310

You must include Your Member Identification Number when submitting an appeal.

Upon request, the *claims administrator* will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the *plan*, applied consistently for similarly-situated claimants; or
- is a statement of the *plan*'s policy or guidance about the treatment or benefit relative to your diagnosis.

The *claims administrator* will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an adverse benefit determination on review based on a new or additional rationale, the *claims administrator* will provide you, free of charge, with the rationale.

For Out of State Appeals You have to file Provider appeals with the Host Plan. This means Providers must file appeals with the same plan to which the claim was filed.

How Your Appeal will be Decided

When the *claims administrator* considers your appeal, the *claims administrator* will not rely upon the initial benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not *medically necessary*, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal

If you appeal a claim involving urgent/concurrent care, the *claims administrator* will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

If you appeal any other pre-service claim, the *claims administrator* will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.

If you appeal a post-service claim, the *claims administrator* will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

Appeal Denial

- If your appeal is denied, that denial will be considered an adverse benefit determination. The notification from the *claims administrator* will include all of the information set forth in the above subsection entitled “Notice of Adverse Benefit Determination.”

Voluntary Second Level Appeals

If you are dissatisfied with the *Plan*'s mandatory first level appeal decision, a voluntary second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.

External Review

If the outcome of the mandatory first level appeal is adverse to you and it was based on medical judgment, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to the *claims administrator* within four (4) months of the notice of your final internal adverse determination.

A request for a External Review must be in writing unless the *claims administrator* determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the *claims administrator's* internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the *claims administrator*'s decision, can be sent between the *claims administrator* and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact the *claims administrator* at the phone number listed on your ID card and provide at least the following information:

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;
- the provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless the *claims administrator* determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Anthem Blue Cross Life and Health Insurance Company
ATTN: Appeals
P.O. Box 4310, Woodland Hills, CA 91365-4310

You must include Your Member Identification Number when submitting an appeal.

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care *plan*. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA (if applicable).

Requirement to file an Appeal before filing a lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within three years of the *Plan*'s final decision on the claim or other request for benefits. If the *Plan* decides an appeal is untimely, the *Plan*'s latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the *Plan*'s internal Appeals Procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the *Plan*.

The *claims administrator* reserves the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

FOR YOUR INFORMATION

ANTHEM BLUE CROSS WEB SITE

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

Identity Protection Services

The *claims administrator* has made identity protection services available to *members*. To learn more about these services, please visit www.anthem.com/resources**.**

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 *members* with limited English proficiency.

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

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

- Spanish
- Chinese
- Vietnamese
- Korean
- Tagalog

Oral interpretation services are available in additional languages.

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

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

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 the Member Services telephone number listed on your ID card.

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

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

GENERAL PLAN INFORMATION

The following information, together with the preceding material, forms a *benefit booklet*. The benefit booklet covers group medical coverage to eligible *subscribers* of *participating employers* of CSAC Excess Insurance Authority. CSAC Excess Insurance Authority Health Program is administered on a self-insured basis with benefit claims processed by Anthem Blue Cross, on behalf of Anthem Blue Cross Life and Health Insurance Company (Claims Administrator).

1. **Plan Name.** The designated name of the Plan is: CSAC Excess Insurance Authority Health Program.

2. **Plan Sponsor.** The name and address of the entity which established and maintains the Plan is:

   CSAC EIA
   75 Iron Point Circle, Suite 200
   Folsom, CA 95630

3. **Type of Plan.** The Plan is an employee welfare benefit plan providing group medical benefits.

4. **Plan Year.** The Plan's records are maintained on a plan year basis beginning each year on January 1 and ending on the following December 31.

5. **Type of Administration/Funding.** Medical benefits are furnished under a health care plan funded by the Plan Sponsor. Anthem Blue Cross Life and Health furnishes only certain claim processing and provider contracting services and has no financial responsibility for benefits.

   Anthem Blue Cross Life and Health's address is:

   Anthem Blue Cross Life and Health Insurance Company
   21555 Oxnard Street
   Woodland Hills, CA 91367

6. **Plan Administrator**. The name and address of the Plan Administrator are:

   CSAC EIA
   75 Iron Point Circle, Suite 200
   Folsom, CA 95630

7. **Agent for Service of Legal Process.** The name and address of the designated agent for the service of legal process for the Plan are the same as the Plan Administrator's.

8. **Description of Benefits.** The Benefit Booklet sets forth the benefits, deductibles, copays, benefit maximums, limitations and exclusions, and the extent to which preventive care is provided under the Prudent Buyer Exclusive Plan. A brief explanation of these benefits, deductibles, copays, benefit maximums, limitations and exclusions, and the extent to which preventive care is covered may be found in the section entitled SUMMARY OF BENEFITS. A more detailed description of the benefits, deductibles, copays, benefit maximums, limitations and exclusions, and the extent to which preventive care is covered appears in the sections entitled TYPES OF PROVIDERS, YOUR MEDICAL BENEFITS (including subsections MAXIMUM ALLOWED AMOUNT, DEDUCTIBLE, CO-PAYMENTS, OUT-OF-POCKET AMOUNT AND MEDICAL BENEFIT MAXIMUMS, CONDITIONS OF COVERAGE, MEDICAL CARE THAT IS COVERED, and MEDICAL CARE THAT IS NOT COVERED), SUBROGATION AND REIMBURSEMENT, COORDINATION OF BENEFITS, BENEFITS FOR MEDICARE ELIGIBLE MEMBERS, UTILIZATION REVIEW PROGRAM (including the subsections DECISION AND NOTICE REQUIREMENTS, HEALTH PLAN INDIVIDUAL CASE MANAGEMENT, EXCEPTIONS TO THE UTILIZATION REVIEW PROGRAM, and QUALITY ASSURANCE, and DEFINITIONS.

   Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

   If you or your spouse are required, due to a QMCSO, to provide coverage for your child(ren), you may ask your employer or Plan Administrator to provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

9. **Eligibility for Participation**. The eligibility requirements for participation under the Prudent Buyer Exclusive Plan are set forth in the Benefit Booklet in the section entitled HOW COVERAGE BEGINS AND ENDS under the subsection HOW COVERAGE BEGINS.

10. **Grounds for Ineligibility or Loss or Denial of Benefits.** Details describing the circumstances which may result in: (a) disqualification from the Prudent Buyer Exclusive Plan; (b) ineligibility for benefits; or (c) denial, loss, forfeiture or suspension of benefits under the Plan are set forth and identified in the Benefit Booklet, as outlined below:

    - Reasons for ineligibility or loss of benefits may be found in the section entitled HOW COVERAGE BEGINS AND ENDS under the subsection HOW COVERAGE ENDS.

- Benefits may be denied or suspended if statements a Plan participant has made in connection with obtaining coverage were false.

- Information concerning situations under which benefits may be reduced or denied may also be found in the sections entitled TYPES OF PROVIDERS, YOUR MEDICAL BENEFITS (including subsections MAXIMUM ALLOWED AMOUNT, DEDUCTIBLE, CO-PAYMENTS, OUT-OF-POCKET AMOUNT AND MEDICAL BENEFIT MAXIMUMS, CONDITIONS OF COVERAGE, MEDICAL CARE THAT IS COVERED, and MEDICAL CARE THAT IS NOT COVERED), SUBROGATION AND REIMBURSEMENT, COORDINATION OF BENEFITS, BENEFITS FOR MEDICARE ELIGIBLE MEMBERS, UTILIZATION REVIEW PROGRAM (including the subsections DECISION AND NOTICE REQUIREMENTS, HEALTH PLAN INDIVIDUAL CASE MANAGEMENT, EXCEPTIONS TO THE UTILIZATION REVIEW PROGRAM, and QUALITY ASSURANCE, and DEFINITIONS.

11. **Claims Procedures.** The plan document and this booklet entitled "Benefit Booklet," contain information on reporting claims, including the time limitations on submitting a claim. Claim forms may be obtained from the Plan Administrator or from the Claims Administrator.

    Urgent Care. The Claims Administrator must notify you, within 72-hours after they receive your request for benefits, that they have it and what they determine your benefits to be. If your request for benefits does not contain all the necessary information, they must notify you within 24-hours after they get it and tell you what information is missing. Any notice to you by them will be orally, by telephone, or in writing by facsimile or other fast means. You have at least 48-hours to give them the additional information they need to process your request for benefits. You may give them the additional information they need orally, by telephone, or in writing by facsimile or other fast means.

    If your request for benefits is denied in whole or in part, you will receive a notice of the denial within 72-hours after the Claims Administrator's receipt of the request for benefits, or 48 hours after receipt of all the information they need to process your request for benefits if the information is received within the time frame noted above. The notice will explain the reason for the adverse benefit determination and the plan provisions upon which the denial decision was based. You have 180-days to appeal their adverse benefit determination. You may appeal their decision orally, by telephone, or in writing by facsimile or other fast means. Within 72-hours after they receive your appeal, they must notify you of their decision, except as otherwise noted below. They will notify you orally, by telephone, or in writing by facsimile or other fast means. If your request for benefits is no longer considered

urgent, it will be handled in the same manner as a Non-Urgent Care Pre-Service or Post-service appeal, depending upon the circumstances.

Non-Urgent Care Pre-Service (when care has not yet been received). The Claims Administrator must notify you within 15-days after they receive your request for benefits that they have it and what they have determined your benefits to be. If they need more than 15-days to determine your benefits, due to reasons beyond their control, they must notify you within that 15-day period that they need more time to determine your benefits. But, in any case, even with an extension, they cannot take more than 30-days to determine your benefits. If you do not properly submit all the necessary information for your request for benefits to them, they must notify you, within 5-days after they get it and tell you what information is missing. You have 45-days to provide them with the information they need to process your request for benefits. The time period during which the Claims Administrator is waiting for receipt of the necessary information is not counted toward the time frame in which the Claims Administrator must make the benefit determination.

If your request for benefits is denied in whole or in part, you will receive a written notice of the denial within the time frame stated above after the Claims Administrator has all the information they need to process your request for benefits, if the information is received within the time frame noted above. The written notice will explain the reason for the adverse benefit determination and the plan provisions upon which the denial decision is based. You have 180-days to appeal their adverse benefit determination. Your appeal must be in writing. Within 30-days after they receive your appeal, they must notify you of their decision about it. Their notice of their decision will be in writing.

Concurrent Care Decisions:

- **Reduction of Benefits –** If, after approving a request for benefits in connection with your illness or injury, the Claims Administrator decides to reduce or end the benefits they have approved for you, in whole or in part:
  - They must notify you sufficiently in advance of the reduction in benefits, or the end of benefits, to allow you the opportunity to appeal their decision before the reduction in benefits or end of benefits occurs. In their notice to you, the Claims Administrator must explain their reason for reducing or ending your benefits and the plan provisions upon which the decision was made.

- To keep the benefits you already have approved, you must successfully appeal the Claims Administrator's decision to reduce or end those benefits. You must make your appeal to them at least 24-hours prior to the occurrence of the reduction or ending of benefits. If you appeal the decision to reduce or end your benefits when there is less than 24-hours to the occurrence of the reduction or ending of benefits, your appeal may be treated as if you were appealing an urgent care denial of benefits (see the section "Urgent Care," above), depending upon the circumstances of your condition.

- If the Claims Administrator receives your appeal for benefits at least 24-hours prior to the occurrence of the reduction or ending of benefits, they must notify you of their decision regarding your appeal within 24-hours of their receipt of it. If the Claims Administrator denies your appeal of their decision to reduce or end your benefits, in whole or in part, they must explain the reason for their denial of benefits and the plan provisions upon which the decision was made. You may further appeal the denial of benefits according to the rules for appeal of an urgent care denial of benefits (see the section "Urgent Care," above).

- **Extension of Benefits –** If, while you are undergoing a course of treatment in connection with your illness or injury, for which benefits have been approved, you would like to request an extension of benefits for additional treatments:

  - You must make a request to the Claims Administrator for the additional benefits at least 24-hours prior to the end of the initial course of treatment that had been previously approved for benefits. If you request additional benefits when there is less than 24-hours till the end of the initially prescribed course of treatment, your request will be handled as if it was a new request for benefits and not an extension and, depending on the circumstances, it may be handled as an Urgent or Non-Urgent Care Pre-service request for benefits.

  - If the Claims Administrator receives your request for additional benefits at least 24-hours prior to the end of the initial course of treatment, previously approved for benefits, they must notify you of their decision regarding your request within 24-hours of their receipt of it if your request is for urgent care benefits. If the Claims Administrator denies your request for additional benefits, in whole or in part, they must explain the reason for their denial of benefits and the plan provisions upon which the decision was made.

- You may appeal the adverse benefit determination according to the rules for appeal for Urgent, Pre-Service or Post-Service adverse benefit determinations, depending upon the circumstances.

Non - Urgent Care Post-Service (reimbursement for cost of medical care). The Claims Administrator must notify you, within 30-days after they receive your claim for benefits, that they have it and what they determine your benefits to be. If they need more than 30-days to determine your benefits, due to reasons beyond their control, they must notify you within that 30-day period that they need more time to determine your benefits. But, in any case, even with an extension, they cannot take more than 45-days to determine your benefits. If you do not submit all the necessary information for your claim to them, they must notify you, within 30-days after they get it and tell you what information is missing. You have 45-days to provide them with the information they need to process your claim. The time period during which the Claims Administrator is waiting for receipt of the necessary information is not counted toward the time frame in which the Claims Administrator must make the benefit determination.

If your claim is denied in whole or in part, you will receive a written notice of the adverse benefit determination within the time frame stated above, or after the Claims Administrator has all the information they need to process your claim, if the information is received within the time frame noted above. The written notice will explain the reason for the adverse benefit determination and the plan provisions upon which the denial decision is based. You have 180-days to appeal their decision. Your appeal must be in writing. Within 60-days after they receive your appeal, they must notify you of their decision about it. Their notice to you or their decision will be in writing.

Note: You, your beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits with the Claims Administrator and request a review of the denial. In connection with such a request:

- Documents pertinent to the administration of the Plan may be reviewed free of charge; and
- Issues outlining the basis of the appeal may be submitted.

You may have representation throughout the appeal and review procedure.

Get help in your language

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

You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

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

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda**. (TTY/TDD: 711)**

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك

للمساعدة(TTY/TDD: 711).

Armenian
Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

Hindi
आपके पास यह जानकारी और मदद अपनी भाषा में मुफ़्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें।(TTY/TDD: 711)

Hmong
Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Khmer
អ្នកមានសិទ្ធិក្នុងការទទួលព័ត៌មាននេះ និងទទួលជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើប័ណ្ណ ID របស់អ្នកដើម្បីទទួលជំនួយ។(TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Punjabi
ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ।(TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Thai
ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ(TTY/TDD: 711)

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

It's important we treat you fairly

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