July 1, 2014

ASCC

BC PPO
(non-California resident)
COMPLAINT NOTICE

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

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

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

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

1-800-927-HELP (4357) – In California
1-213-897-8921 – Out of California
1-800-482-4833 – Telecommunication Device for the Deaf

E-mail Inquiry: “Consumer Services” link at
www.insurance.ca.gov
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This Certificate of Insurance, including any amendments and endorsements to it, is a summary of the important terms of your health plan. It replaces any older certificates issued to you for the coverages described in the Summary of Benefits. The Group Policy, of which this certificate is a part, must be consulted to determine the exact terms and conditions of coverage. If you have special health care needs, you should read those sections of the Certificate of Insurance that apply to those needs. Your employer will provide you with a copy of the Group Policy upon request.

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

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

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

- **PPO Providers** are providers who participate in a Blue Cross and/or Blue Shield Plan. PPO Providers have agreed to a rate they will accept as reimbursement for covered services that is generally lower than the rate charged by Traditional Providers. Participating providers have agreed to a rate they will accept as reimbursement for covered services.

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

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

- If your plan identification card (ID card) shows a PPO suitcase logo and:
  - You go to a PPO Provider, you will get the higher level of benefits of this plan.
  - You go to a Traditional Provider because there are no PPO Providers in your area, you will get the higher level of benefits of this plan.

- If your ID card does NOT have a PPO suitcase logo, you must go to a Traditional Provider to get the higher level of benefits of this plan.

**How to Access Primary and Specialty Care Services**

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

- To make an appointment call your physician’s office:
  - Tell them you are a Prudent Buyer Plan member.
  - Have your Member ID card handy. They may ask you for your group number, member I.D. number, or office visit copay.
  - Tell them the reason for your visit.
  - When you go for your appointment, bring your Member ID card.

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

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

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

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

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

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

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

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

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

Care Outside the United States—BlueCard Worldwide

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

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

- Always carry your current ID card.

- In an emergency, seek medical treatment immediately.

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

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

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

**Claim Filing**

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

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

**Additional Information About BlueCard Worldwide Claims.**

• You are responsible, at your expense, for obtaining an English-language translation of foreign country provider claims and medical records.

• Exchange rates are determined as follows:
  - For inpatient **hospital** care, the rate is based on the date of admission.
  - For outpatient and professional services, the rate is based on the date the service is provided.

**Claim Forms**

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

  www.bcbs.com/bluecardworldwide.

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

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

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

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

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

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

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

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

MEDICAL BENEFITS

DEDUCTIBLES

Calendar Year Deductibles

- Insured Person Deductible ................................................................. $200
- Family Deductible ................................................................................. $600

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

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

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

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

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

- The Calendar Year Deductible will not apply to hospice care services provided by a physician who is a participating provider.

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

Co-Payments.* After you have met your Calendar Year Deductible, and any other applicable deductible, you will be responsible for the following percentages of the maximum allowed amount:

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

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

*Exceptions:

- There will be no Co-Payment for any covered services provided by a participating provider under the Preventive Care benefit.
- No Co-Payment is required for the following services when provided by a participating provider:
  a. Hospital medical services (other than emergency room care)
  b. Outpatient surgery, services and supplies provided by an ambulatory surgical center that is a participating provider.
  c. Services provided under the skilled nursing facility benefit.
  d. Outpatient diagnostic imaging and laboratory services.
  e. Facility-based care for the treatment of mental or nervous disorders or substance abuse.
  f. Sterilization procedures.
- No Co-Payment is required for services provided under the Hospice Care benefit.
- No Co-Payment is required for services provided under the Ambulance benefit.
- Your Co-Payment for office visits to a physician who is a participating provider will be $20. This Co-Payment will not apply toward the satisfaction of any deductible.

Note: This exception applies only to the charge for the visit itself. It does not apply to any other charges made during that visit, such as testing procedures, surgery, etc.
Your Co-Payment for diabetes education program services provided by a physician who is a participating provider will be $20. This Co-Payment will not apply toward the satisfaction of any deductible.

Your Co-Payment for outpatient physician visits provided by a participating provider under the Mental or Nervous and Substance Abuse benefit will be $20.

No Co-Payment is required for services provided by a participating provider for a normal or complicated delivery under the Pregnancy and Maternity Care benefit.

Your Co-Payment for services provided by a non-participating provider under the Pregnancy and Maternity Care benefit for a normal or complicated delivery will be 30%. You will be responsible for charges which exceed the maximum allowed amount.

Your Co-Payment for the services provided by a non-participating provider for outpatient diagnostic radiology or laboratory services will be 20%. You may be responsible for charges which exceed the maximum allowed amount.

Your Co-Payment for services provided by a non-participating provider under the Prosthetic Devices benefit will be 20%. You may be responsible for charges which exceed the maximum allowed amount.

Your Co-Payment for emergency room services and supplies will be $100. For non-participating providers, you may be responsible for charges which exceed the maximum allowed amount. The co-payment will not apply if you are admitted as a hospital inpatient immediately following emergency room treatment.

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

a. All emergency services;

b. An authorized referral from us to a non-participating provider;

c. Charges by a type of physician not represented in a Blue Cross and/or Blue Shield Plan (for example, an audiologist);

or

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

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

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

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

– Your Co-Payment for services provided by a *non-participating provider* under the Hospital, Ambulatory Surgical Center and Skilled Nursing Facility benefits will be **30%**. You may be responsible for charges which exceed the *maximum allowed amount*.

– Your Co-Payment for *hospital or day treatment center* care provided by a *non-participating provider* under the Mental or Nervous and Substance Abuse benefits will be **30%**. You may be responsible for charges which exceed the *maximum allowed amount*.

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

**Out-of-Pocket Amount**. After you have made 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*.

- *Participating providers and other health care providers*..........................$1,700/insured person

- *Non-participating providers*..................................................$3,000/insured person
*Exception:
- Expense which is incurred for non-covered services or supplies, or which is in excess of the maximum allowed amount, will not be applied toward your Out-of-Pocket Amount, and is always your responsibility.

**MEDICAL BENEFIT MAXIMUMS**

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

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

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

**Well Baby and Well Child Care (Dependent Children Under Age 7)**
- For physician’s services for each routine examination ..................$20*
- For each immunization .....................................................................$12*
  *Non-participating providers only

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

- Co-Payment for each *accidental injury*..............................**No Charge**
- Medical Benefit Maximum...........................................**$500**
  for all covered services incurred
  within 90 days of the injury
  date for treatment of each
  *accidental injury* **per member**

Lifetime Maximum

- For all medical benefits...............................................**Unlimited**
PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG DEDUCTIBLES

Calendar Year Deductible

- Member Deductible...........................................................................................................$100

PRESCRIPTION DRUG CO-PAYMENTS. The following co-payments apply for each prescription after you have met your Prescription Drug Deductible:

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

Participating Pharmacies

- **Generic Drugs**............................................................................................................$10

- **Brand Name Drugs:**
  - Formulary brand name drugs when no generic drug equivalent is available, or the prescriber has specified “dispense as written”.................................................................$30
  - Non-Formulary brand name drugs when a generic drug equivalent is available, and the prescriber has not specified “dispense as written”..................................................$30
    plus the difference of prescription drug covered expense between the generic drug and the brand name drug

- Non-formulary brand name drugs.................................................................................$50

- Compound medications ..............................................................................................$50
Please note that presentation of a prescription to a pharmacy or pharmacist does not constitute a claim for benefit coverage. If you present a prescription to a participating pharmacy, and the participating pharmacy indicates your prescription cannot be filled, your deductible, if any, needs to be satisfied, or requires an additional Co-Payment, this is not considered an adverse claim decision. If you want the prescription filled, you will have to pay either the full cost, or the additional Co-Payment, for the prescription drug. If you believe you are entitled to some plan benefits in connection with the prescription drug, submit a claim for reimbursement to the pharmacy benefits manager.

Non-Participating Pharmacies*

- **Generic Drugs**.................................................................$10
  plus 50% of the remaining prescription drug covered expense

- **Brand Name Drugs:**
  - **Formulary brand name drugs** when no generic drug equivalent is available, or the prescriber has specified “dispense as written”..........................$30
    plus 50% of the remaining prescription drug covered expense

  - **Non-formulary brand name drugs** when a generic drug equivalent is available, and the prescriber has not specified “dispense as written”..........................$30
    plus 50% of the remaining prescription drug covered expense and the difference of prescription drug covered expense between the generic drug and the brand name drug

- **Non-formulary brand name drugs**...............................$50
Home Delivery Prescriptions: The following co-payments apply for a 90-day supply of medication.

- **Generic Drugs**.......................................................... $20

- **Brand Name Drugs**:
  - *Formulary brand name drugs* when no *generic drug* equivalent is available, or the prescriber has specified “dispense as written”................................. $60
  - *Non-formulary brand name drugs* when a *generic drug* equivalent is available, and the prescriber has not specified “dispense as written”................................. $60

  plus the difference of *prescription drug covered expense* between the *generic drug* and the *brand name drug*

- **Non-formulary brand name drugs**........................................... $100

Exception to Prescription Drug Co-payments

“Preventive Prescription Drugs and Other Items” covered under YOUR PRESCRIPTION DRUG BENEFITS .................................................. **No charge**

Out-of-Pocket Amounts - Home Delivery Prescriptions ONLY. After each insured person has made the following total out-of-pocket payments for home delivery prescriptions, each insured person will no longer be required to pay a Co-Payment for home delivery prescriptions for the remainder of that year:

- **Per member**............................................................... $500
- **Per family** ............................................................... $1,000
Important Note About Prescription Drug Covered Expense and Your Co-Payment: Prescription drug covered expense for non-participating pharmacies is significantly lower than what providers customarily charge, so you will almost always have a higher out-of-pocket expense when you use a non-participating pharmacy.

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

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

Preferred Generic Program

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

General

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

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

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

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

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

- The insured person receives services from a non-participating surgeon. The charge is $2,000. The maximum allowed amount under the plan for the surgery is $1,000. The insured person’s Co-Payment responsibility when a non-participating surgeon is used is 50% of $1,000, or $500. We pay the remaining 50% of $1,000, or $500. In addition, the non-participating surgeon could bill the insured person the difference between $2,000 and $1,000. So the insured person’s total out-of-pocket charge would be $500 plus an additional $1,000, for a total of $1,500.
When you receive covered services, we will, to the extent applicable, apply claim processing rules to the claim submitted. We use these rules to evaluate the claim information and determine the accuracy and appropriateness of the procedure and diagnosis codes included in the submitted claim. Applying these rules may affect the maximum allowed amount if we determine that the procedure and/or diagnosis codes used were inconsistent with procedure coding rules and/or reimbursement policies. For example, if your provider submits a claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed, the maximum allowed amount will be based on the single procedure code.

Provider Network Status

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

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

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

If you are planning to have outpatient surgery, you should first find out if the facility where the surgery is to be performed is an ambulatory surgical center. An ambulatory surgical center is licensed as a separate facility even though it may be located on the same grounds as a hospital (although this is not always the case). If the center is licensed separately, you should find out if the facility is a participating provider before undergoing the surgery.
Note: If an other health care provider is participating in a Blue Cross and/or Blue Shield Plan at the time you receive services, such provider will be considered a participating provider for the purposes of determining the maximum allowed amount.

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

Non-Participating Providers and Other Health Care Providers.*

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

Providers who are not contracted for this product, but are contracted for other products, are also considered non-participating providers. For this plan, the maximum allowed amount for services from these providers will be one of the methods shown above unless the provider’s contract specifies a different amount.
Unlike participating providers, non-participating providers and other health care providers may send you a bill and collect for the amount of the non-participating provider’s or other health care provider’s charge that exceeds our maximum allowed amount under this plan. You may be responsible for paying the difference between the maximum allowed amount and the amount the non-participating provider or other health care provider charges. This amount can be significant. Choosing a participating provider will likely result in lower out of pocket costs to you. Please call the customer service number on your ID card for help in finding a participating provider or visit our website at www.anthem.com/ca. Customer service is also available to assist you in determining this plan’s maximum allowed amount for a particular covered service from a non-participating provider or other health care provider.

Please see the “Blue Cross and/or Blue Shield Providers” section in the Part entitled “GENERAL PROVISIONS” for additional information.

*Exceptions:

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

- **If Medicare is the primary payor, the maximum allowed amount does not include any charge:**
  1. By a hospital, in excess of the approved amount as determined by Medicare; or
  2. By a physician who is a participating provider who accepts Medicare assignment, in excess of the approved amount as determined by Medicare; or
  3. By a physician who is a non-participating provider or other health care provider who accepts Medicare assignment, in excess of the lesser of maximum allowed amount stated above, or the approved amount as determined by Medicare; or
  4. By a physician or other health care provider who does not accept Medicare assignment, in excess of the lesser of the maximum allowed amount stated above, or the limiting charge as determined by Medicare.

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

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

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

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

**Authorized Referrals**

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

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

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 insured person's Calendar Year Deductible before we begin to pay benefits. If insured person's of an enrolled family pay deductible expense in a year equal to the Family Deductible, the Calendar Year Deductible for all family members will be considered to have been met.

Covered charges incurred during the last quarter of a calendar year and applied toward the Calendar Year Deductible for that calendar year is also applied toward the deductible for the next calendar year.

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

CO-PAYMENTS

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

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

OUT-OF-POCKET AMOUNTS

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

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

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

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

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

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

**MEDICAL BENEFIT MAXIMUMS**

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

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

**CONDITIONS OF COVERAGE**

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

1. You must incur this expense while you are covered under this **plan**. Expense is incurred on the date you receive the service or supply for which the charge is made.
2. The expense must be for a medical service or supply furnished to you as a result of illness or injury or pregnancy, unless a specific exception is made.

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

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

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

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

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

MEDICAL CARE THAT IS COVERED

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

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

Hospital

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

2. Services in special care units.
3. Outpatient services and supplies provided by a hospital, including outpatient surgery.

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

**Skilled Nursing Facility.** Inpatient services and supplies provided by a skilled nursing facility. 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.

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

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

2. Short-term inpatient hospital care when required in periods of crisis or as respite care. Coverage of inpatient respite care is provided on an occasional basis and is limited to a maximum of five consecutive days per admission.

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

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

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

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

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

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

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

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

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

**Home Infusion Therapy.** The following services and supplies when provided by a home infusion therapy provider in your home for the intravenous administration of your total daily nutritional intake or fluid requirements, medication related to illness or injury, chemotherapy, antibiotic therapy, aerosol therapy, tocolytic therapy, special therapy, intravenous hydration, or pain management:
1. Medication, ancillary medical supplies and supply delivery, (not to exceed a 14-day supply); but medication which is delivered but not administered is not covered;

2. Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications;

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

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

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

Our maximum payment will not exceed $600 for the services or supplies received during any one day when provided by a home infusion therapy provider which is not a participating provider.

*Home infusion therapy provider* services are subject to pre-service review to determine medical necessity. See UTILIZATION REVIEW PROGRAM for details.

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

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

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

Professional Services

1. Services of a *physician*.

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

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

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

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

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

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

Ambulance services are subject to medical necessity reviews. Pre-service review is required for air ambulance in a non-medical emergency. When using an air ambulance in a non-emergency situation, we reserve the right to select the air ambulance provider. If you do not use the air ambulance we select in a non-emergency situation, no coverage will be provided.

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

Coverage includes medically necessary treatment of an illness or injury by medical professionals from an ambulance service, even if you are not transported to a hospital. If provided through the 911 emergency...
response system*, ambulance services are covered if you reasonably believed that a medical emergency existed even if you are not transported to a hospital.

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

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

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

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

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

**Radiation Therapy**

**Chemotherapy**

**Hemodialysis Treatment**
Prosthetic Devices

1. Breast prostheses following a mastectomy.

2. Prosthetic devices to restore a method of speaking when required as a result of a covered medically necessary laryngectomy.

3. We will pay for other medically necessary prosthetic devices, including:
   a. Surgical implants;
   b. Artificial limbs or eyes;
   c. The first pair of contact lenses or eye glasses when required as a result of a covered medically necessary eye surgery;
   d. Therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications; and
   e. Orthopedic footwear used as an integral part of a brace; shoe inserts that are custom molded to the patient.

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

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

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

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

1. Nebulizers, including face masks and tubing. These items are covered under the plan’s medical benefits and are not subject to any limitations or maximums that apply to coverage for durable medical equipment (see "Durable Medical Equipment").
2. Inhaler spacers and peak flow meters. These items are covered under your prescription drug benefits and are subject to the
copayment for brand name drugs (see YOUR PRESCRIPTION DRUG BENEFITS).

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

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

**Dental Care**

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

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

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

4. **Cleft Palate.** Medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. “Cleft palate” means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.
5. **Orthognathic surgery.** Orthognathic surgery for a physical abnormality that prevents normal function of the upper or lower jaw and is *medically necessary* to attain functional capacity of the affected part.

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

**Pregnancy and Maternity Care**

1. All medical benefits for an *insured person* when provided for pregnancy or maternity care, including the following services:
   a. Prenatal and postnatal care;
   b. Ambulatory care services (including ultrasounds, fetal non-stress tests, physician office visits, and other *medically necessary* maternity services performed outside of a hospital);
   c. Involuntary complications of pregnancy;
   d. Diagnosis of genetic disorders in cases of high-risk pregnancy; and
   e. Inpatient hospital care including labor and delivery.

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

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

3. Certain services are covered under the “Preventive Care Services” benefit. Please see that provision for further details.
**Organ and Tissue Transplants.** Services provided in connection with a non-investigative organ or tissue transplant, if you are: (1) the organ or tissue recipient; or (2) the organ or tissue donor.

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

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

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

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

Services that are excluded on the basis that they are cosmetic include, but are not limited to, liposuction, facial bone reconstruction, voice modification surgery, breast implants, and hair removal. Transgender services are subject to prior authorization in order for coverage to be provided. Please refer to **UTILIZATION REVIEW PROGRAM** for information on how to obtain the proper reviews.

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

- Ground transportation to and from the *hospital* when it is 75 miles or more from your place of residence.
• Coach airfare to and from the hospital when it is 300 miles or more from your residence.

• Lodging, limited to one room, double occupancy.

• Other reasonable expenses. Tobacco, alcohol, drug, and meal expenses are excluded.

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

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

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

1. Inpatient hospital services and services from a residential treatment center as stated in the “Hospital” provision of this section, for inpatient services and supplies.

2. Partial hospitalization, including intensive outpatient programs and visits to a day treatment center. Partial hospitalization is covered as stated in the “Hospital” provision of this section, for outpatient services and supplies.

3. Physician visits during a covered inpatient stay.

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

5. Behavioral health treatment for pervasive developmental disorder or autism. See the section BENEFITS FOR PERVERSIVE DEVELOPMENTAL DISORDER OR AUTISM for a description of the services that are covered. Note: You must obtain pre-service review for all behavioral health treatment services for the treatment of pervasive developmental disorder or autism in order for these services to be covered by this plan (see UTILIZATION REVIEW PROGRAM for details).
No benefits are payable for these services if pre-service review is not obtained.

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

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

1. A *physician's* services for routine physical examinations. For a dependent *child* under 7 years of age, for *non-participating providers* only, we will pay a maximum of $20 for each examination.

2. Immunizations prescribed by the examining *physician*. For a dependent *child* under 7 years of age, for *non-participating providers* only, we will pay a maximum of $12 for each immunization.

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 methods for women, including over-the-counter items, if prescribed by a physician. In order to be covered as preventive care, contraceptive prescription drugs must be either a generic or single-source brand name drug. Also covered are sterilization procedures and counseling.

b. Breast feeding support, supplies, and counseling. One breast pump will be covered per pregnancy under this benefit.

c. Gestational diabetes screening.

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

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

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

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

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

3. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.
4. Reconstructive surgery of both breasts performed to restore and achieve symmetry following a medically necessary mastectomy.

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

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

Clinical Trials. Coverage is provided for 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 insured persons who are not enrolled in a clinical trial.

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.

When a service is part of an approved clinical trial, it is covered even though it may otherwise be an investigational service as defined by the plan (see the DEFINITIONS section).

Participation in the clinical trial must be recommended by your physician after determining participation has a meaningful potential to benefit you.

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, or should have been paid for, by the sponsor of the trial.

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

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

Physical Therapy, Physical Medicine and Occupational Therapy.

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

1. Physical therapy and physical medicine provided on an outpatient basis for the treatment of illness or injury including the therapeutic use of heat, cold, exercise, electricity, ultra violet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care which are customarily provided by chiropractors, physical therapists and osteopaths.)

2. Occupational therapy provided on an outpatient basis when the ability to perform daily life tasks has been lost or reduced by, or has not been developed due to, illness or injury including programs which are
designed to rehabilitate mentally, physically or emotionally handicapped persons. Occupational therapy programs are designed to maximize or improve a patient's upper extremity function, perceptual motor skills and ability to function in daily living activities.

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

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

- Injectable drugs and implants for birth control, administered in a physician's office, if medically necessary.

- Intrauterine contraceptive devices (IUDs) and diaphragms, dispensed by a physician if medically necessary.

- Professional services of a physician in connection with the prescribing, fitting, and insertion of intrauterine contraceptive devices or diaphragms.

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

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

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

1. Audiological evaluations to measure the extent of hearing loss and determine the most appropriate make and model of hearing aid. These evaluations will be covered under plan benefits for office visits to physicians.

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

3. Visits for fitting, counseling, adjustments and repairs for a one year period after receiving the covered hearing aid.
These items and services are covered under your plan’s benefits for durable medical equipment (see “Durable Medical Equipment”).

No benefits will be provided for the following:

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

2. Surgically implanted hearing devices (i.e., cochlear implants, audient bone conduction devices). *Medically necessary* surgically implanted hearing devices may be covered under your plan’s benefits for prosthetic devices (see “Prosthetic Devices”).

Outpatient Speech Therapy.

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

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

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

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

3. The following items are covered under your prescription drug benefits:
   b. Insulin syringes, disposable pen delivery systems for insulin administration.
   c. Testing strips, lancets, and alcohol swabs.

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

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

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

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

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

**Accidental Injury Benefits.** If you are accidentally injured while covered under the agreement, payment is provided for 100% of the maximum allowed amount incurred within 90 days of the injury date for treatment of an accidental injury, up to $500 maximum for each injury.
MEDICAL CARE THAT IS NOT COVERED

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

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

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

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

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

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

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

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

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if you do not claim those benefits.
Government Treatment. Any services actually given to you by a local, state, or federal government agency, or by a public school system or school district, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if you are not required to pay for them or they are given to you for free. You are not required to seek any such services prior to receiving medically necessary health care services that are covered by this plan.

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

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

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

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

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

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

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use, if the program is not affiliated with Anthem. Smoking cessation drugs, except as specifically stated under YOUR PRESCRIPTION DRUG BENEFITS section of this booklet.
Orthodontia. Braces and other orthodontic appliances or services, except as specifically stated in the “Reconstructive Surgery” or “Dental Care” provisions of MEDICAL CARE THAT IS COVERED.

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

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

This exclusion does not apply to the following:

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

Hearing Aids or Tests. Hearing aids, except as specifically stated in the “Hearing Aid Services” provision of MEDICAL CARE THAT IS COVERED. Routine hearing tests, except as provided as part of routine physical examinations under “Preventive Care Services” or “Hearing Aid Services” provisions of MEDICAL CARE THAT IS COVERED.

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

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

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

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

**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 will be covered only when criteria is met as recommended by our Medical Policy.

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

**Sterilization Reversal.** Reversal of sterilization.

**Infertility Treatment.** Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to, diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal, and gamete intrafallopian transfer.
**Surrogate Mother Services.** For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

**Orthopedic Supplies.** Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes, as specifically stated in the “Prosthetic Devices” provision of MEDICAL CARE THAT IS COVERED.

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

**Custodial Care or Rest Cures.** Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Custodial care 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 PERVERSIVE 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 and Facsimile Machine Consultations.** Consultations provided by telephone or facsimile machine.

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

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

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

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

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

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

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

**Private Duty Nursing.** Private duty nursing services.

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

**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.

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**BENEFITS FOR PERVERSIVE DEVELOPMENTAL DISORDER OR AUTISM**

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

Behavioral health treatment services covered under this plan are subject to the same deductibles, coinsurance, and copayments that apply to services provided for other covered medical conditions. Services provided by Qualified Autism Service Providers, Qualified Autism Service Professionals, and Qualified Autism Service Paraprofessionals (see the “Definitions” below) will be covered under plan benefits for office visits to physicians, whether services are provided in the provider’s office or in the patient’s home. Services provided in a facility, such as the outpatient department of a hospital, will be covered under plan benefits that apply to such facilities.

You must obtain pre-service review for all behavioral health treatment services for the treatment of Pervasive Developmental Disorder or autism in order for these services to be covered by this plan (see UTILIZATION REVIEW PROGRAM for details). No benefits are payable for these services if pre-service review is not obtained.
The meanings of key terms used in this section are shown below. Whenever any of the key terms shown below appear in this section, the first letter of each word will be capitalized. When you see these capitalized words, you should refer to this “Definitions” provision.

**DEFINITIONS**

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

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

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

**Qualified Autism Service Provider** is either of the following:

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

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

The network of participating providers may be limited to licensed Qualified Autism Service Providers who contract with a Blue Cross and/or Blue Shield Plan and who may supervise and employ Qualified Autism Service Professionals or Qualified Autism Service Paraprofessionals who provide and administer Behavioral Health Treatment.
Qualified Autism Service Professional is a provider who meets all of the following requirements:

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

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

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

BEHAVIORAL HEALTH TREATMENT SERVICES COVERED

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

- The treatment must be prescribed by a licensed physician and surgeon (an M.D. or D.O.) or developed by a licensed clinical psychologist,
The treatment must be provided under a treatment plan prescribed by a Qualified Autism Service Provider and administered by one of the following: (a) Qualified Autism Service Provider, (b) Qualified Autism Service Professional supervised and employed by the Qualified Autism Service Provider, or (c) Qualified Autism Service Paraprofessional supervised and employed by a Qualified Autism Service provider, and

The treatment plan must have measurable goals over a specific timeline and be developed and approved by the Qualified Autism Service Provider for the specific patient being treated. The treatment plan must be reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate, and must be consistent with applicable state law that imposes requirements on the provision of Applied Behavioral Analysis services and Intensive Behavioral Intervention services to certain persons pursuant to which the Qualified Autism Service Provider does all of the following:

- Describes the patient's behavioral health impairments to be treated,
- Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the intervention plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported,
- Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Pervasive Developmental Disorder or autism,
- Discontinues Intensive Behavioral Intervention services when the treatment goals and objectives are achieved or no longer appropriate, and
- The treatment plan is not used for purposes of providing or for the reimbursement of respite care, day care, or educational services, and is not used to reimburse a parent for participating in the treatment program. No coverage will be provided for any of these services or costs. The treatment plan must be made available to us upon request.
REIMBURSEMENT FOR ACTS OF THIRD PARTIES

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

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

   - If we paid the provider other than on a capitated basis, our lien will not be more than amount we paid for those services.
   - If we paid the provider on a capitated basis, our lien will not be more than 80% of the usual and customary charges for those services in the geographic area in which they were given.
   - If you hired an attorney to gain your recovery from the third party, our lien will not be for more than one-third of the money due you under any final judgment, compromise, or settlement agreement.
   - If you did not hire an attorney, our lien will not be for more than one-half of the money due you under any final judgment, compromise or settlement agreement.
   - If a final judgment includes a special finding by a judge, jury, or arbitrator that you were partially at fault, our lien will be reduced by the same comparative fault percentage by which your recovery was reduced.
   - Our lien is subject to a pro rata reduction equal to your reasonable attorney's fees and costs in line with the common fund doctrine.

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

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

YOUR PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG COVERED EXPENSE

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

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

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

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

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

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

PRESCRIPTION DRUG DEDUCTIBLE AND COPAYMENTS

*Prescription Drug Calendar Year Deductible.* After the *pharmacy benefits manager* determines *prescription drug covered expense*, they will subtract your *prescription drug deductible* from the total amount they consider *prescription drug covered expense*. Each year, you be will responsible for satisfying the *insured person’s calendar year deductible* before they begin to pay *prescription drug benefits*. 
Prescription Drug Copayments. After you have met the deductible for the calendar year, the pharmacy benefits manager will subtract your prescription drug copayment for each prescription during the remainder of the year.

If your prescription drug copayment includes a percentage of prescription drug covered expense, the pharmacy benefits manager will apply that percentage to such expense. This will determine the dollar amount of your prescription drug copayment.

The Prescription Drug Deductible and Copayments are set forth in the SUMMARY OF BENEFITS.

HOW TO USE YOUR PRESCRIPTION DRUG BENEFITS

When You Go to a Participating Pharmacy. To identify you as an insured person covered for prescription drug benefits, you will be issued an identification card. You must present this card to participating pharmacies when you have a prescription filled. Provided you have properly identified yourself as an insured person, a participating pharmacy will only charge your Co-Payment. For information on how to locate a participating pharmacy in your area, call 1-800-700-2541 (or TTY/TDD 1-800-905-9821).

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

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

Prescription Drug Program
ATTN: Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872
Participating pharmacies usually have claims forms, but, if the participating pharmacy does not have claim forms, claim forms and customer service are available by calling 1-800-700-2541 (or TTY/TDD 1-800-905-9821). Mail your claim, with the appropriate portion completed by the pharmacist, to the pharmacy benefits manager within 90 days of the date of purchase. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed.

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

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

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

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

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

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

Your first home delivery prescription must also include a completed Patient Profile questionnaire. The Patient Profile questionnaire can be obtained by calling the toll-free number shown on your ID card. You need only enclose the prescription or refill notice, and the appropriate payment for any subsequent home delivery prescriptions, or call the toll-free number. Co-payments can be paid by check, money order or credit card.
Order forms can be obtained by contacting us at 1-800-700-2541 (or TTY/TDD 1-800-905-9821) to request one. The form is also available online at www.anthem.com/ca.

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

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

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

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

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

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

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

PRESCRIPTION DRUG FORMULARY

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

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

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

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

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

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

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

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

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

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

- If more information is needed to make a decision, we will tell your physician in writing within 5-business days or a shorter period as applicable by state or federal law after we get the request what information is missing, and why we cannot make a decision. If, for reasons beyond our control, we cannot tell your physician what information is missing within 5-business days, we will tell your physician that there is a problem as soon as we know that we cannot respond within 5-business days. In any event, we will tell you and your physician that there is a problem in writing by facsimile, and when appropriate, by telephone to your physician, and in writing to you by mail.
• As soon as we can, based on your medical condition, as *medically necessary*, within 5-business days or a shorter period as applicable by state or federal law, and after we have all the information we need to decide if we will approve benefits, we will tell you and your *physician* what we have decided in writing - by fax to your *physician* and by mail to you.

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

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

If we deny a request for prior authorization of a *drug* that is not part of our *formulary drug* list, you or your prescribing *physician* may appeal our decision by calling us at 1-800-700-2541 (or TTY/TDD 1-800-905-9821). If you are dissatisfied with the resolution of your inquiry and want to file a grievance, you may write us at Anthem Blue Cross Life and Health Insurance Company, 21555 Oxnard Street, Woodland Hills, CA 91367, and follow the formal grievance process.

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

• Your coverage under this *plan* ends;

• The *policy* with the *group* terminates;

• You reach a benefit maximum that applies to *prescription drugs*, if the *plan* includes such a maximum;

• Your *prescription drug* benefits under the *plan* change so that *prescription drugs* are no longer covered or are covered in a different way.

A revocation or modification of a prior authorization of benefits for *prescription drugs* applies only to unfilled portions or remaining refills of the *prescription*, if any, and not to *drugs* you have already received.
New drugs and changes in the prescription drugs covered by the plan. The outpatient prescription drugs included on the list of formulary drugs covered by the plan is decided by the Pharmacy and Therapeutics Process, which is comprised of independent nurses, physicians and pharmacists. The Pharmacy and Therapeutics Process meets quarterly and decides on changes to make in the formulary drug list based on recommendations from us and a review of relevant information, including current medical literature.

PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS

Your prescription drug benefits include certain preventive drugs, medications, and other items as listed below that may be covered under this plan as preventive care services. In order to be covered as a preventive care service, these items must be prescribed by a physician and obtained from a participating pharmacy or through the home delivery program. This includes items that can be obtained over the counter for which a physician’s prescription is not required by law.

When these items are covered as preventive care services, the Calendar Year Deductible, if any, will not apply and no co-payment will apply. In addition, any separate deductible that applies to prescription drugs will not apply.

- All FDA-approved contraceptives for women, including oral contraceptives, diaphragms, patches, and over-the-counter contraceptives. In order to be covered as a preventive care service, in addition to the requirements stated above, contraceptive prescription drugs must be generic drugs or single source brand name drugs.

- Shingles, seasonal flu and pneumonia vaccinations.

- Prescription drugs to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products.

- FDA-approved smoking cessation products and over-the-counter nicotine replacement products. Coverage is provided as follows, in accordance with current FDA guidelines:
  - You must be at least 18 years old.
  - Coverage is limited to skin patches, chewing gum, and lozenges, for up to a 30-day supply per product, per prescription.
  - Coverage is limited to one of the above products at a time, for up to three months per product.
• Aspirin to reduce the risk of heart attack or stroke, for men ages 45-79 and women ages 55-79.
• Folic acid supplementation for women age 55 years and younger (folic acid supplement or a multivitamin).
• Vitamin D for women over age 65.
• Iron supplements for children from birth through 12 months old.
• Fluoride supplements for children from birth through 6 years old (drops or tablets).

**PRESCRIPTION DRUG CONDITIONS OF SERVICE**

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

1. It must be prescribed by a licensed prescriber and be dispensed within one year of being prescribed, subject to federal and state laws. This requirement will not apply to covered vaccinations provided at a participating pharmacy.
2. It must be approved for general use by the Food and Drug Administration (FDA).
3. It must be for the direct care and treatment of your illness, injury or condition. Dietary supplements, health aids or drugs for cosmetic purposes are not included. However the following items are covered:
   a. Formulas prescribed by a *physician* for the treatment of phenylketonuria.
   b. Vaccinations provided at a *participating pharmacy* as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS, subject to all terms of this *plan* that apply to those benefits.
   c. Vitamins, supplements, and health aids as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS, subject to all terms of this *plan* that apply to those benefits.
4. It must be dispensed from a licensed retail *pharmacy*, through our home delivery program or through our specialty drug program.
5. If it is an approved *compound medication*, be dispensed by a participating *pharmacy*. Call 1-800-700-2541 (or TTY/TDD 1-800-905-9821) to find out where to take your prescription for an approved *compound medication* to be filled. (You can also find a participating pharmacy at www.anthem.com/ca.) Some compound medications must be approved before you can get them (See PRESCRIPTION
DRUG FORMULARY: PRIOR AUTHORIZATION). You will have to pay the full cost of the compound medications you get from a pharmacy that is not a participating pharmacy.

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

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

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

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

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

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

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

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

SUMMARY OF BENEFITS: PRESCRIPTION DRUG BENEFITS: PRESCRIPTION DRUG CO-PAYMENTS for the 72-hour supply of your drug.

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

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

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

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

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

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

10. For the home delivery program, the prescription must not exceed a 90-day supply.
11. The drug will be covered under YOUR PRESCRIPTION DRUG BENEFITS only if it is not covered under another benefit of your plan.

12. Drugs for the treatment of impotence and/or sexual dysfunction are limited to six tablets/units for a 30-day period and are available at retail pharmacies only.

**PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED**

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

2. Insulin.

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

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

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

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

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

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

9. Prescription drugs for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.
PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED

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

1. Immunizing agents, biological sera, blood, blood products or blood plasma. While not covered under this prescription drug benefit, these items are covered under the “Blood,” and “Preventive Care Services” provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this plan that apply to those benefits.

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

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

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

5. Professional charges in connection with administering, injecting or dispensing of drugs. While not covered under this prescription drug benefit, these services are covered as specified under the “Professional Services” and “Home Infusion Therapy” provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this plan that apply to those benefits.
6. Drugs and medications which may be obtained without a physician’s written prescription, except insulin or niacin for cholesterol reduction.

Note: Vitamins, supplements, and certain over-the-counter items as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS are covered under this plan only when obtained with a physician’s prescription, subject to all terms of this plan that apply to those benefits.

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

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

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

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

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

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

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

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

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

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

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

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

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

21. Herbal supplements, nutritional and dietary supplements. However, formulas prescribed by a physician for the treatment of phenylketonuria that are obtained from a pharmacy are covered as specified under PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED. Special food products that are not available from a pharmacy are covered as specified under the “Special Food Products” provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this plan that apply to the benefit. Also, vitamins, supplements, and certain over-the-counter items as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS are covered under this plan only when obtained with a physician’s prescription, subject to all terms of this plan that apply to those benefits.

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

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

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

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

COORDINATION OF BENEFITS

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

DEFINITIONS

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

Allowable Expense is any necessary, reasonable and customary item of expense which is at least partially covered by at least one Other Plan covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage;

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

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

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

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

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

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

EFFECT ON BENEFITS

This provision will apply in determining a person’s benefits under This Plan for any calendar year if the benefits under This Plan and any Other Plans, exceed the Allowable Expenses for that calendar year.
1. If This Plan is the Principal Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan.

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

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

ORDER OF BENEFITS DETERMINATION

The following rules determine the order in which benefits are payable:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

BENEFITS FOR MEDICARE ELIGIBLE INSURED PERSONS

For Active Employees and Family Members. If you are a full-time employee or a family member of a full-time employee, 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, our 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. We will not provide benefits under this plan that duplicate any benefits to which you would be entitled under Medicare. This exclusion applies to all parts of Medicare in which you can enroll without paying additional premium. If you are required to pay additional premium for any part of Medicare, this exclusion will apply to that part of Medicare only if you are enrolled in that part.

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

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

2. For services you receive that are covered both by Medicare and under this plan, coverage under this plan will apply only to Medicare deductibles, coinsurance, and other charges for covered services over and above what Medicare pays.

3. For any given claim, the combination of benefits provided by Medicare and the benefits provided under this plan will not exceed the maximum allowed amount for the covered services.

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

**UTILIZATION REVIEW PROGRAM**

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

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

**Important:** The Utilization Review Program requirements described in this section do not apply when coverage under this plan is secondary to another plan providing benefits for you or your family members.
The utilization review program evaluates the medical necessity and appropriateness of care and the setting in which care is provided. You and your physician are advised if we have determined that services can be safely provided in an outpatient setting, or if an inpatient stay is recommended. Services that are medically necessary and appropriate are certified by us and monitored so that you know when it is no longer medically necessary and appropriate to continue those services.

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

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

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

It is to your benefit to see that your physician starts the utilization review process before scheduling you for any service subject to the utilization review program. If you receive any such service, and do not follow the procedures set forth in this section, your benefits will be reduced as shown in “Utilization Review Requirements and Effect on Benefits”.
UTILIZATION REVIEW REQUIREMENTS AND EFFECT ON BENEFITS

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

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

1. The appropriate utilization reviews must be performed in accordance with this plan. When pre-service review is not performed as required for the services listed below, the benefits to which you would have been otherwise entitled will be subject to the Non-Certification Deductible shown in the SUMMARY OF BENEFITS.

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

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

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

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

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

   - Transplant services will be provided only if the physicians on the surgical team and the facility in which the transplant is to take place are approved for the transplant requested.

   - Air ambulance in a non-medical emergency.

   - 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.

   - Admissions to a skilled nursing facility, if you require daily skilled nursing or rehabilitation, as certified by your attending physician.
• Advanced imaging procedures, including but not limited to: Magnetic Resonance Imaging (MRI), Computerized Tomography (CT scan), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography, and Nuclear Cardiac Imaging. You may call the toll-free customer service telephone number on your identification card to find out if an imaging procedure requires pre-service review.

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

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

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

Retrospective review for medical necessity is performed to review services that have already been provided. This applies in cases when pre-service or care coordination review was not completed, or in order to evaluate and audit medical documentation subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified. Services that are not reviewed prior to or during service delivery will be reviewed retrospectively when the bill is submitted for benefit payment. If that review results in the determination that part or all of the services were not medically necessary and appropriate, benefits will not be provided for those services. Remaining benefits will be subject to previously noted reductions that apply when the required reviews are not obtained.

HOW TO OBTAIN UTILIZATION REVIEWS

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

Pre-service Reviews. Penalties will result for failure to obtain pre-service review, before receiving scheduled services, as follows:
1. For all scheduled services that are subject to utilization review, you or your physician must initiate the pre-service review at least five working days prior to when you are scheduled to receive services. The toll-free telephone number for pre-service reviews is printed on your identification card.

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

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

Care Coordination Reviews

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

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

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

Retrospective Reviews

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

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

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

THE MEDICAL NECESSITY REVIEW PROCESS

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

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

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

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

3. A decision on the medical necessity of a retrospective review will be made and communicated in writing no later than 30 days from receipt of the information necessary to make the decision to you and your physician.
4. If we do not have the information we need, we will make every attempt to obtain that information from you or your physician. If we are unsuccessful, and a delay is anticipated, we will notify you and your physician of the delay and what we need to make a decision. We will also inform you of when a decision can be expected following receipt of the needed information.

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

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

7. If the request fails to satisfy these criteria or medical policy, the request is referred to a Peer Clinical Reviewer. Peer Clinical Reviewers are health professionals clinically competent to evaluate the specific clinical aspects of the request and render an opinion specific to the medical condition, procedure and/or treatment under review. Peer Clinical Reviewers are licensed in California with the same license category as the requesting provider. When the Peer Clinical Reviewer is unable to certify the service, the requesting physician is contacted by telephone for a discussion of the case. In many cases, services can be certified after this discussion. If the Peer Clinical Reviewer is still unable to certify the service, your provider will be given the option of having the request reviewed by a different Peer Clinical Reviewer.

8. Only the Peer Clinical Reviewer may determine that the proposed services are not medically necessary and appropriate. Your physician will be notified by telephone within 24 hours of a decision not to certify and will be informed at that time of how to request reconsideration. Written notice will be sent to you and the requesting provider within two business days of the decision. This written notice will include:

- an explanation of the reason for the decision,
• reference of the criteria used in the decision to modify or not certify the request,

• the name and phone number of the Peer Clinical Reviewer making the decision to modify or not certify the request,

• how to request reconsideration if you or your provider disagree with the decision.

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

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

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

• The information submitted with the claim differs from that given by phone;

• The service is excluded from coverage; or

• You are not eligible for coverage when the service is actually provided.

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

• Your coverage under this plan ends;

• The policy with the group terminates;

• You reach a benefit maximum that applies to the services in question;

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

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

**HOW PERSONAL CASE MANAGEMENT WORKS**

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

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

1. You require extensive long-term treatment;

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

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

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

**Alternative Treatment Plan.** If we determine that your needs could be met more efficiently, an alternative treatment plan may be recommended. This may include providing benefits not otherwise covered under this plan. A case manager will review the medical records and discuss your treatment with the attending physician, you and your family.

We make treatment recommendations only; any decision regarding treatment belongs to you and your physician. The group will, in no way, compromise your freedom to make such decisions.

**EFFECT ON BENEFITS**

1. Benefits are provided for an alternative treatment plan on a case-by-case basis only. We have absolute discretion in deciding whether or not to authorize services in lieu of benefits for any insured person, which alternatives may be offered and the terms of the offer.
2. Any authorization of services in lieu of benefits in a particular case in no way commits us to do so in another case or for another insured person.

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

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

DISAGREEMENTS WITH MEDICAL MANAGEMENT DECISIONS

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

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

3. If the appeal decision is still unsatisfactory, your remedy may be binding arbitration. (See BINDING ARBITRATION.)

QUALITY ASSURANCE

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

HOW COVERAGE BEGINS

ELIGIBLE STATUS

1. **Insured Employees.** You are in an eligible status if you are a *retired employee*, whose usual residence is not in the State of California. A *retired employee* is retired from active full-time employment, eligible to receive health plan benefits as part of the group’s collective bargaining and was covered under a *group* sponsored plan immediately prior to retirement from a California Retirement system.

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

Definition of Family Member

1. **Spouse** is the *employee’s* spouse under a legally valid marriage. Spouse does not include any person who is: (a) covered as a *domestic partner*; or (b) in active service in the armed forces. A person may be covered as both an *insured employee* and a *family member*, if eligible as both. However, the total amount of benefits we would then pay shall not exceed the *maximum allowed amount*.

2. **Domestic partner** is the *employee’s* domestic partner under a legally registered and valid domestic partnership. Domestic partner does not include any person who is: (a) covered as a *spouse*; or (b) in active service in the armed forces. A person may be covered as both an *insured employee* and a *family member*, if eligible as both. However, the total amount of benefits we would then pay shall not exceed the *maximum allowed amount*.

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

   a. The child is under 26 years of age.

   b. The unmarried child is 26 years of age, or older and: (i) was covered under the *prior plan*, was covered as a family member of the *employee* under another plan or health insurer, or has six or more months of *creditable coverage*, (ii) is chiefly dependent on the *employee, spouse or domestic partner* for support and maintenance, and (iii) is incapable of self-sustaining employment due to a physical or mental condition. A *physician* must certify in writing that the child is incapable of self-sustaining employment.
due to a physical or mental condition. We must receive the certification, at no expense to us, within 60-days of the date the employee receives our request. We may request proof of continuing dependency and that a physical or mental condition still exists, but not more often than once each year after the initial certification. This exception will last until the child is no longer chiefly dependent on the employee, spouse or domestic partner for support and maintenance due to a continuing physical or mental condition. A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

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

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

d. A child for whom the employee 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 Employees: You become eligible for coverage in accordance with rules established by your employer. For specific information about your employer’s eligibility rules for coverage, please contact your Human Resources or Benefits Department.

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

ENROLLMENT

1. To enroll as a retired employee, or to enroll family members, the retired employee must properly file an application. An application is considered properly filed, only if it is personally signed, dated, and
given to the group within 31 days from your eligibility date. We must receive this application from the group within 90 days. If any of these steps are not followed, your coverage may be denied.

2. To enroll a domestic partner as a family member, the current eligible District employee who meets the Domestic Partnership requirements listed must properly file an application. An application is considered properly filed, only if it is personally signed, dated, and given to the group within 31 calendar days from the effective date of the Domestic Partnership agreement to make application for Domestic Partnership coverage. We must receive this application from the group within 90 days. If any of these steps are not followed, your coverage may be denied.

If application is not made within 31 calendar days, then the District employee must wait until the District’s next open enrollment period to apply.

EFFECTIVE DATE

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

1. Timely Enrollment. If you enroll for coverage before, on, or within 31 days after your eligibility date, then your coverage will begin as follows: (a) for employees, on your eligibility date; and (b) for family members, on the later of (i) the date the employee’s coverage begins, or (ii) the first day of the month after the family member becomes eligible. If you become eligible before the policy takes effect, coverage begins on the effective date of the policy, provided the enrollment application is on time and in order.

2. Late Enrollment. If you fail to enroll within 31 days after your eligibility date, you must wait until the group’s next Open Enrollment Period to enroll.

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

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

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

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

Special Enrollment Periods

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

1. You have met all of the following requirements:
   a. You were covered as an individual or dependent under either:
      i. Another employer group health plan or health insurance coverage, including coverage under a COBRA or CalCOBRA continuation; or
      ii. A state Medicaid plan or under a state child health insurance program (SCHIP), including the Healthy Families Program or the Access for Infants and Mothers (AIM) Program.
   b. You certified in writing at the time you became eligible for coverage under this plan that you were declining coverage under this plan because you were covered under another health plan as stated above and you were given written notice that if you choose to enroll later, you may be required to wait until the group’s next open enrollment period to do so.
   c. Your coverage under the other health plan wherein you were covered as an individual or dependent ended as follows:
i. If the other health plan was another employer group health plan or health insurance coverage, including coverage under a COBRA or CalCOBRA continuation, coverage ended because you lost eligibility under the other plan, your coverage under a COBRA or CalCOBRA continuation was exhausted, or employer contributions toward coverage under the other plan terminated. You must properly file an application with the group within 31 days after the date your coverage ends or the date employer contributions toward coverage under the other plan terminate.

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

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

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

3. We do not have a written statement from the group stating that prior to declining coverage, 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 and later file an enrollment application, your coverage may not begin until July 1st.

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

a. If you are enrolling following marriage or domestic partnership, you and your new spouse or domestic partner must enroll within 31 days of the date of marriage or domestic partnership. Your new spouse or domestic partner’s children may also enroll at that
time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above.

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

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

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

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

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

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

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

OPEN ENROLLMENT PERIOD

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

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

HOW COVERAGE ENDS

Your coverage ends without notice from us as provided below:

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

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

3. Coverage for family members ends when employee’s coverage ends.

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

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

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

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

Note: If a marriage or domestic partnership terminates, the employee must give or send to the group written notice of the termination. Coverage for a former spouse or domestic partners, and their dependent children, if any, ends according to the “Eligible Status” provisions. If Anthem Blue Cross Life and Health suffers a loss because of the employee failing to notify the group of the termination of their marriage or domestic partnership, Anthem Blue Cross Life and Health may seek recovery from the employee for any actual loss resulting thereby. Failure to provide written notice to the group will not delay or prevent termination of the marriage or domestic partnership. If the employee notifies the group in writing to cancel coverage for a former spouse or domestic partner and the children of the spouse or domestic partner, if any, immediately upon termination of the employee’s marriage or domestic partnership, such notice will be considered compliance with the requirements of this provision.
You may be entitled to continued benefits under terms which are specified elsewhere under CONTINUATION OF COVERAGE, CALCObRA CONTINUATION OF COVERAGE, and EXTENSION OF BENEFITS.

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

CONTINUATION OF COVERAGE

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

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.

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

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

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

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

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

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

**ELIGIBILITY FOR COBRA CONTINUATION**

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

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

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

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

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

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

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

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

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

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

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

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

2. A child, if neither the employee nor the spouse has enrolled for this COBRA continuation coverage (if more than one child is so enrolled, the premium will be the two-party or three-party rate depending on the number of children enrolled); and
3. A child whose COBRA continuation began due to the person no longer meeting the dependent child definition.

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

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

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

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

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

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

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

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

4. The date the policy terminates;

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

6. The date, following the election of COBRA, the insured person first becomes covered under any other group health plan; or
7. The date, following the election of COBRA, the *insured person* first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

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

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

**EXTENSION OF CONTINUATION DURING TOTAL DISABILITY**

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

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

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

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

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

1. The date of the Social Security Administration's determination of the disability;
2. The date on which the original Qualifying Event occurs;

3. The date on which the Qualified Beneficiary loses coverage; or

4. The date on which the Qualified Beneficiary is informed of the obligation to provide the disability notice.

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

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

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

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

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

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

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

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

3. The date the policy terminates;

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

5. The date, following the election of COBRA, the insured person first becomes covered under the other group health plan; or
6. The date, following the election of COBRA, the insured person first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

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

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

**CALCOBRA CONTINUATION OF COVERAGE**

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

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

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

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

**TERMS OF CALCOBRA CONTINUATION**

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

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

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

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

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

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

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

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

**Premium Rate Change.** The premium rates may be changed by us as of any premium due date. We will provide you with written notice at least 60 days prior to the date any premium rate increase goes into effect.
Accuracy of Information. You are responsible for supplying up-to-date eligibility information. We shall rely upon the latest information received as correct without verification; but we maintain the right to verify any eligibility information you provide.

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

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

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

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

1. The date that is 36 months after the date of your qualifying event under federal COBRA*;
2. The date the policy terminates;
3. The date the group no longer provides coverage to the class of employees to which you belong;
4. The end of the period for which premium is last paid (your coverage will be cancelled upon written notification, as explained under "Payment Dates", above);
5. The date you become covered under any other health plan;
6. The date you become entitled to Medicare; or
7. The date you become covered under a federal COBRA continuation.

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

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

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

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

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

3. Your extension of benefits will end when any one of the following circumstances occurs:
   a. You are no longer totally disabled.
   b. The maximum benefits available to you under this **plan** are paid.
   c. You become covered under another group health plan that provides benefits without limitation for your disabling condition.
   d. A period of up to 12 months has passed since your extension began.

GENERAL PROVISIONS

**Providing of Care.** We are not responsible for providing any type of **hospital**, medical or similar care, nor are we responsible for the quality of any such care received.
**Independent Contractors.** Our relationship with providers is that of an independent contractor. *Physicians,* and other health care professionals, *hospitals,* *skilled nursing facilities* and other community agencies are not our agents nor are we, or any of our employees, an employee or agent of any *hospital,* medical group or medical care provider of any type.

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

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

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

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

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

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

Often, this “negotiated price” will consist of a simple discount, which reflects the actual price paid by the Host Blue to your healthcare provider. But sometimes it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and other credits or charges. Occasionally it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.
Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

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

Non-Participating Health Care Providers

Member Liability Calculation. When covered health care services are provided by non-participating health care providers, the amount you pay for such services will generally be based on either the Host Blue’s non-participating health care provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating health care provider bills and the payment we will make for the covered services as set forth in this paragraph.

Exceptions. In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the health care services had been obtained within California, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount we will pay for services rendered by non-participating health care providers. In these situations, you may be liable for the difference between the amount that the non-participating health care provider bills and the payment we will make for the covered services as set forth in this paragraph.

If you obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If you see a provider who is not part of an exclusive network arrangement, that provider’s services will be considered non-network care, and you may be billed the difference between the charge and the maximum allowable amount. You may call the customer service number on your ID card or go to www.anthem.com/ca for more information about such arrangements.

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

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

2. The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date you receive the service or supply for which the charge is made.

3. The policy is subject to amendment, modification or termination according to the provisions of the policy without your consent or concurrence.

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

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

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

You must be under the care of the participating provider at the time the provider’s contract terminates. The terminated provider must agree in writing to provide services to you in accordance with the terms and conditions of his or her agreement with the Blue Cross or Blue Shield plan prior to termination. The provider must also agree in writing to accept the terms and reimbursement rates under his or her agreement with the Blue Cross or Blue Shield plan prior to termination. If the provider does not agree with these contractual terms and conditions, we are not required to continue the provider’s services beyond the contract termination date.
We will provide such benefits for the completion of covered services by a terminated provider only for the following conditions:

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by us in consultation with you and the terminated provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.

3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.

5. The care of a newborn child between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.

6. Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the date the provider's contract terminates.

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

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

Medical Necessity. The benefits of this plan are provided only for services which are medically necessary. The services must be ordered by the attending physician for the direct care and treatment of a covered condition. They must be standard medical practice where received for the condition being treated and must be legal in the United States.

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

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

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

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

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

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

Services received and charges for the services must be itemized, and clearly and accurately described. Claim forms must be used; canceled checks or receipts are not acceptable.
Timely Payment of Claims. Any benefits due under this plan shall be due once we have received proper, written proof of loss, together with such reasonably necessary additional information we may require to determine our obligation.

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

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

1. Proof of payment of medical services and the provider's itemized bill for such services;

2. If the insured employee does not reside with the patient, either a copy of the judicial order requiring the insured employee to provide coverage for the patient or a state approved form verifying the existence of such judicial order which would be filed with us on an annual basis;

3. If the insured employee does not reside with the patient, and if the provider is seeking direct reimbursement, an itemized bill with the signature of the custodian or guardian certifying that the services have been provided and supplying on an annual basis, either a copy of the judicial order requiring the insured employee to provide coverage for the patient or a state approved form verifying the existence of such judicial order;

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

Right of Recovery. Whenever payment has been made in error, we will have the right to recover such payment from you or, if applicable, the provider, in accordance with applicable laws and regulations. In the event we recover a payment made in error from the provider, except in cases of fraud or misrepresentation on the part of the provider, we will only recover such payment from the provider within 365 days of the date we made the payment on a claim submitted by the provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.
Under certain circumstances, if we pay your healthcare provider amounts that are your responsibility, such as deductibles, co-payments or co-insurance, we may collect such amounts directly from you. You agree that we have the right to recover such amounts from you.

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

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

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

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

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

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

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

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

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

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

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

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

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

**INDEPENDENT MEDICAL REVIEW OF DENIALS OF EXPERIMENTAL OR INVESTIGATIVE TREATMENT**

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

- You have a life-threatening or seriously debilitating condition, described as follows:
  - A life-threatening condition is a condition or disease where the likelihood of death is high unless the course of the disease is interrupted or a condition or disease with a potentially fatal outcome where the end point of clinical intervention is the patient’s survival.
- A seriously debilitating condition is a disease or condition that causes major, irreversible morbidity.

- Your *physician* must certify that either (a) standard treatment has not been effective in improving your condition, (b) standard treatment is not medically appropriate, or (c) there is no more beneficial standard treatment covered by this *plan* than the proposed treatment.

- The proposed treatment must either be:
  - Recommended by a *participating provider* who certifies in writing that the treatment is likely to be more beneficial than standard treatments, or
  - Requested by you or by a licensed board certified or board eligible *physician* qualified to treat your condition. The treatment requested must be likely to be more beneficial for you than standard treatments based on two documents of scientific and medical evidence from the following sources:
    
    a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized standards;

    b) Medical literature meeting the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database of Health Services Technology Assessment Research (HSTAR);

    c) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;

    d) Either of the following: (i) The American Hospital Formulary Service’s Drug Information, or (ii) the American Dental Association Accepted Dental Therapeutics;

    e) Any of the following references, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: (i) the Elsevier Gold Standard’s Clinical Pharmacology, (ii) the National Comprehensive Cancer Network Drug and Biologics Compendium, or (iii) the Thomson Micromedex DrugDex;
f) Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and

g) Peer reviewed abstracts accepted for presentation at major medical association meetings.

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

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

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

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

INDEPENDENT MEDICAL REVIEW OF GRIEVANCES INVOLVING A DISPUTED HEALTH CARE SERVICE

You may request an independent medical review ("IMR") of disputed health care services from the California Department of Insurance ("CDI") if you believe that we have improperly denied, modified, or delayed health care services. A "disputed health care service" is any health care service eligible for coverage and payment under your plan that has been denied, modified, or delayed by us, in whole or in part because the service is not medically necessary.
The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. We must provide you with an IMR application form and an addressed envelope for you to use to request IMR with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against us regarding the disputed health care service.

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

1. (a) Your provider has recommended a health care service as medically necessary, or
   (b) You have received urgent care or emergency services that a provider determined was medically necessary, or
   (c) You have been seen by a participating provider for the diagnosis or treatment of the medical condition for which you seek independent review;

2. The disputed health care service has been denied, modified, or delayed by us, based in whole or in part on a decision that the health care service is not medically necessary; and

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

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

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

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

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

**BINDING ARBITRATION**

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

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

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

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

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

The arbitration is initiated by the insured person making written demand on Anthem Blue Cross Life and Health. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS"), according to its applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by agreement of the insured person and Anthem Blue Cross Life and Health, or by order of the court, if the insured person and Anthem Blue Cross Life and Health cannot agree.
The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, Anthem Blue Cross Life and Health will assume all or a portion of the costs of the arbitration.

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

**DEFINITIONS**

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

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

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

**Authorized referral** occurs when you, because of your medical needs, are referred to a non-participating provider, but only when:

1. There is no participating provider who practices in the appropriate specialty, which provides the required services, or which has the necessary facilities within a 50-mile radius of your residence; and

2. We have authorized the referral before services are rendered.

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.

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

**Child** meets the plan’s eligibility requirements for children as outlined under HOW COVERAGE BEGINS AND ENDS.
Compound Medication is a mixture of prescription drugs and other ingredients, of which at least one of the components is commercially available as a prescription product. Compound medications do not include:

1. Duplicates of existing products and supplies that are mass-produced by a manufacturer for consumers; or

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

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.

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

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

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

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

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

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

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

Emergency is a sudden, serious, and unexpected acute illness, injury, or condition (including without limitation sudden and unexpected severe pain), or a psychiatric emergency medical condition, which the insured person reasonably perceives could permanently endanger health if medical treatment is not received immediately. We will have sole and final determination as to whether services were rendered in connection with an emergency.

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

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

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

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

Generic prescription drug (generic drug) is a pharmaceutical equivalent of one or more brand name drugs and must be approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength, and effectiveness as the brand name drug.

Group refers to the business entity to which we have issued this policy. The name of the group is VENTURA COUNTY COMMUNITY COLLEGE DISTRICT.
Home health agencies are home health care providers which are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in your home, and recognized as home health providers under Medicare and/or accredited by a recognized accrediting agency such as the Joint Commission on the Accreditation of Healthcare Organizations.

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

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

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

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

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

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

Insured family member (family member) meets the plan’s eligibility requirements for family members as outlined under HOW COVERAGE BEGINS AND ENDS.
**Insured person** is the *insured employee or insured family member*.

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

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

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

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Provided for the diagnosis or direct care and treatment of the medical condition;
3. Within standards of good medical practice within the organized medical community;
4. Not primarily for your convenience, or for the convenience of your physician or another provider; and
5. The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:
   a. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and
   b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
   c. For hospital stays, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received by you as an outpatient or in a less intensified medical setting.

**Mental or nervous disorders**, including substance abuse, for the purposes of this plan, are conditions that are listed in the most current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders. Mental or nervous disorders include *severe mental disorders* as defined in this plan (see definition of "severe mental disorders").
Non-participating pharmacy is a pharmacy which does not have a contract in effect with the pharmacy benefits manager at the time services are rendered. In most cases, you will be responsible for a larger portion of your pharmaceutical bill when you go to a non-participating pharmacy.

Non-participating provider is one of the following providers which is NOT participating in a Blue Cross and/or Blue Shield Plan at the time services are rendered:

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

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

Other health care provider is one of the following providers:

- A certified registered nurse anesthetist
- A blood bank

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

Participating pharmacy is a pharmacy which has a Participating Pharmacy Agreement in effect with the pharmacy benefit manager at the time services are rendered. Call your local pharmacy to determine whether it is a participating pharmacy or call the toll-free customer service telephone number.
**Participating provider** is one of the following providers or other licensed health care professionals who are participating in a Blue Cross and/or Blue Shield Plan at the time services are rendered:

- A hospital
- A physician
- An ambulatory surgical center
- A home health agency
- A facility which provides diagnostic imaging services
- A durable medical equipment outlet
- A skilled nursing facility
- A clinical laboratory
- A home infusion therapy provider
- An urgent care center
- *Centers for Medical Excellence (CME)*
- *Blue Distinction Centers for Specialty Care (BDCSC)*
- A retail health clinic
- A hospice
- A licensed ambulance company
- A licensed qualified autism service provider

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

**Pharmacy** means a licensed retail pharmacy.

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

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

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

2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license and such license is required to render that service, and is providing a service for which benefits are specified in this booklet:
   - A dentist (D.D.S. or D.M.D.)
   - An optometrist (O.D.)
   - A dispensing optician
   - A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
   - A licensed clinical psychologist
   - A licensed educational psychologist for the provision of behavioral health treatment services for the treatment of pervasive developmental disorder or autism only
   - A chiropractor (D.C.)
   - An acupuncturist (A.C.)
   - A nurse midwife
   - A nurse practitioner
   - A physician assistant
   - 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 psychiatric mental health nurse (R.N.)*
   - Any agency licensed by the state to provide services for the treatment of mental or nervous disorders or substance abuse, when we are required by law to cover those services.
   - A registered dietitian (R.D.)* or another nutritional professional* with a master’s or higher degree in a field covering clinical nutrition sciences, from a college or university accredited by a regional accreditation agency, who is deemed qualified to provide
these services by the referring M.D. or D.O. A registered dietitian or other nutritional professional as described here are covered for the provision of diabetic medical nutrition therapy and nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa only.

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

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

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

Prescription means a written order or refill notice issued by a licensed prescriber.

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

Prescription drug formulary (formulary) is a list which we have developed of outpatient prescription drugs which may be cost-effective, therapeutic choices. Any participating pharmacy can assist you in purchasing drugs listed on the formulary. You may also get information about covered formulary drugs by calling 1-800-700-2541 or going to our internet website anthem.com/ca.

Prescription drug maximum allowed amount is the maximum amount allowed for any drug. The amount is determined by using prescription drug cost information provided to us by the pharmacy benefits manager. The amount is subject to change. You may determine the prescription drug maximum allowed amount of a particular drug by calling 1-800-700-2541 (or TTY/TDD 1-800-905-9821).

Preventive Care Services include routine examinations, screenings, tests, education, and immunizations administered with the intent of preventing future disease, illness, or injury. Services are considered preventive if you have no current symptoms or prior history of a medical condition associated with that screening or service. These services shall meet requirements as determined by federal and state law. Sources for determining which services are recommended include the following:
1. Services with an “A” or “B” rating from the United States Preventive Services Task Force (USPSTF);

2. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

3. Preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.

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

http://www.healthcare.gov/center/regulations/prevention.html

http://www.ahrq.gov/clinic/uspsfix.htm

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

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

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

Psychiatric emergency medical condition is a mental or nervous disorder that manifests itself by acute symptoms of sufficient severity that the patient is either (1) an immediate danger to himself or herself or to others, or (2) immediately unable to provide for or utilize food, shelter, or clothing due to the mental or nervous disorder.
Psychiatric health facility is an acute 24-hour facility operating within the scope of a state license, or in accordance with a license waiver issued by the State. It must be:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Totally disabled family members** are *family members* who are unable to perform all activities usual for persons of that age.

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

**Urgent care** is the services received for a sudden, serious, or unexpected illness, injury or condition, other than one which is life threatening, which requires immediate care for the relief of severe pain or diagnosis and treatment of such condition.
Urgent care center is a physician's office or a similar facility which meets established ambulatory care criteria and provides medical care outside of a hospital emergency department, usually on an unscheduled, walk-in basis. Urgent care centers are staffed by medical doctors, nurse practitioners and physician assistants primarily for the purpose of treating patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room.

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

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

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

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

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

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

These are your rights and responsibilities:

You have the right to:

- Speak freely and privately with your doctors and other health providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it’s covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect and dignity.
• Expect us to keep your personal health information private. This is as long as it follows state and Federal laws, and our privacy policies.

• Get the information you need to help make sure you get the most from your health plan, and share your feedback. This includes information on:
  o Our company and services
  o Our network of doctors and other health care providers
  o Your rights and responsibilities
  o The rules of your health care plan
  o The way your health plan works

• Make a complaint or file an appeal about:
  o Your health care plan
  o Any care you get
  o Any covered service or benefit ruling that your health care plan makes

• Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your doctor tell you how that may affect your health now and in the future.

• Get all of the most up-to-date information from a doctor or other health care professional about the cause of your illness, your treatment and what may result from it. If you don’t understand certain information, you can choose another person to be with you to help you to understand.

You have the responsibility to:

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

• Follow all health care plan rules and policies.

• Choose any primary care physician (doctor), also called a PCP, who is in our network if your health care plan requires it.

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

• Keep all scheduled appointments with your health care providers and call their office if you may be late or need to cancel.

• Understand your health problems as well as you can and work with your doctors or other health care providers to make a treatment plan that you all agree on.

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

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

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

We are committed to providing quality benefits and customer service to insured persons. Benefits and coverage for services provided under the benefit program are governed by the certificate and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact us, please go to www.anthem.com/ca and select “Customer Support> Contact Us”, or you may call the customer service number on your ID card.

WEB SITE

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

LANGUAGE ASSISTANCE PROGRAM

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

The Language Assistance Program makes it possible for you to access oral interpretation services and certain written materials vital to understanding your health coverage at no additional cost to you.
Written materials available for translation include grievance and appeal letters, consent forms, claim denial letters, and explanations of benefits. These materials are available in the following languages:

- Spanish
- Chinese
- Vietnamese
- Korean
- Tagalog

Oral interpretation services are available in additional languages.

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

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

STATEMENT OF RIGHTS UNDER THE NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

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

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

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, please call us at the customer service telephone number listed on your ID card.
STATEMENT OF RIGHTS UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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