Anthem Blue Cross

UNIVERSITY OF CALIFORNIA

January 1, 2011

Anthem Blue Cross PLUS Plan
Retirees with Medicare
(Includes Members with Medicare Part A Only or Part B Only)

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

Anthem Blue Cross
21555 Oxnard Street
Woodland Hills, California 91367

This Combined Evidence of Coverage and Disclosure (Evidence of Coverage) Form is a summary of the important terms of your health plan. The health plan contract 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 Evidence of Coverage that apply to those needs. Your employer will provide you with a copy of the health plan contract upon request.

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UNIVERSITY OF CALIFORNIA – ANTHEM BLUE CROSS PLUS PLAN
RETIREES WITH MEDICARE (INCLUDES MEMBERS WITH MEDICARE PART A ONLY OR PART B ONLY)

BENEFITS AT A GLANCE

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits. This proposed benefit summary is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care.

All network services must be authorized by the primary care physician (PCP) and/or the medical group, except services provided under the "ReadyAccess" program and OB/GYN services received within the member's medical group/IPA.

For Out-of-Network providers (PPO & non-PPO), in addition to the per member copays, there is a deductible. Please review the deductible information below to know if a deductible applies to a specific covered service. Regardless from whom they receive services, members are also responsible for all costs over the plan maximums. Important information appears in *italics*.

Explanation of Covered Expense

Network (POS)—Charges incurred for covered services received from or authorized by the member's PCP or medical group, not to exceed the negotiated rate for some services.

Out-of-Network Providers—Plan payments for PPO providers are based on the Anthem Blue Cross PPO negotiated rate or fee. Members are not responsible for the difference between the provider's usual charges & the negotiated amount.

Non-PPO & Other Health Care Providers *(includes those not represented in the Anthem Blue Cross PPO provider network)*—The customary & reasonable charge for professional services or the reasonable charge for institutional services.

When using Non-PPO & Other Health Care Providers, members are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copays.

	Network	Out-of-Network Providers	
		PPO	Non-PPO
Calendar Year Deductible	N/A	$500/member; $1,500/family* **in the aggregate, but nor more than $500 for any one member in the family*	
Penalty for not obtaining preauthorization where required (certification)	N/A	$200/occurrence	
Annual Out-of-Pocket maximums *(Network & Out-of-Network) out-of-pocket maximums are exclusive of each other)*	$1,500/member $4,500/family*	$5,000/member $15,000/family** *(Combined for PPO & Non-PPO)*	

**In the aggregate, but not more than $1,500 for any one member in the family.*
***In the aggregate, but not more than $5,000 for any one member in the family.*

For Network (POS) services – percentage copays for chiropractic services, acupuncture services & non-covered expenses are not applied to the out-of-pocket maximum.

For Out-of-Network (PPO & Non-PPO) services –copays for infertility services & non-covered expenses are not applied to the out-of-pocket maximum. After a member reaches the out-of-pocket maximum, the member remains responsible for copays for infertility services, non-compliance penalties and, for non-PPO & other health care providers, costs in excess of the covered expense.

Lifetime Maximum	Unlimited	Unlimited

Covered Services	Network	Out-of-Network Providers	
		PPO	Non-PPO
	Per Member Copay	Per Member Copay	Per Member Copay
Hospital Medical Services *(preauthorization required for non-emergency admissions)*			
➢ Semi-private room, meals, special diets & ancillary services	$250 copay	30%	30%
➢ Outpatient medical care *(hospital care other than emergency room services)*	No copay	30%	30%
Ambulatory Surgical Center			
➢ Outpatient surgery, services & supplies	No copay	30%	30%
Skilled Nursing Facility *(PPO & non-PPO providers' services will not be covered if services are not preauthorized)*			
➢ Semi-private room & necessary services & supplies *(excludes take-home drugs)*	No copay	30% *(limited to 240 days/calendar year)*	30%
Hospice Care			
➢ Inpatient or outpatient services	No copay	30%	30%
Home Health Care *(preauthorization required under the Out-of-Network benefit; one visit by home health aide equals four hours or less; Out-of-Network benefit limited to 100 visits per calendar year.* ***Home Care is not available while you are receiving Hospice Care****)*	No copay	30%	30%
Outpatient Private Duty Nursing *(requires preauthorization; limited to $10,000/calendar year)*	No copay	30%	30%
Physician Medical Service			
➢ Web visits*	$10/visit	Not covered	Not covered
➢ Office & home visits (*no copay to age 7*)	$20/visit	30%	30%
➢ Hospital & skilled nursing facility visits	No copay	30%	30%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	No copay	30%	30%
➢ Specialists & consultants	$20/visit	30%	30%
➢ Short-term physical therapy, physical medicine, occupational therapy	$20/visit	30%	30%
➢ Speech therapy following injury, illness or other medical condition, as *medically necessary*	$20/visit	30%	30%
➢ Chiropractic care**	$20 copay	Not covered	Not covered
➢ Acupuncture** services for the treatment of disease, illness or injury	$20 copay	Not covered	Not covered
*These benefits are available through the RelayHealth program. See page 21 for additional information.			
**These benefits are available on a self-referral basis to an American Specialty Health Provider (ASHP) network provider only.			
General Medical Services			
➢ Diagnostic X-ray & laboratory procedures *(excluding X-ray & lab services performed for a routine exam)*	No copay	30%	30%
➢ Allergy testing and treatment (including serum)	$20 copay	30%	30%
➢ Radiation therapy, chemotherapy & hemodialysis treatment	No copay	30%	30%
➢ Prosthetic & Orthotic Devices	No copay	30%	30%
➢ Durable Medical Equipment	No copay	30%	30%
➢ Hearing Aids *(maximum of 2 hearing aids every 36 months, analog and digital devices are covered)*	50%	50%	50%

Covered Services	Network	Out-of-Network Providers	
		PPO	Non-PPO
	Per Member Copay	Per Member Copay	Per Member Copay
Organ & Tissue Transplants *(preauthorization required)*			
➢ Inpatient services provided in connection with non-investigative organ or tissue transplants	No copay	*(specified organ transplants only at Centers of Medical Excellence*)	
➢ Physician office visits *(including specialists & consultants)*	$20/visit		
➢ Transplant travel expense for an authorized, specified transplant at a *CME* (recipient & companion transportation limited to 6 trips/episode & $250/person/trip for round-trip coach airfare, hotel limited to 1 room double occup`ancy/$100/day for21 days/trip, other expenses limited to $25/day/person for 21 days/trip; donor transportation limited to 1 trip/episode & $250 for round-trip coach airfare, hotel limited to $100/day for 7 days, other expenses limited to $25/day for 7 days)	Not covered	No copay *(deductible waived)*	
Bariatric Surgery *(preauthorization required)* *Specified Bariatric surgery under PPO Out-of-Network will be covered only when performed at a Centers of Medical Excellence (CME).*			
➢ Inpatient services provided in connection with Bariatric Surgery	No copay	30%	Not covered
➢ Physician office visits *(including specialists & consultants)*	$20/visit	30%	Not covered
➢ Bariatric travel expense when member's home is 50 miles or more from the nearest Bariatric *Centers of Medical Excellence* (member's transportation to & from *CME* limited to $130/trip for 3 trips [pre-surgical visit, initial surgery & one follow-up visit]; one companion's transportation to & from *CME* limited to $130/trip for 2 trips [initial surgery & one follow-up visit]; hotel for member & one companion limited to one room double occupancy & $100/day for 2 days/trip, or as medically necessary, for pre-surgical & follow-up visit; hotel for one companion limited to one room double occupancy & $100/day for duration of member's initial surgery stay for 4 days; other reasonable expenses limited to $25/day for 4 days/trip)	Not covered	No copay *(deductible waived)*	
Autologous blood *(self-donated blood collection, testing, processing & storage)*	No copay	30%	30%
Injections & injected substances (administered in *physician's* office, including allergy serum & medication)	No copay	30%	30%
Home Infusion Therapy Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	No copay	30%	30%
Preventive Care *(Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits)*			
➢ Well baby care *(birth through age 6)*	No copay	No copay *(deductible waived)*	No copay
➢ Well child care *(age 7 through age 18)*	No copay	30%	30%
➢ Routine physical exams performed by a physician *(age 19 and over)*	No copay	30%	30%
➢ Routine gynecological exams for females, including Pap smears & mammograms	No copay	30% *(limited to 1 exam/calendar year)*	30%
➢ Prostate cancer screenings	No copay	30%	30%
➢ Diagnostic X-ray & lab for routine physical exam	No copay	30%	30%
➢ Hearing exams	No copay	30%	30%
➢ Specified immunizations *(birth through age 6)*	No copay	No copay	No copay
➢ Specified immunizations *(age 7 and above)*	No copay	30%	30%
➢ Vision Exams *(vision screening to determine medical necessity of vision exam evaluation with initiation of diagnostic & treatment programs & refractions if authorized by the PCP)*	No copay	Not covered	Not covered

Covered Services	Network	Out-of-Network Providers	
		PPO	Non-PPO
	Per Member Copay	Per Member Copay	Per Member Copay
Health Education & Wellness Programs			
➢ Instruction in health maintenance & wellness	No copay	Not covered	Not covered
➢ Health education programs *(as announced)*	Possible charge	Not covered	Not covered
Emergency Care			
➢ Physician & medical services	No copay	No copay	No copay
➢ Outpatient hospital emergency room services *(copay waived if admitted)*	$75/visit	$75/visit	$75/visit
➢ Inpatient hospital services	No copay	No copay	No copay
Ambulance			
➢ Ground or air ambulance transportation when medically necessary, including medical services & supplies	No copay	30% *(No copay, if emergency)*	30%
Urgent Care (Freestanding)	$20 copay	30%	30%
Pregnancy/Maternity Care/Therapeutic Abortions			
➢ Physician office visits *(including therapeutic abortions)*	$20 *(1st visit only)*	30% *(deductible waived, if PPO)*	30%
➢ Inpatient physician services	No copay	30%	30%
➢ Alternative birthing centers *(normal delivery)*	No copay	30%	30%
➢ Hospital & ancillary services *(normal delivery, cesarean section, complications of pregnancy and therapeutic abortions)*	$250 copay	30%	30%
Elective Abortion *(including prescription drug for abortion [mifepristone])*	$150	30%	30%
Genetic Testing of Fetus	No copay	30%	30%
Family Planning Services/Birth Control/Infertility			
➢ Family planning *(counseling & consultation)*	No copay	50%	50%
➢ Tubal ligation	$150	50%	50%
➢ Vasectomy	$75	50%	50%
➢ Artificial insemination,***** subject to criteria as specified in the EOC as covered *(maximum of 6 cycles/lifetime)*	Not covered	$20/visit	Not covered
➢ *Infertility* studies & tests.*****	Not covered	50%	Not covered
➢ *Infertility* surgery.*****	Not covered	30%	Not covered
➢ Injectable *infertility* drugs.*****	Not covered	30%	Not covered

*****These benefits are available through Out-of-Network PPO providers only. No deductible.

Covered Services	Network	Out-of-Network Providers	
		PPO	Non-PPO
	Per Member Copay	Per Member Copay	Per Member Copay
Transgender Surgery*			
➢ Inpatient hospital	Not covered	$250 copay	Not covered
➢ Physicians visits *(including specialists)*	Not covered	$20	Not covered
➢ Surgeon, assistant surgeon	Not covered	No copay	Not covered
➢ Anesthesia	Not covered	No copay	Not covered
➢ Skilled nursing facility (*preauthorization required/ limited to 240 days/calendar year)*	Not covered	No copay	Not covered
➢ Rehabilitative care	Not covered	$20	Not covered
➢ Transgender surgery travel expense transportation limited to 6 trips/episode & $250/person/trip for round trip, coach fare, hotel limited to 1 room double occupancy $100/day for 21 days/trip, other expenses limited to $25/day/person for 21 days/trip	Not Covered	Covered	Not covered
➢ Transgender Surgery Lifetime Maximum	$75,000		

***Benefits provided through authorized Transgender Surgery physicians only.*

Mental and Nervous Disorders & Substance Abuse Benefits are provided through United Behavioral Health (UBH).

Medical benefits while traveling out of the country will be reimbursed at the out-of-network benefit level. Members are responsible for 30% of the billed charges.

UNIVERSITY OF CALIFORNIA

ELIGIBILITY, ENROLLMENT, TERMINATION AND PLAN ADMINISTRATION PROVISIONS

January 1, 2011

The following information applies to the University of California plan and supersedes any corresponding information that may be contained elsewhere in the document to which this insert is attached. The University establishes its own medical plan eligibility, enrollment and termination criteria based on the University of California Group Insurance Regulations ("Regulations") and any corresponding Administrative Supplements. Portions of these Regulations are summarized below.

ELIGIBILITY

The following individuals are eligible to enroll in this Plan. If the Plan is a Point of Service (POS) Plan, they are only eligible to enroll in the Plan if they meet the Plan's geographic service area criteria as residents of California. Anyone enrolled in a non-University Medicare Advantage Managed Care contract or enrolled in a non-University Medicare Part D Prescription Drug Plan will be deenrolled from this health plan (not applicable to members of the Anthem Blue Cross PPO Medicare without Prescription Drug Plan).

Subscribers

Employee: You are eligible if you are appointed to work at least 50% time for twelve months or more or are appointed at 100% time for three months or more or have accumulated 1,000***** hours while on pay status in a twelve-month period. To remain eligible, you must maintain an average regular paid time****** of at least 17.5 hours per week and continue in an eligible appointment. If your appointment is at least 50% time, your appointment form may refer to the time period as follows: "Ending date for funding purposes only; intent of appointment is indefinite (for more than one year)."

* Lecturers - see your benefits office for eligibility.

****** Average Regular Paid Time - For any month, the average number of regular paid hours per week (excluding overtime, stipend or bonus time) worked in the preceding twelve (12) month period. Average regular paid time does not include full or partial months of zero paid hours when an employee works less than 43.75% of the regular paid hours available in the month due to furlough, leave without pay or initial employment.

Retiree: A former University Employee receiving monthly benefits from a University-sponsored defined benefit plan.

You may continue University medical plan coverage as a Retiree when you start collecting retirement or disability benefits from a University-sponsored defined benefit Plan provided that you also meet the following requirements:

(a) you meet the University's service credit requirements for Retiree medical eligibility;

(b) the effective date of your Retiree status is within 120 calendar days of the date employment ends; and

(c) you elect to continue (or effective 1/1/05 suspend) medical coverage at the time of retirement.

Survivor: A deceased Employee's or Retiree's Family Member receiving monthly benefits from a University-sponsored defined benefit plan—may be eligible to continue coverage as set forth in the University's Group Insurance Regulations. For more information, see the UC *Group Insurance*

Eligibility Factsheet for Retirees and Eligible Family Members or the *Survivor and Beneficiary Handbook*.

If you are eligible for Medicare, you must follow UC's Medicare Rules. See "Effect of Medicare on Retiree Enrollment" below.

Eligible Dependents (Family Members)

When you enroll any Family Member, your signature on the enrollment form or the confirmation number on your electronic enrollment attests that your Family Member meets the eligibility requirements outlined below. The University and/or the Plan reserves the right to periodically request documentation to verify eligibility of Family Members, including any who are required to be your tax dependent(s). Documentation could include a marriage certificate, birth certificate(s), domestic partner verification, adoption records, Federal Income Tax Return, or other official documentation.

Eligible Adults:

Spouse: Your legal spouse.

Same Sex-Domestic Partner: You may enroll a same-sex domestic partner (and the same-sex domestic partner's children/grandchildren) as set forth in the University of California Group Insurance Regulations.

Opposite-Sex Domestic Partner: The University recognizes an opposite-sex domestic partner as a family member that is eligible for coverage in UC-sponsored benefits if the employee/retiree or domestic partner is age 62 or older and eligible to receive Social Security benefits and both the employee/retiree and domestic partner are at least 18 years of age.

Note: An adult dependent relative is no longer eligible for coverage. Only an adult dependent relative who was enrolled as an eligible dependent as of December 31, 2003 and continues to be ineligible for Medicare Part A may continue coverage in UC-sponsored plans.

Child: All eligible children must be under the limiting age of 26 (18 for legal wards) except for a child who is incapable of self-support due to a physical or mentally disabling injury, illness or condition. The following categories are eligible:

(a) your natural or legally adopted children;

(b) your spouse's natural or legally adopted children (your stepchildren);

(c) your eligible domestic partner's natural or legally adopted children;

(d) grandchildren of you, your spouse or your eligible domestic partner if living with you, dependent on you, your spouse or your eligible domestic partner for at least 50% of their support and are your, your spouse's, or your eligible domestic partner's dependents for income tax purposes;

(e) children for whom you are the legal guardian if living with you, dependent on you for at least 50% of their support and are your dependents for income tax purposes.

(f) children for whom you are legally required to provide group health insurance pursuant to an administrative or court order. (Child must also meet UC eligibility requirements.)

Any child described above (except a legal ward) who is incapable of self-support due to a physical or mental disability may continue to be covered past age 26 provided:

- the plan-certified disability began before age 26, the child was enrolled in a UC group medical plan before age 26 and coverage is continuous;
- the child is chiefly dependent upon you. your spouse, or your eligible domestic partner for support and maintenance; and
- the child is claimed as your, your spouse's or your eligible domestic partner's dependent for income tax purposes, or if not claimed as such dependent for income tax purposes, is eligible for Social Security Income or Supplemental Security Income as a disabled person, or working in supported employment which may offset the Social Security or Supplemental Security Income.

Application for coverage beyond age 26 due to disability must be made to the Plan sixty days prior to the date coverage is to end due to reaching limiting age. If application is received timely but Plan does not complete 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 Plan's determination. The Plan may periodically request proof of continued disability, but not more than once a year after the initial certification. Disabled children approved for continued coverage under a University-sponsored medical plan are eligible for continued coverage under any other University-sponsored medical plan; if enrollment is transferred from one plan to another, a new application for continued coverage is not required; however, the new Plan may require proof of continued disability, but not more than once a year.

If you are a newly hired Employee with a disabled child over age 26 or if you newly acquire a disabled child over age 26 (through marriage or adoption), you may also apply for coverage for that child. The child's disability must have begun prior to the child turning age 26. Additionally, the child must have had continuous group medical coverage since age 26, and you must apply for University coverage during your Period of Initial Eligibility. The Plan will ask for proof of continued disability, but not more than once a year after the initial certification.

Important Note: Health and welfare benefits and eligibility requirements, including dependent eligibility requirements are subject to change (e.g., for compliance with applicable laws and regulations). UC dependent eligibility requirements may change following final health care reform legislation, regulatory guidance, or other applicable laws.

No Dual Coverage

Eligible individuals may be covered under only one of the following categories: as an Employee, a Retiree, a Survivor or a Family Member. If an Employee and the Employee's spouse or domestic partner are both eligible Subscribers, each may enroll separately or one may enroll and cover the other as a Family Member. If they enroll separately, neither may enroll the other as a Family Member. Eligible children may be enrolled under either parent's or eligible domestic partner's coverage but not under both. Additionally, a child who is also eligible as an Employee may not have dual coverage through two University-sponsored medical plans.

More Information

For information on who qualifies and how to enroll, contact your local Benefits Office or the University of California's (UC) Customer Service Center at (800) 888-8267. You may also access eligibility factsheets on UC's *At Your Service* web site: http://atyourservice.ucop.edu.

ENROLLMENT

For information about enrolling yourself or an eligible Family Member, see the person at your location who handles benefits. If you are a Retiree, contact the UC Customer Service Center. Enrollment transactions may be completed by paper form or electronically, according to current University practice. To complete the enrollment transaction, paper forms must be received by the local Accounting or Benefits office or by the UC Customer Service Center by the last business day within the applicable enrollment period. Electronic transactions must be completed by the deadline on the last day of the enrollment period.

During a Period of Initial Eligibility (PIE)

A PIE begins the day you become eligible and ends 31 days after it began (but see exception under "Special Circumstances" paragraph 1.d below). Also see "At Other Times for Employees and Retirees" below. If the last day of a PIE falls on a weekend or holiday, the PIE is extended to the following business day when enrolling with forms.

If you are an Employee, you may enroll yourself and any eligible Family Members during your PIE. Your PIE starts the day you become an eligible Employee.

You may enroll any newly eligible Family Member during his or her PIE. The Family Member's PIE starts the day your Family Member becomes eligible, as described below. During this PIE you may also enroll yourself and/or any other eligible Family Member if not enrolled during your own or their own PIE. You must enroll yourself in order to enroll any eligible Family Member. Family members are only eligible for the same plan in which you are enrolled.

(a) For a spouse, on the date of marriage.

(b) For a Domestic Partner, on the date the domestic partnership is legally established. Also see "At Other Times for Employees and Retirees" below.

(c) For a natural child, on the child's date of birth.

(d) For an adopted child, the earlier of:

(i) the date the child is placed for adoption with the Employee/Retiree, or

(ii) the date the Employee/Retiree or Spouse/Domestic Partner has the legal right to control the child's health care.

A child is "placed for adoption" with the Employee/Retiree as of the date the Employee/Retiree assumes and retains a legal obligation for the child's total or partial support in anticipation of the child's adoption.

If the child is not enrolled during the PIE beginning on that date, there is an additional PIE beginning on the date the adoption becomes final.

(e) Where there is more than one eligibility requirement, the date all requirements are satisfied.

If you are in a Health Maintenance Organization (HMO), Exclusive Provider Organization (EPO), or Point of Service (POS) Plan and you move or are transferred out of that Plan's service area, or will be away from the Plan's service area for more than two months, you will have a PIE to enroll yourself and your eligible Family Members in another University medical plan available in the new location. Your PIE starts with the effective date of the move or the date you leave the Plan's service area. Upon return to the service area, you will have a PIE to reenroll yourself and eligible Family Members in the same HMO, EPO or POS you had at the time of the move out of the area. The PIE begins with the effective date of the return to the service area.

At Other Times for Employees and Retirees

Group Open Enrollment Period. You and your eligible Family Members may also enroll during a group open enrollment period established by the University.

90-Day Waiting Period. If you are an Employee and opt out of medical coverage or fail to enroll yourself during a PIE or open enrollment period, you may enroll yourself at any other time upon completion of a 90 consecutive calendar day waiting period unless one of the "Special Circumstances" described below applies.

If you are an Employee or Retiree and fail to enroll your eligible Family Members during a PIE or open enrollment period, you may enroll your eligible Family Members at any other time upon completion of a 90 consecutive calendar day waiting period unless one of the "Special Circumstances" described below applies.

The 90-day waiting period starts on the date the enrollment form is received by the local Accounting or Benefits office and ends 90 consecutive calendar days later.

Newly Eligible Child. If you have one or more children enrolled in the Plan, you may add a newly eligible Child at any time. See "Effective Date".

Special Circumstances. You may enroll before the end of the 90-day waiting period or without waiting for the University'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 under another health plan as an individual or dependent, including coverage under COBRA or CalCOBRA (or similar program in another state), the Children's Health Insurance Program or "CHIP" (called the Healthy Families Program in California), or Medicaid (called Medi-Cal in California).

    b. You stated at the time you became eligible for coverage under this Plan that you were declining coverage under this Plan or disenrolling because you were covered under another health plan as stated above.

    c. Your coverage under the other health plan wherein you or your eligible Family Members were covered as an individual or dependent ended because you lost eligibility under the other plan or employer contributions toward coverage under the other plan terminated, your coverage under COBRA or CalCOBRA continuation was exhausted, or you lost coverage under CHIP or Medicaid because you were no longer eligible for those programs.

    d. You properly file an application with the University during the PIE which starts on the day after the other coverage ends. **Note that if you lose coverage under CHIP or Medicaid, your PIE is 60 days.**

2. You or your eligible Family Members are not currently enrolled and you or your eligible Family Members become eligible for premium assistance under the Medi-Cal Health Insurance Premium Payment (HIPP) Program or a Medicaid or CHIP premium assistance program in another state. Your PIE is 60 days from the date you are determined eligible for premium assistance. If the last day of the PIE falls on a weekend or holiday, the PIE is extended to the following business day. Electronic transactions must be completed by the deadline on the last day of the enrollment period.

3. A court has ordered coverage be provided for a spouse, domestic partner or dependent child under your UC-sponsored medical plan and an application is filed within the PIE which begins the date the court order is issued. (Family member(s) must also meet UC eligibility requirements.)

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

    a. If you are enrolling following marriage or establishment of a domestic partnership, you and your new spouse or domestic partner must enroll during the PIE. Your new spouse or domestic partner's eligible children may also enroll at that time. Coverage will be effective as of the date of marriage or domestic partnership provided you enroll during the PIE.

    b. If you are enrolling following the birth, adoption, or placement for adoption of a child, your spouse or domestic partner, who is eligible but not enrolled, may also enroll at that time. Application must be made during the PIE; coverage will be effective as of the date of birth, adoption, or placement for adoption provided you enroll during the PIE.

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. Coverage will be effective on the first day of the month following the date you file the enrollment application.

If you are an Employee or a Retiree and there is a lifetime maximum for all benefits under this plan, and you or a Family Member reaches that maximum, you and your eligible Family Members may be eligible to enroll in another UC-sponsored medical plan. Contact the person who handles benefits at your location (or the UC Customer Service Center if you are a Retiree).

If you are a Retiree, you may continue coverage for yourself and your enrolled Family Members in the same plan (or its Medicare version) you were enrolled in immediately before retiring, and you may

change your plan during the University's next open enrollment period. You must elect to continue enrollment for yourself and enrolled Family Members before the effective date of retirement (or the date disability or survivor benefits begin). Retirement alone does not grant a PIE to enroll or change your medical plan.

If you are a Survivor, you may not enroll your legal spouse or domestic partner.

Effective Date

The following effective dates apply provided the appropriate enrollment transaction (paper form or electronic) has been completed within the applicable enrollment period.

If you enroll during a PIE, coverage for you and your Family Members is effective the date the PIE starts.

If you are a Retiree continuing enrollment in conjunction with retirement, coverage for you and your Family Members is effective on the first of the month following the first full calendar month of retirement income.

The effective date of coverage for enrollment during an open enrollment period is the date announced by the University.

For enrollees who complete a 90-day waiting period, coverage is effective on the 91st consecutive calendar day after the date the enrollment transaction is completed.

An Employee or Retiree already enrolled in adult plus child(ren) or family coverage may add additional children, if eligible, at any time after their PIE. Retroactive coverage is limited to the later of:

(a) the date the Child becomes eligible, or

(b) a maximum of 60 days prior to the date your Child's enrollment form is received by your local Benefits or Payroll Office.

Change in Coverage

In order to make any of the changes described above, contact the person who handles benefits at your location (or the UC Customer Service Center if you are a Retiree).

Effect of Medicare on Retiree Enrollment

If you are a Retiree and you and/or an enrolled Family Member is or becomes eligible for premium-free Medicare Part A (Hospital Insurance) as primary coverage, then that individual must also enroll in and remain in Medicare Part B (Medical Insurance). Once Medicare coverage is established, coverage in both Part A and Part B must be continuous. This includes anyone who is entitled to Medicare benefits through their own or their spouse's employment. Individuals enrolled in both Part A and Part B are then eligible for the Medicare premium applicable to this plan.

Retirees or their Family Member(s) who become eligible for premium-free Medicare Part A on or after January 1, 2004 and do not enroll in Part B will permanently lose their UC-sponsored medical coverage.

Retirees and their Family Members who were eligible for premium-free Medicare Part A between July 1, 1991 and January 1, 2004, but declined to enroll in Part B of Medicare, are assessed a monthly offset fee by the University to cover increased costs. The offset fee may increase annually, but will stop when the Retiree or Family Member becomes covered under Part B.

Retirees or Family Members who are not eligible for premium-free Part A will not be required to enroll in Part B, they will not be assessed an offset fee, nor will they lose their UC-sponsored medical coverage. Documentation attesting to their ineligibility for Medicare Part A will be required.

(Retirees/Family Members who are not entitled to Social Security and premium-free Medicare Part A will not be required to enroll in Part B.)

An exception to the above rules applies to Retirees or Family Members in the following categories who will be eligible for the non-Medicare premium applicable to this plan and will also be eligible for the benefits of this plan without regard to Medicare:

a) Individuals who were eligible for premium-free Part A, but not enrolled in Medicare Part B prior to July 1, 1991.
b) Individuals who are not eligible for premium-free Part A.

You should contact Social Security three months before your or your Family Member's 65th birthday to inquire about your eligibility and how to enroll in Part A and Part B of Medicare. If you qualify for disability income benefits from Social Security, contact a Social Security office for information about when you will be eligible for Medicare enrollment.

Upon Medicare eligibility, you or your Family Member must complete a University of California *Medicare Declaration* form, as well as submit a copy of your Medicare card. This notifies the University that you are covered by Part A and Part B of Medicare. The University's *Medicare Declaration* form is available through the UC Customer Service Center or from the web site: http://atyourservice.ucop.edu. Completed forms should be returned to University of California, Human Resources, Retiree Insurance Program, Post Office Box 24570, Oakland, CA 94623-1570.

Any individual enrolled in a University-sponsored Medicare Advantage Managed Care contract must assign his/her Medicare benefit (including Part D) to that plan or lose UC-sponsored medical coverage. Anyone enrolled concurrently in a non-University Medicare Advantage Managed Care contract will be deenrolled from this health plan. Any individual enrolled in a University-sponsored Medicare Part D Prescription Drug Plan must assign his/her Part D benefit to the plan or lose UC-sponsored medical coverage. Anyone enrolled concurrently in a non-University Medicare Part D Prescription Drug Plan will be deenrolled from this health plan (not applicable to members of the Anthem Blue Cross PPO Medicare Without Prescription Drug Plan).

Medicare Secondary Payer Law (MSP)

The Medicare Secondary Payer (MSP) Law affects the order in which claims are paid by Medicare and an employer group health plan. Employees or their spouses, age 65 or over, and UC Retirees re-hired into positions making them eligible for UC-sponsored medical coverage, including CORE and mid-level benefits, are subject to MSP. For those eligible for a group health plan due to employment, MSP indicates that Medicare becomes the secondary payer and the employer plan becomes the primary payer. You and your spouse should carefully consider the impact on your health benefits and premiums at age 65 or should you decide to return to work after you retire. Continued employment past age 65 may delay enrollment into Part B, however, once enrolled, Part B must be continuous.

Medicare Private Contracting Provision and Providers Who do Not Accept Medicare

Federal Legislation allows physicians or practitioners to opt out of Medicare. Medicare beneficiaries wishing to continue to obtain services **(that would otherwise be covered by Medicare)** from these physicians or practitioners will need to enter into written "private contracts" with these physicians or practitioners. These private agreements will require the beneficiary to be responsible for all payments to such medical providers. Since services provided under such "private contracts" are not covered by Medicare or this Plan, the Medicare limiting charge will not apply.

Some physicians or practitioners have **never** participated in Medicare. Their services (that would be covered by Medicare if they participated) will not be covered by Medicare or this Plan, and the Medicare limiting charge will not apply.

If you are classified as a Retiree by the University (or otherwise have Medicare as a primary coverage), are enrolled in Medicare Part B, and choose to enter into such a "private contract" arrangement as described above with one or more physicians or practitioners, or if you choose to obtain services from a provider who does not participate in Medicare, under the law you have in effect

"opted out" of Medicare for the services provided by these physicians or other practitioners. In either case, no benefits will be paid by this Plan for services rendered by these physicians or practitioners with whom you have so contracted, even if you submit a claim. You will be fully liable for the payment of the services rendered. Therefore, it is important that you confirm that your provider takes Medicare prior to obtaining services for which you wish the Plan to pay.

However, even if you do sign a private contract or obtain services from a provider who does not participate in Medicare, you may still see **other** providers who have not opted out of Medicare and receive the benefits of this Plan for those services.

TERMINATION OF COVERAGE

The termination of coverage provisions that are established by the University of California in accordance with its Regulations are described below. Additional Plan provisions apply and are described elsewhere in the document.

Deenrollment Due to Loss of Eligible Status

If you are an Employee and lose eligibility, your coverage and that of any enrolled Family Member stops at the end of the last month for which premiums are taken from earnings based on an eligible appointment. If you are hospitalized or undergoing treatment of a medical condition covered by this Plan, benefits will cease to be provided and you may have to pay for the cost of those services yourself. You may be entitled to continued benefits under terms which are specified elsewhere in this document. (If you apply for an individual HIPAA or conversion plan, the benefits may not be the same as you had under this Plan.)

If you are a Retiree or Survivor and your annuity terminates, your coverage and that of any enrolled Family Member stops at the end of the last month in which you are eligible for an annuity.

If your Family Member loses eligibility, you must complete the appropriate transaction to delete him or her within 60 days of the date the Family Member is no longer eligible. Coverage stops at the end of the month in which he or she no longer meets all the eligibility requirements. For information on deenrollment procedures, contact the person who handles benefits at your location (or the UC Customer Service Center if you are a Retiree).

Deenrollment Due to Fraud or Intentional Misrepresentation

Coverage for you and/or your Family Members may be suspended for up to 12 months if you or a Family Member commit fraud or make an intentional misrepresentation of material fact relating to Plan coverage. Individuals who are enrolled, but who are not eligible Family Members will be permanently deenrolled.

Leave of Absence, Layoff, Change in Employment Status or Retirement

Contact your local Benefits Office for information about continuing your coverage in the event of an authorized leave of absence, layoff, change of employment status, or retirement.

Optional Continuation of Coverage

As a participant in this plan you may be entitled to continue health care coverage for yourself, spouse or family members if there is a loss of coverage under the plan as a result of a qualifying event under the terms of the federal COBRA continuation requirements under the Public Health Service Act,, as amended, and, if that continued coverage ends, you may be eligible for further continuation under California law. You or your family members will have to pay for such coverage. You may direct questions about these provisions to CONEXIS, UC's COBRA administrator or visit the website http://atyourservice.ucop.edu/employees/health_welfare/cobra.html

Grace Period

There shall be a Grace Period which provides additional time for UC to complete full payment of monthly premiums to Plan following the premium Due Date. The Due Date is the date the full

premium is due and payable to Plan for a coverage month. The Grace Period shall be in force 31 days following the Due Date. The Agreement shall remain in force during the Grace Period. No penalties or late fees shall be charged by the insurance carrier to UC during the Grace Period. If UC fails to pay the insurance carrier the premiums due during the Grace Period, the carrier will not end coverage for covered Employee Members or Family Members until the end of the Grace Period. The Employee Members will not be required by the carrier to pay the premiums for UC nor will Members be required to pay more than their copay for any services received during the Grace Period.

If premiums due are not paid by the end of the Grace Period, the Agreement will be canceled as described above. If you are hospitalized or undergoing treatment of a medical condition covered by this Plan, benefits will cease to be provided and you may have to pay for the cost of those benefits yourself. You may be entitled to continued benefits under terms which are specified elsewhere in this document. (If you apply for an individual HIPAA or conversion plan, the benefits may not be the same as you had under this Plan.)

PLAN ADMINISTRATION

By authority of the Regents, University of California Human Resources, located in Oakland, California, administers this plan in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts/service agreements, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by the Regents. The terms of those documents apply if information in this document is not the same. The University of California Group Insurance Regulations will take precedence if there is a difference between its provisions and those of this document and/or the group insurance contracts. What is written in this document does not constitute a guarantee of plan coverage or benefits--particular rules and eligibility requirements must be met before benefits can be received.

This section describes how the Plan is administered and what your rights are.

Sponsorship and Administration of the Plan

The University of California is the Plan sponsor and plan administrator for the Plan provisions described in this insert to the Plan Evidence of Coverage booklet. If you have a question about eligibility or enrollment, you may direct it to:

University of California
Human Resources
300 Lakeside Drive
Oakland, CA 94612
(800) 888-8267

Retirees and Survivors may also direct questions to the UC Customer Service Center at the above phone number.

Claims under the Plan are processed by Anthem Blue Cross at the following address and phone number:

Anthem Blue Cross
21555 Oxnard Street
Woodland Hills, CA 91367

Anthem Blue Cross' Customer Service number is (888) 209-7975

Group Case Number. The Group Case Number for this Plan is: 175011

Type of Plan. This Plan is a health and welfare plan that provides group medical care benefits. This Plan is one of the benefits offered under the University of California's employee health and welfare benefits program.

Plan Year. The plan year is January 1 through December 31.

Continuation of the Plan. The University of California intends to continue the Plan of benefits described in this booklet but reserves the right to terminate or amend it at any time. *Plan benefits are not accrued or vested benefit entitlements.* The right to terminate or amend applies to all Employees, Retirees and plan beneficiaries. The amendment or termination shall be carried out by the President or his or her delegates. The University of California will also determine the terms of the Plan, such as benefits, premiums and what portion of the premiums the University will pay. The portion of the premiums *that University pays is determined by UC and may change or stop altogether, and may be affected by the state of California's annual budget appropriation.*

Financial Arrangements. The benefits under the Plan are provided by Anthem Blue Cross under a Group Benefit Agreement. The cost of the premiums is currently shared between you and the University of California.

Agent for Serving of Legal Process. Legal process may be served on Anthem Blue Cross at the address listed above.

Your Rights under the Plan. As a participant in a University of California medical plan, you are entitled to certain rights and protections. All Plan participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office and other specified sites, all Plan documents, including the Group Benefit Agreement, at a time and location mutually convenient to the participant and the Plan Administrator.

Obtain copies of all Plan documents and other information for a reasonable charge upon written request to the Plan Administrator.

Claims under the Plan. To file a claim or to file an appeal regarding denied claims of benefits or services, refer to the appeal section found later in this document. Any appeals regarding coverage denials that relate to eligibility requirements are subject to the UC Group Insurance Regulations. To obtain a copy of the Eligibility Claims Appeal Process, please contact the person who handles benefits at your location (or the UC Customer Service Center if you are a retiree).

Nondiscrimination Statement. In conformance with applicable law and University policy, the University of California is an affirmative action/equal opportunity employer.

Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to Director of Diversity and Employee Programs, University of California Office of the President, 300 Lakeside Drive, Oakland, CA 94612 and for faculty to Director of Academic Affirmative Action, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

INTRODUCTION TO ANTHEM BLUE CROSS PLUS

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED. IF YOU HAVE SPECIAL HEALTH CARE NEEDS, YOU SHOULD CAREFULLY READ THOSE SECTIONS THAT APPLY TO THOSE NEEDS. THE MEANINGS OF WORDS AND PHRASES IN ITALICS ARE DESCRIBED IN THE SECTION OF THIS BOOKLET ENTITLED DEFINITIONS.

With the Anthem Blue Cross PLUS Plan, you have access to both the Anthem Blue Cross PLUS network of providers, plus Anthem Blue Cross's Prudent Buyer Plan network of PPO providers or any licensed provider.

The type of provider you choose, however, will determine the benefits that will be provided for services covered by your Anthem Blue Cross PLUS Plan. **You will be entitled to the maximum benefits only when services are received from or authorized by your Primary Care Physician or Medical Group.** You may "opt out" to a *PPO provider* or *non-PPO provider.* You may not "opt out" to your own *primary care physician*, or for Direct Access program services provided by a *physician* who works with your *medical group* (See "Direct Access" later in this section).

When you enroll for the *plan*, you must choose a *medical group* and *primary care provider*. You must also follow our rules when obtaining care from the Network providers. However, you do not need a referral from your *primary care physician* or *medical group* when you are using your Out-of-Network benefits.

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

Note: In most cases, if you need to be referred to a *specialist,* it is to your advantage to obtain a referral through your *primary care physician* or *medical group*. Under your Network benefits, you will not be required to satisfy a Calendar Year Deductible.

Physicians. As the term is used in this booklet, "physician" means a number of types of health care providers, in addition to a medical doctor (M.D.). While these providers cannot provide all of the services that an M.D. can provide, when they practice within their specialty their services will be covered in accordance with the provisions of this *plan*. Please read the definition of "physician" in the DEFINITIONS section to determine which health care providers' services are covered. Only providers listed in the definition of "physician" are covered as *physicians*.

When using your Network benefits, *physician* services must be provided or authorized by your *primary care physician* or *medical group* except as specifically stated in this booklet. When using your Out-of-Network benefits, you may select any health care provider listed in the definition of "physician". Please note also that certain providers' services are covered only upon referral of an M.D. (medical doctor) or D.O. (doctor of osteopathy). Providers for whom referral is required are indicated in the definition of "physician" by an asterisk (*).

Your ID Card. Your identification card not only identifies you, but this card also shows the *medical group* to which you belong and gives your *medical group's* address and telephone number. Be sure to keep this card with you at all times and to present it whenever you receive care. You will also need to present this card when you receive care from an Out-of-Network *PPO provider*.

Your Medical Group and Primary Care Physician. When a *subscriber* enrolls, he or she chooses an Anthem Blue Cross PLUS *medical group* for himself or herself, plus all covered *family members*. Not every *member* in that family must be enrolled at the same *medical group*. You may choose any

medical group that is accepting new patients. However, each *member* must live or work within the *enrollment area* of the *medical group* chosen for him or her.

There are two types of Anthem Blue Cross PLUS *medical groups*. A *primary medical group* is a group medical practice staffed by a team of *physicians,* nurses, and other health professionals. We also contract with *independent practice associations* which are medical partnerships, corporations or associations of *physicians* who practice in private offices, and are usually organized around a *hospital* with which they are associated. Either type of *medical group* can provide you with *medically necessary* care, or authorize a referral to another provider or *specialist* if appropriate.

From your *medical group*, you must choose your own *primary care physician*. For a child, you may choose a *primary care physician* who is a pediatrician. This *physician* will diagnose and treat most illness, coordinate all your health care, and refer you to *specialists* when necessary. In most cases, the *specialist* will be a member of your *medical group* or will have an arrangement with your *medical group* to provide needed care for its patients. Referrals are made at the sole and absolute discretion of your *primary care physician* and your *medical group*.

Obstetrical and gynecological services may be received without obtaining referral or approval from your *primary care physician* or from us, from an obstetrician, gynecologist or family practice physician who is a member of your *medical group* or who has an arrangement with your *medical group* to provide care for its patients, and who has been identified by your *medical group* as available for providing obstetrical and gynecological care. A *participating provider* who specializes in obstetrical and gynecological care may refer you to another *physician* or health care provider and order related obstetrical and gynecological items and services if you need additional *medically necessary* care. The conditions for a referral from a *participating provider* who specializes in obstetrical and gynecological care are the same conditions for referral from your *primary care physician* (see the "Referral Care" provision under USING YOUR NETWORK BENEFITS). All other terms and conditions of this *plan* apply to covered services received from a *participating provider* who specializes in obstetrical and gynecological care.

All other Network care must be provided, or coordinated, by your Primary Care Physician, except as specifically stated in this booklet.

You should choose a *primary care physician* immediately upon enrollment and arrange for an appointment with that *physician*, to help establish a patient-to-doctor relationship.

Standing Referrals. If you need continuing care from a *specialist*, your *primary care physician* may provide you with a standing referral to a *specialist*. This referral may be made according to a treatment plan, which will be made if necessary, to decide the course of care, that may limit the number of visits to the *specialist* or the period of time these visits are authorized. If you have a life-threatening, degenerative, or disabling condition (including HIV and AIDS) requiring specialized care for a prolonged period of time, your *primary care physician* may provide you with a referral to a *specialist* or a specialty care center for the purpose of having the *specialist* coordinate your health care. This referral may also be made according to a treatment plan. For both types of standing referrals, the *specialist* or specialty care center to which you are referred will in most cases be part of your *medical group* or will have an arrangement with your *medical group* to provide care for its patients.

ReadyAccess. There are two ways you can access specialists without authorization from your *medical group*. The two programs are Direct Access and Speedy Referral. Not all medical groups participate in the ReadyAccess program. Your Anthem Blue Cross PLUS directory and our provider finder on our website will indicate which *medical groups* participate in these programs.

Direct Access. You may be able to get some special care without an approval from your *primary care physician*. We have a program called "Direct Access", which lets you get special care, without an approval from your *primary care physician* for:

- Allergy
- Dermatology
- Ear/Nose/Throat

Ask your *Anthem Blue Cross PLUS coordinator* if your *medical group* takes part in the "Direct Access" program. If your *medical group* participates in the Direct Access program, you must still get your care from a *physician* who works with your *medical group*. Your *Anthem Blue Cross PLUS coordinator* will give you a list of those *physicians*. You may not "opt out" for these services when provided by a *physician* who works with your *medical group.*

Speedy Referral. Your *primary care physician* can refer you to specialists without further authorization from the *medical group*. Certain specialties are accessible through the Speedy Referral depending on your *medical group*.

Revoking or Modifying a Referral or Authorization. A referral or authorization for services or care that was approved by your *medical group*, your *primary care physician*, or by us 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 *agreement* 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.

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 doctor, medical group, independent practice association, 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.

Changing Medical Groups. There are three ways you can change *medical groups:*

1. During an Open Enrollment Period, you may choose any *medical group* within the *enrollment area* in which you live or work that is accepting new patients.
2. You must live or work within the *enrollment area* of your *medical group*. If you change your permanent residence or employment location, and your new residence or employment location is not within the *enrollment area* of your current *medical group*, you must request a transfer to another *medical group* by calling the Customer Service number shown on your ID card or by properly filing a membership change form with the *group* within 31 days of your move.

   The change in your *medical group* will take effect on the first day of the month if the request is received prior to the 15th of the month, or on the first day of the month following the date we receive the request if we receive it on or after the 15th of the month.
3. You can request a transfer, by calling the Customer Service number shown on your ID card or by properly filing a membership change form with the *group* within 31 days of the special circumstance prompting your request. You must include the reasons for your request. We must approve your request for the transfer to become effective.

The change in your *medical group* will take effect on the first day of the month if the request is received prior to the 15th of the month, or on the first day of the month following the date we receive the request if we receive it on or after the 15th of the month.

Please see the "Enrollment" provision in HOW COVERAGE BEGINS AND ENDS for information on how to properly file a membership change form.

If you move your residence to outside the Anthem Blue Cross PLUS service area, you must contact your employer to enroll in a different health care plan.

Your Anthem Blue Cross PLUS Coordinator. If you need help selecting a *primary care physician* from the staff of your *medical group* or need information including financial arrangements and any incentives about the *physicians* in your *medical group,* contact the *Anthem Blue Cross PLUS coordinator,* located at your *medical group*. Your *Anthem Blue Cross PLUS coordinator* will also provide you with any information you may need about Anthem Blue Cross PLUS services and procedures. You may contact your *Anthem Blue Cross PLUS coordinator* by phone or by letter.

Member Rights and Responsibilities. Anthem Blue Cross is committed to maintaining a mutually respectful relationship with our *members*, and at the same time we expect our *members* to assume certain responsibilities. Your Member Rights and Responsibilities are described below and your rights, our legal duties, and our privacy practices related to HIPAA are described in our "Notice of Privacy Practices" found on our website at http://www.anthem.com/uc or by calling the customer service telephone number on your ID card.

Anthem Blue Cross is committed to:

- Recognizing and respecting you as a *member*;
- Encouraging your open discussions with your health care professionals and providers;
- Providing information to help you become an informed health care consumer;
- Providing access to health benefits and our network providers;
- Sharing our expectations of you as a *member*.

Member Rights. You have the right to:

- Participate with your health care professionals and providers in making decisions about your health care;
- Receive the benefits for which you have coverage;
- Be treated with respect and dignity;
- Privacy of your personal health information, consistent with state and federal laws, and our policies;
- Receive information about our organization and services, our network of health care professionals and providers, and your rights and responsibilities;
- Candidly discuss with your *physicians* and providers appropriate or *medically necessary* care for your condition, regardless of cost or benefit coverage;
- Make recommendations regarding the organization's *members'* rights and responsibilities policies;
- Voice complaints or appeals about our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided;
- Refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by your *physician(s)* of the medical consequences;

- Participate in matters of the organization's policy and operations.

Member Responsibilities. To assist participating health care professionals and providers in meeting these responsibilities to you, it is your responsibility to:

- Choose a participating primary care *physician* if required by your health benefit plan;
- Treat all health care professionals and staff with courtesy and respect;
- Keep scheduled appointments with your doctor, and call the doctor's office if you have a delay or cancellation;
- Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it;
- Understand your health problems and participate, along with your health care professionals and providers in developing mutually agreed upon treatment goals to the degree possible;
- Supply, to the extent possible, information that we and/or your health care professionals and providers need in order to provide care;
- Follow the plans and instructions for care that you have agreed on with your health care professional and provider;
- Tell your health care professional and provider if you do not understand your treatment plan or what is expected of you;
- Follow all health benefit plan guidelines, provisions, policies and procedures;
- Let our Customer Service Department know if you have any changes to your name, address, or *family members* covered under your policy;
- Provide us with accurate and complete information needed to administer your health benefit plan, including other health benefit coverage and other insurance benefits you may have in addition to your coverage with us.

We are committed to providing quality benefits and customer service to our *members*. Benefits and coverage for services provided under the benefit program are governed by the entire Combined Evidence of Coverage and Disclosure (Evidence of Coverage) Form and the health plan contract and not by this Member Rights and Responsibilities statement.

RelayHealth. We have made arrangements with RelayHealth to provide an online health care information and communication program. This program will allow you to contact your *physician* on the internet if your *physician* is a participant in RelayHealth. To see if your *physician* is enrolled in the program, use the "Find Your Doctor" function on the website, www.relayhealth.com. Through this private, secure internet program, you can consult your *physician*, schedule appointments, and get lab results. You will only be required to pay a co-payment for consultations. This co-payment will be **$10** and must be paid by credit card. You will not be required to pay a co-payment when you request prescription refills, schedule appointments and get lab results.

The following medical groups participate in the RelayHealth (Web Visit) program:

- Alta Bates Medical Group
- Bristol Park Medical Management
- Children's Hospital Oakland
- Community Hospital of the Monterey Peninsula
- East Bay Women's Medical Group
- Eisenhower Medical Group

- Empire Physicians Medical Group
- Fremont Rideout Health Group
- Hill Physicians Medical Group
- Greater Newport Physicians
- John Muir Medical Group
- Marin IPA
- Menlo Medical Group IPA
- Muir Nextgen IPA
- Physician Associates of the Greater San Gabriel Valley
- Physician Medical Group of Santa Cruz
- San Diego State University - Student Health Services
- Santa Clara County Individual Practice Association/SCCIPA
- Santa Cruz PMG
- Stanford Family Medicine
- Stanford Freidenrich Breast Center
- Stanford Medical Group
- UCD Medical Group
- UCI Medical Center
- UCLA Medical Group
- UCSF Medical Center & Clinics

SUMMARY OF BENEFITS

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

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

For your convenience, this summary provides a brief outline of your benefits. You need to refer to the entire Combined Evidence of Coverage and Disclosure (Evidence of Coverage) Form for more complete information, and you must consult your employer's health plan contract with us to determine the exact terms and conditions of your coverage.

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.

IMPORTANT INFORMATION ABOUT YOUR MEDICAL BENEFITS

UTILIZATION REVIEW PROGRAM REQUIREMENTS -- Under your Out-of-Network Benefits, your *plan* has UTILIZATION REVIEW PROGRAM requirements. These are explained in the UTILIZATION REVIEW PROGRAM section beginning on page 66. **Your benefits may be reduced** if you do not follow the procedures outlined. If you have any questions about the UTILIZATION REVIEW PROGRAM requirements, call us at the toll-free number on your identification card.

EMERGENCY CARE -- If you are admitted to the hospital in an emergency or have experienced an emergency medical procedure, call Blue Cross immediately using the number on your ID card or call 888-209-7975.

Please read the section called USING YOUR NETWORK BENEFITS: EMERGENCY CARE (page 63) for important information about *emergency room* treatment and *emergency* admissions. Failure to follow this *plan's* procedures for such care may result in your benefits being denied or reduced.

For Out-of-Network *emergency* services, we must be notified within one working day of the admission or procedure, unless "extraordinary circumstances" prevent such notification within that time period. Please refer to the section entitled UTILIZATION REVIEW PROGRAM, beginning on page 66, for details

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

Please read the definition of "Emergency" in the DEFINITIONS section carefully. This definition will be strictly enforced.

DISPUTES/APPEALS -- The Agent for Service of Legal Process is Anthem Blue Cross. Provisions describing the process for member disputes, complaints, and requests for review of denied claims can be found in the booklet sections called "GRIEVANCE PROCEDURES" and "BINDING ARBITRATION. See pages 89 through 94 for details.

NETWORK MEDICAL BENEFITS

CO-PAYMENT LIST

The following is a list of the amounts for which you are responsible for each covered medical service or supply. See YOUR MEDICAL BENEFITS.

Hospital Services

- Inpatient services and supplies **$250**
- Operating room and special treatment room ..... **No charge**
- Intensive care ..... **No charge**
- Nursing care ..... **No charge**
- Blood, blood plasma, derivatives and factors ..... **No charge**
- Inpatient drugs, medications and oxygen ..... **No charge**
- Outpatient services (except emergency room) ..... **No charge**

Skilled Nursing Facility Services

- Skilled nursing care ..... **No charge**

Home Health Care

- Home health care visit ..... **No charge**

Outpatient Private Duty Nursing

- Private duty nursing care ..... **No charge**

Hospice

- Hospice care ..... **No charge**

Ambulatory Surgical Center

- Outpatient surgery ..... **No charge**

Physician

- Office visit (**no co-payment to age 7**) **$20**
- Visit to *member's* home (**no co-payment to age 7**) **$20**
- Speech therapy **$20**
- Specialists and consultants **$20**
- Inpatient visit ..... **No charge**
- Surgeon, including surgical assistant ..... **No charge**
- Administration of anesthesia ..... **No charge**
- Visit for Physical Therapy, Physical Medicine and Occupational Therapy **$20**
- Visit for Acupuncture Treatment or Chiropractic Care **$20***

*****These services are available on a self-referral basis through AMERICAN SPECIALTY HEALTH PROVIDER (ASHP) network only. Please see the "Chiropractic Care and Acupuncture Treatment Amendment" at the back of this booklet for specifics.

- Web Visit **$10****

****This service is available through **RelayHealth.** If your *physician* participates in the RelayHealth Program, you can contact your enrolled *physician* by internet to schedule appointments, obtain lab results and for consultations. Please refer to the section entitled INTRODUCTION TO BLUE CROSS PLUS for more information.

General Medical Care

- Ambulance ..... **No charge**
- Hemodialysis ..... **No charge**
- Hearing aids **50%**
- Durable medical equipment ..... **No charge**
- Medical social services ..... **No charge**
- Prosthetic & orthotic devices ..... **No charge**
- Chemotherapy and radiation therapy ..... **No charge**
- Diagnostic x-ray and laboratory procedures ..... **No charge**
- Allergy testing and treatment **$20**
- Diabetes education programs **$20**
- Organ and tissue transplants ..... **The applicable co-payment specified herein**

Urgent Care Services

- Professional services **$20**

Emergency Services

- Professional services ..... **No charge**
- Hospital emergency room **$75***
- Hospital inpatient services ..... **No charge**

***Exception:** The emergency room co-payment does not apply if you are admitted as a *hospital* inpatient immediately following emergency room treatment.

Pregnancy and Maternity Care

- Office visit (including therapeutic abortions) ..... **$20** (First visit only, no charge thereafter)
- Physician's services for normal delivery or cesarean section ..... **No charge**
- Hospital services (including therapeutic abortions):
  - Inpatient services **$250**
  - Outpatient services ..... **No charge**
- Birth Center services ..... **No charge**

- Genetic testing ..... **No charge**
- Elective abortions including Mifeprestone (abortion *drug*) when administered in the *physician's* office..... **$150**

Family Planning Services and Birth Control

- Family planning (counseling and consultation)..... **No charge**
- Tubal ligation..... **$150**
- Vasectomy **$75**

Preventive Care Services

- Routine physical examinations ordered by your *primary care physician* ..... **No Charge**
- Immunizations prescribed by your *primary care physician* ..... **No Charge**
- Routine x-ray and laboratory tests in connection with a routine physical examination ordered by your *primary care physician* ..... **No Charge**
- Medically accepted routine cancer screening tests ..... **No Charge**
- HIV testing..... **No Charge**
- Routine vision or hearing examinations..... **No Charge**
- Health education programs other than diabetes education..... **Selected programs at no charge**
- Preventive counseling and risk factor reduction intervention services related to tobacco use..... **No Charge**

MAXIMUM CO-PAYMENT LIMITS

Member..... **$1,500**

Family **$4,500***

*In the aggregate, but not more than **$1,500** for any one *member* in a family.

Exception: The following co-payments will not be applied to the Maximum Co-Payment Limits:

- Co-payments made for chiropractic and acupuncture services covered under the CHIROPRACTIC CARE AND ACUPUNCTURE TREATMENT AMENDMENT included with this booklet.

OUT-OF-NETWORK MEDICAL BENEFITS

DEDUCTIBLES

Calendar Year Deductibles

- Member Deductible..... **$500**
- Family Deductible..... **$1,500**
  in the aggregate, but not more than **$500** for any one *member* in a family

Non-Certification Deductible.....**$200**

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

– The Calendar Year Deductible will not apply to *physician's* services for routine examinations or to immunizations for a child under seven years of age.

– The Calendar Year Deductible will not apply to office visits to a *physician* who is a *PPO provider* if those visits are for pregnancy or maternity care. **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 *infertility* studies and tests. **Note:** Charges for *infertility* studies and tests performed by a *non-PPO provider* are NOT COVERED.

– The Calendar Year Deductible will not apply to office visits for covered *infertility* treatment services. **Note:** Charges for *infertility* treatment services by a *non-PPO provider* are NOT COVERED.

– The Calendar Year Deductible will not apply to transplant travel expenses authorized by us in connection with a specified transplant procedure provided at a designated *CME*.

– The Calendar Year Deductible will not apply to bariatric travel expense in connection with an authorized bariatric surgical procedure provided at a designated *CME*.

– The Non-Certification Deductible will not apply to *emergency* admissions, nor to the services provided by a *PPO provider*. See UTILIZATION REVIEW PROGRAM.

CO-PAYMENTS AND OUT-OF-POCKET AMOUNTS

Co-Payments. After you have met your Calendar Year Deductible, and any other applicable deductible, you will be responsible for **30%** of *covered expense* you incur PLUS any amount in excess of *covered expense* for services of *other health care providers* or *non-PPO providers*.

Exceptions:

– No Co-Payment will be required for routine examinations or immunizations for a child under seven years of age.

– Your Co-Payment will be **50%** for infertility studies and tests. **Note:** Charges for *infertility* studies and tests performed by a *non-PPO provider* are NOT COVERED.

– Your Co-Payment will be **$20** for each *physician* visit for covered *infertility* treatment services. **Note:** Charges for *infertility* treatment services by a *non-PPO provider* are NOT COVERED.

– Your Co-Payment for the following services will be **50%**, plus charges in excess of *covered expense:*

- Sterilization for males;
- Sterilization for females;
- Family planning (counseling and visit); and
- Hearing aids.

– Your Co-Payment will be **$75** for *emergency* room services and supplies. This Co-Payment will not apply if you are admitted as a *hospital* inpatient immediately following emergency room treatment.

– You are not required to make a Co-Payment for the following services. You may be responsible for charges that exceed *covered expense*.

a. *Emergency services* provided by a *hospital.* You may be responsible for charges which exceed *covered expense.*

b. Organ and tissue transplants authorized by us and performed at an approved transplant center. See UTILIZATION REVIEW PROGRAM.

c. "Specified" organ transplants (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures) authorized by us and performed at a designated *CME*. **Services for specified organ transplants are not covered when performed at other than a designated *CME*.** See UTILIZATION REVIEW PROGRAM.

NOTE: Co-Payments do not apply for the transplant travel expenses approved by us. Transplant travel expense is available when the closest *CME* is more than 250 miles from the recipient or donor's residence.

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

NOTE: Co-Payments do not apply for bariatric travel expenses approved by us. Bariatric travel expense is available when the closest *CME* is in excess of 50 miles from the *member's* residence.

Out-of-Pocket Amount. After you have made the following total out-of-pocket payments (including the Calendar Year Deductible) for *covered expense* incurred during a *calendar year,* you will no longer be required to pay a Co-Payment for the remainder of that *year,* but will remain responsible for costs in excess of *covered expense*.

- Member.....**$5,000**
- Family.....**$15,000** in the aggregate, but not more than **$5,000** for any one *member* in a family

***Exceptions:**

- You will be required to continue to pay your Co-Payment for the following services even after you have reached your Out-of-Pocket Amount. In addition, any Co-Payments you make for such services will not be applied toward reaching that amount.

– *Infertility* studies and tests;

- Office visits for covered *infertility* treatment services;
- Chiropractic and acupuncture services covered under the CHIROPRACTIC CARE AND ACUPUNCTURE TREATMENT AMENDMENT included with this booklet; and

- Co-Payments made for services covered through **United Behavioral Health**, your mental health care benefits carrier, will also be applied toward the satisfaction of your Out-of-Pocket Amount under this *plan.*
- Expense which is incurred for non-covered services or supplies, or which is in excess of the amount of *covered expense*, will not be applied toward your Out-of-Pocket Amount, and is always your responsibility.
- UTILIZATION REVIEW PROGRAM penalties will not be applied toward your Out-of-Pocket Amount and are always your responsibility.

MEDICAL BENEFIT MAXIMUMS

OUT-OF-NETWORK MEDICAL BENEFIT MAXIMUMS

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

Home Health Care*

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

***Pre-authorization applied.

Skilled Nursing Facility

- For covered *skilled nursing facility* care ..... **240 days**
  per *calendar year*

Infertility Treatment

- For covered artificial insemination services ..... **6 cycles**
  Per lifetime

*These services are NOT covered when provided by a *non-PPO provider*.

Transplant Travel Expense

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

– For other reasonable expenses
(excluding meals, tobacco, alcohol and drug expenses) .....up to **$25**
per day, for each person
for up to 21 days per trip

- For the Donor per Transplant Episode (limited to one trip per episode)

  – For transportation to the *CME* **$250**
  for round trip coach airfare

  – For hotel accommodations **$100**
  per day, for up to 7 days

  – For other reasonable expenses
  (excluding meals, tobacco, alcohol and drug expenses) .....up to **$25**
  per day, for up to 7 days

Bariatric Travel Expense

- For the *member* (limited to three (3) trips – one pre-surgical visit, the initial surgery and one follow-up visit)

  – For transportation to the *CME* ..... up to **$130**
  per trip

- For the companion (limited to two (2) trips – the initial surgery and one follow-up visit)

  – For transportation to the *CME* ..... up to **$130**
  per trip

- For the *member* and one companion (for the pre-surgical visit and the follow-up visit)

  Hotel accommodations ..... up to **$100**
  per day, for up to 2 days per trip,
  limited to one room,
  double occupancy

- For one companion (for the duration of the *member's* initial surgery stay)

  Hotel accommodations ..... up to **$100**
  per day, for up to 4 days,
  limited to one room,
  double occupancy

- For other reasonable expenses
  (excluding meals, tobacco, alcohol and drug expenses) .....up to **$25**
  per day, for up to 4 days per trip

Out-of-Network Lifetime Maximum

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

COMBINED NETWORK AND OUT-OF-NETWORK MEDICAL BENEFIT MAXIMUMS

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

Outpatient Private Duty Nursing

- For covered private duty nursing services ..... **$10,000** per *calendar year*

Hearing Aids

- For covered charges ..... **Two** hearing aids, every thirty-six (36) month period

IMPORTANT NOTE

Medical benefits while traveling out of the country will be reimbursed at the out-of-network benefit level. Members are responsible for 30% of the billed charges.

TRANSGENDER SURGERY BENEFITS

CO-PAYMENTS

The following is a list of the amounts for which you are responsible for each covered medical service or supply. If a co-payment is expressed as a percentage, it is a percentage of *covered expense*. Please see the section entitled YOUR MEDICAL BENEFITS: TRANSGENDER SURGERY BENEFITS for more details.

Hospital Services

- Inpatient services and supplies ..... **$250** per admission
- Operating room and special treatment room ..... **No charge**
- Intensive care ..... **No charge**
- Nursing care ..... **No charge**
- Blood, blood plasma, derivatives and factors ..... **No charge**
- Inpatient drugs, medications and oxygen ..... **No charge**
- Outpatient services (except emergency room) ..... **No charge**

Skilled Nursing Facility Services

- Skilled nursing care ..... **No charge**

Physician

- Office visit **$20**
- Visit to *member's* home **$20**
- Inpatient visit ..... **No charge**
- Surgeon, including surgical assistant ..... **No charge**
- Administration of anesthesia ..... **No charge**
- Rehabilitative care **$20**
- Visit to a *specialist* **$20**

MAXIMUMS

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

Skilled Nursing Facility

- For covered *skilled nursing facility* care ..... **240 days** per *calendar year*

Transgender Surgery Travel Expense

- For each surgical procedure (limited to 6 trips)
  - For transportation to the facility where the surgery is to be performed.....**$250** for round trip coach airfare
  - For hotel accommodations.....**$100** per day, for up to 21 days per trip, limited to one room, double occupancy
  - For expenses such as meals.....**$25** per day, for up to 21 days per trip

Transgender Surgery Lifetime Maximum.....**$75,000** during your lifetime

YOUR MEDICAL BENEFITS

NETWORK BENEFIT CO-PAYMENTS

While you are not required to make any payment for most supplies and services provided under the Network Benefit, you are required to pay a co-payment amount for certain services. It is customary to make the co-payment at the time services are rendered.

If you do not make required co-payments within 31 days from the date you are notified of payment due, your coverage may be cancelled.

The Network co-payments are listed in the SUMMARY OF BENEFITS: NETWORK BENEFITS.

MAXIMUM CO-PAYMENT LIMITS*

Member. If you pay co-payments during a *calendar year* equal to the Maximum Co-Payment Limit for a *member,* and you notify us as shown below, you will not be required to make any further co-payments for the remainder of the *calendar year* for that *member*.

Family. If the enrolled *members* of a family pay co-payments during a *calendar year* equal to the Maximum Co-Payment Limit shown for a family*,* not counting more than the Maximum Co-payment Limit that applies to a *member* for any individual *member* of the family, and you notify us as shown below, no further co-payment will be required from any *member* of that family for the remainder of that *year*.

The Maximum Co-Payment Limits are shown in the SUMMARY OF BENEFITS: NETWORK MEDICAL BENEFITS.

*****Any co-payments under the "Out-of-Network" benefits will not be applied toward the Maximum Co-Payment Limits.

OUT-OF-NETWORK BENEFITS: HOW COVERED EXPENSE IS DETERMINED

We will pay for *covered expense* you incur under your Out-of-Network benefits. A charge is incurred when the service or supply giving rise to the charge is rendered or received. *Covered expense* for medical benefits is based on a maximum charge for each covered service or supply that will be accepted by us for each different type of provider. It is not necessarily the amount a provider bills for the service.

PPO Providers and CME. The maximum *covered expense* for services provided by a *PPO provider* or *CME* will be the lesser of the billed charge or the *negotiated rate*. *PPO providers* and *CME* have agreed not to charge you more than the *negotiated rate* for covered services. When you choose a *PPO provider,* you will not be responsible for any amount in excess of the *negotiated rate*. If you receive an authorized, specified organ transplant at a *CME*, you will not be responsible for any amount in excess of the *CME negotiated rate* for the covered services of a *CME*.

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

Non-PPO Providers and Other Health Care Providers. The maximum *covered expense* for services provided by a *non-PPO provider* or *other health care provider* will always be the lesser of the billed charge or (1) for a *physician,* the *customary and reasonable charge* or (2) for other than a *physician,* the *reasonable charge*. You will be responsible for any billed charge which exceeds the *customary and reasonable charge* or the r*easonable charge*.

The maximum *covered expense* for *non-PPO providers* 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 *PPO provider*.

Exception: If Medicare is the primary payor, *covered expense* 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 *PPO provider* who accepts Medicare assignment, in excess of the approved amount as determined by Medicare; or
3. By a *physician* who is a *non-PPO provider* or *other health care provider* who accepts Medicare assignment, in excess of the lesser of maximum *covered expense* 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 *covered expense* stated above, or the limiting charge as determined by Medicare.

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

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

After we subtract any applicable deductible and your Co-Payment, we will pay benefits up to the amount of *covered expense,* 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 charges that are considered *covered expense* will apply toward satisfaction of any deductible.

Calendar Year Deductibles. Each *year* you will be responsible for satisfying the *member's* Calendar Year Deductible before we begin to pay benefits. If the *members* of an enrolled family pay deductible expense in a *year* equal to the Family Deductible, the Calendar Year Deductible for all family members will be considered to have been met. For the purposes of the Family Deductible, *covered expense* over an individual *member's* Calendar Year Deductible will not be counted toward the Family Deductible.

The Calendar Year Deductible will not include any Co-Payments you must pay in connection with services provided under your Network Benefits.

Non-Certification Deductible. Each time you are admitted to a *hospital* without properly obtaining certification, you are responsible for paying the Non-Certification Deductible. This deductible will not apply to an *emergency* admission, or to services provided at a *PPO provider*. Certification is explained in UTILIZATION REVIEW PROGRAM.

CO-PAYMENTS

After you have satisfied any applicable deductible, we will subtract your Out-of-Network Co-Payment from the amount of *covered expense* remaining. If your Out-of-Network Co-Payment is a percentage, we will apply the applicable percentage to the amount of *covered expense* remaining after any deductible has been met. This will determine the dollar amount of your Out-of-Network Co-Payment.

OUT-OF-POCKET AMOUNT

If the Out-of-Network Co-Payments you paid, together with the Calendar Year Deductible you satisfied, equal your Out-of-Pocket Amount per *member* during a *calendar year*, you will no longer be required to make Co-Payments for any *covered expense* you incur during the remainder of that *year,* other than for *covered expense* incurred for the following services:

- *Infertility* studies and tests.
- Office visits for covered *infertility* treatment services.
- Chiropractic and acupuncture services covered under the CHIROPRACTIC CARE AND ACUPUNCTURE TREATMENT AMENDMENT included with this booklet.

Notes:

- Utilization Review Program penalties and the services listed above will not be applied toward satisfaction of the Out-of-Pocket Amount.
- Co-Payments made for services covered through **United Behavioral Health**, your mental health care benefits carrier, will also be applied toward the satisfaction of your Out-of-Pocket Amount under this *plan*.

OUT-OF-NETWORK MEDICAL BENEFIT MAXIMUMS

We will not make benefit payments under your Out-of-Network in excess of any of the Out-of-Network Medical Benefit Maximums. After you have reached any Medical Benefit Maximum for your Out-of-Network Benefits, any further care must be obtained through your Blue Cross PLUS *medical group*. If you continue to receive care outside of the Blue Cross PLUS network after you have reached a maximum, you will be responsible for any expense incurred for such care.

COMBINED NETWORK AND OUT-OF-NETWORK MEDICAL BENEFIT MAXIMUMS

We will not make benefit payments under this *plan* in excess of any of the Combined Network and Out-of-Network Medical Benefit Maximums. After you have reached any of these Medical Benefit Maximums, you will be responsible for any expense incurred for such care.

CONDITIONS OF COVERAGE

The following conditions of coverage must be met for benefits to be provided under this *plan* for a medical service or supply.

1. You must receive this service or supply while you are covered under this *plan*.

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

3. The service or supply must be included in YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.

4. The service or supply must not be listed in YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS NOT COVERED. If the service or supply is partially excluded, then only benefits for the portion which is not excluded will be provided.

5. The service or supply must not exceed any of the maximum benefits or limitations of this *plan*. For covered services or supplies obtained from a PPO *provider,* expense incurred must not exceed the amount of *covered expense*.

   Limits are included under specific benefits and in the SUMMARY OF BENEFITS.

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 authorized by a *physician*. If care is obtained through the Network Benefits, all care must be authorized by your *primary care physician,* or *medical group* except as specifically stated in this booklet.

MEDICAL CARE THAT IS COVERED

NETWORK BENEFITS

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

Hospital

1. Inpatient services and supplies, provided by a *hospital*. Benefits will not be provided for charges in excess of the *hospital's* prevailing two-bed room rate, unless your *primary care physician* orders, and your *medical group* authorizes, a private room as *medically necessary*.

2. Services in *special care units*.

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

Professional Services

1. Services of a *physician,* including: (a) office visits for a covered illness, injury or condition; and (b) visits to the *member's* home within the *medical group* area, by a *primary care physician,* at that *physician's* discretion.

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

Diagnostic Services. Outpatient diagnostic radiology and laboratory services.

Hemodialysis Treatment. Hemodialysis treatment, including treatment in your home if authorized by your *medical group*.

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, has been ordered by a *physician* (M.D.) and a dentist (D.D.S. or D.M.D.), and is authorized by your *medical group*. *Hospital stays* for the purpose of administering general anesthesia are not considered necessary and are not covered except as specified in #2, below.

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

3. **Dental Injury.** Initial *emergency* care by 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.

Pregnancy and Maternity Care

1. All medical benefits when provided for pregnancy or maternity care, including the diagnosis of genetic disorders in cases of high-risk pregnancy. Inpatient *hospital* benefits in connection with childbirth will be provided for at least 48 hours following a normal delivery or 96 hours following a cesarean section, unless the mother and her *physician* decide on an earlier discharge.

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

Family Planning Services and Birth Control. Family planning services, counseling and planning for problems of fertility, as *medically necessary*.

Sexual Dysfunction. Treatment of sexual dysfunction when the dysfunction is due to physical abnormality, defect or disease. Treatment for a dysfunction which is the result of psychological causes is not covered.

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, provided the recipient is also an enrolled Anthem Blue Cross PLUS *member*.

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

Preventive Care Services.

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

2. Immunizations given as standard medical practice.

3. Routine x-ray and laboratory tests in connection with a routine physical examination when ordered by a *physician*.

4. All generally medically accepted cancer screening tests, including mammograms, pap tests, human papillomavirus (HPV) screening, prostate cancer screening, and colorectal cancer screening.

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

6. Routine vision or hearing examinations. This includes a vision check provided as part of a routine physical examination to determine if it is *medically necessary* for you to have a complete vision exam by a *specialist*. Hearing screenings include tests to diagnose and correct hearing problems.

7. Health education programs other than diabetes education provided by your *primary care physician* or *medical group*.

8. Preventive counseling and risk factor reduction intervention services in connection with tobacco use and tobacco use-related diseases.

Preventive care services are provided on an outpatient basis or in a *physician's* office. Physical exams, tests, and screenings are covered as *preventive care services* when you have no current symptoms or prior history of any medical condition associated with the service provided. 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*.

When provided by your *primary care physician* under your HMO benefits, no co-payment will apply to any *preventive care services*.

Breast Cancer. Services and supplies provided in connection with the screening for, diagnosis of, and treatment for breast cancer, including:

1. Routine and diagnostic mammogram examinations.
2. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.
3. Reconstructive surgery of both breasts performed to restore and achieve symmetry following a *medically necessary* mastectomy.
4. Breast prostheses following a mastectomy (see "Prosthetic Devices").

Growth Hormone Treatment. Growth hormone treatment when approved by your *primary care physician*.

Diabetes Education. A diabetes instruction program which: (1) is designed to teach a *member* who is a patient and covered members of the patient's family about the disease process and the daily management of diabetic therapy; (2) includes self-management training, education, and medical nutrition therapy to enable the *member* to properly use the equipment, supplies, and medications necessary to manage the disease; and (3) is supervised by a *physician*. Diabetes education services are covered under *plan* benefits for office visits to *physicians*.

OUT-OF-NETWORK BENEFITS

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

Hospital

1. Inpatient services and supplies, provided by a *hospital*. *Covered expense* will not include charges in excess of the *hospital's* prevailing two-bed room rate unless there is a negotiated per diem rate between us and the *hospital,* or unless your *physician* orders, and we authorize, a private room as *medically necessary*.
2. Services in *special care units*.
3. Outpatient services and supplies provided by a *hospital,* including outpatient surgery.

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); however, medication which is delivered but not administered is not covered;
2. Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications;
3. *Hospital* and home clinical visits related to the administration of infusion therapy, including skilled nursing services including those provided for: (a) patient or alternative caregiver training; and (b) visits to monitor the therapy;
4. Rental and purchase charges for durable medical equipment; maintenance and repair charges for such equipment;
5. Laboratory services to monitor the patient's response to therapy regimen.

Professional Services

1. Services of a *physician*.

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

Hemodialysis Treatment

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 a*mbulatory surgical center*. This applies only if (a) the *member* is less than seven years old, (b) the *member* is developmentally disabled, or (c) the *member's* health is compromised and general anesthesia is *medically necessary*. Charges for the dental procedure itself, including professional fees of a dentist, are not covered.

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

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.

Pregnancy and Maternity Care

1. All medical benefits when provided for pregnancy or maternity care, including diagnosis of genetic disorders in cases of high-risk pregnancy. Inpatient *hospital* benefits in connection with childbirth will be provided for at least 48 hours following a normal delivery or 96 hours following a cesarean section, unless the mother and her *physician* decide on an earlier discharge.

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

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

1. The recipient; or

2. The donor.

If you are the recipient, an organ or tissue donor who is not an enrolled *member* is also eligible for services as described. Benefits are reduced by any amounts paid or payable by that donor's own coverage. *Covered expense* for a donor, including donor testing and donor search, is limited to expense incurred for *medically necessary* medical services only. *Reasonable charges* for services incident to obtaining the transplanted material from a living donor or a human organ transplant bank will be covered. Such charges, including complications from the donor procedure for up to six weeks from the date of procurement, are covered. Services for treatment of a condition that is not directly related to, or a direct result of, the transplant are not covered.

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

Specified Transplants

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

Transplant Travel Expense. The following travel expenses in connection with an approved, specified organ transplant (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures) performed at a specific *CME* only when the recipient or donor's home is more than 250 miles from the specific *CME*, provided the expenses are approved by us in advance:

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

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

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

Bariatric Travel Expense. The following travel expense benefits will be provided in connection with a covered bariatric surgical procedure only when the *member's* home is fifty (50) miles or more from the nearest bariatric *CME.* All travel expenses must be approved by Anthem Blue Cross in advance. The fifty (50) mile radius around the *CME* will be determined by the *bariatric CME coverage area*. (See DEFINITIONS.)

- Transportation for the *member* to and from the *CME* up to **$130** per trip for a maximum of three (3) trips (one pre-surgical visit, the initial surgery and one follow-up visit).

- Transportation for one companion to and from the *CME* up to **$130** per trip for a maximum of two (2) trips (the initial surgery and one follow-up visit).

- Hotel accommodations for the *member* and one companion not to exceed **$100** per day for the pre-surgical visit and the follow-up visit, up to two (2) days per trip or as *medically necessary*. Limited to one room, double occupancy.

- Hotel accommodations for one companion not to exceed **$100** per day for the duration of the *member's* initial surgery stay, up to four (4) days. Limited to one room, double occupancy.

- Other reasonable expenses not to exceed **$25** per day, up to four (4) days per trip. Meals, tobacco, alcohol and drug expenses are excluded from coverage.

Customer service will confirm if the bariatric travel benefit is provided in connection with access to the selected bariatric *CME.* Details regarding reimbursement can be obtained by calling the customer service number on your I.D. card. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

Routine Gynecological Examinations for Females. *Physician's* gynecological examinations, once a *year*, including, when ordered by a *physician*:

- a breast examination;

- cervical cancer screening (including services and supplies provided in connection with the test to detect cervical cancer, including pap smears, human papillomavirus (HPV) screening, and any cervical cancer screening test approved by the federal Food and Drug Administration upon referral by your *physician*; and

- a mammogram.

Well Baby and Well Child Care (Dependent Children Under 19 Years of Age). The following services for a dependent *child* under 19 years of age:

1. *Physician's* services for routine physical examinations.

2. Immunizations given as standard medical practice for children.

3. Radiology and laboratory services in connection with routine physical examinations.

4. Screening for blood lead levels as prescribed by a *physician*.

6. Hearing examinations.

Preventive Care (Members Age 19 and Over). The following services for *members* age 19 years and over:

1. *Physician's* services for routine physical examinations.

2. Radiology and laboratory services in connection with routine physical examinations, including colorectal cancer screenings.

3. Immunizations.

4. Hearing examinations.

Prostate Cancer Screening. Services and supplies provided in connection with routine tests to detect prostate cancer.

Other Cancer Screening Tests. Services and supplies provided in connection with all generally medically accepted cancer screening tests.

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

Infertility Studies and Tests. The following services for diagnosis of *infertility*:

- Initial evaluation;
- Ultrasound of ovaries;
- Post-coital test;
- Hysterosalpingogram;
- Endometrial biopsy;
- Hysteroscopy; and
- Semen analysis for a male *member*.

NOTE: Charges for *infertility* studies and tests performed by a non-*PPO provider* are NOT COVERED.

Infertility Treatment. The following *infertility* services provided by a *physician* who is a *PPO provider:*

1. Ovulation induction with bloodwork and ultrasound associated with administration of medication, limited to six (6) cycles per lifetime.*
2. Artificial insemination (AID, AIH, IUI), limited to six (6) cycles per lifetime.*
3. Surgery (diagnostic or therapeutic).
4. Injectable *infertility* drugs administered at the *physician's* office. These include urofollitropin, menotropin, human chronic gonadotropin, progesterone when administered by a *physician* who is a PPO provider.

*Lifetime is defined to include services provided under any plan or any other health insurance or health maintenance organization plan or services that were not covered by any plan.

NOTE: Charges for *infertility* studies and tests performed by a non-*PPO provider* are NOT COVERED.

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.

NETWORK AND OUT-OF-NETWORK BENEFITS

Subject to the applicable Co-Payments and the Medical Benefit Maximum 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:

Skilled Nursing Facility. Inpatient services and supplies provided by a *skilled nursing facility*. Under your Network Benefits, benefits will not be provided for any amount exceeding the prevailing two-bed room rate of the *skilled nursing facility*. Under your Out-of-Network Benefits, the amount by which your room charge exceeds the prevailing two-bed room rate of the *skilled nursing facility* is not considered *covered expense*.

Skilled nursing facility services and supplies under your Out-of-Network Benefits are limited to 240 days per *calendar year* and are subject to prior authorization 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*.

Out-of-Network benefits are limited to 100 visits during a *calendar year*. A visit of four hours or less by a home health aide shall be considered as one home health visit.

Out-of-Network home health care services are subject to prior authorization to determine medical necessity. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

If you have a terminal illness, you have the option of electing Hospice Care benefits, which include professional services of an attending *physician*. An attending *physician* is one who is identified by you at the time you elect Hospice Care benefits as having the most significant role in the determination and delivery of your medical care. If you elect to receive Hospice Care, you must file an election statement with the *hospice*. You may revoke the election at any time. Election and revocation statements are available through the *hospice*.

Home health care services are not covered if received while you are receiving benefits under the "Hospice Care" or "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED.

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.

1. Interdisciplinary team care with the development and maintenance of an appropriate plan of care. Medical direction with the medical director also responsible for meeting your general medical needs to the extent they are not met by your *physician*.
2. Short-term inpatient *hospital* care when required in periods of crisis or as respite care. Coverage of inpatient respite care is provided on an occasional basis and is limited to a maximum of five consecutive days per admission.
3. Skilled nursing services provided by or under the supervision of a registered nurse. Certified home health aide services and homemaker services provided under the supervision of a registered nurse.
4. Social services and counseling services provided by a qualified social worker.
5. Dietary and nutritional guidance. Nutritional support such as intravenous feeding or hyperalimentation.
6. Physical therapy, occupational therapy, speech therapy, and respiratory therapy provided by a licensed therapist.

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

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

9. Bereavement services, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following the *subscriber's* or the *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.

Under your Network Benefits, you must be suffering from a terminal illness, as certified to your *medical group* by your *primary care physician* and submitted to us. Covered services are available on a 24-hour basis for the management of your condition. Your *primary care 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 your *medical group* every 30 days.

Under your Out-of-Network Benefits, you must be suffering from a terminal illness, as certified by your *physician* and submitted to us. Covered services are available on a 24-hour basis for the management of your condition. 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.

Outpatient Private Duty Nursing. We will pay up to **$10,000** per *calendar year* for private duty nursing services of a licensed nurse (R.N., L.P.N. or L.V.N.) for care of a non-hospitalized acute illness or injury. "Private duty" means a session of four or more hours that continuous nursing care is furnished to you alone.

Under your Network Benefits, outpatient private duty nursing care services must be authorized by your *primary care physician.*

Under your Out-of-Network Benefits, private duty nursing care services are subject to prior authorization to determine medical necessity. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

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

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

Ambulance. The following ambulance services:

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

2. Emergency services or transportation services that are provided to you by a licensed ambulance company as a result of a "911" emergency response system* request for assistance if you believe you have an *emergency* medical condition requiring such assistance.

3. Base charge, mileage and non-reusable supplies of a licensed air ambulance company to transport you from the area where you are first disabled to the nearest *hospital* where appropriate treatment is provided if, and only if, such services are *medically necessary* and ground ambulance service is inadequate.
4. Monitoring, electrocardiograms (EKGs; ECGs), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriately licensed person must render the services.

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

Diagnostic Services. Outpatient diagnostic radiology and laboratory services. NOTE: Radiology and laboratory tests performed in connection with a routine physical examination are not covered under your Out-of-Network benefits.

Radiation Therapy

Chemotherapy

Prosthetic and Orthotic Devices

1. Breast prostheses following a mastectomy.
2. *Prosthetic devices* to restore a method of speaking when required as a result of a covered *medically necessary* laryngectomy.
3. 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.

Colostomy supplies required to maintain *prosthetic devices*.

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 (but not disposable);
2. For the exclusive use of the patient;
3. Not primarily for comfort or hygiene;
4. Not for environmental control or for exercise; and
5. Manufactured specifically for medical use.

We will determine whether the item satisfies the conditions above.

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

1. Nebulizers, including face masks and tubing, inhaler spacers, and peak flow meters. These items are covered under the *plan's* medical benefits and are not subject to any limitations or maximums that apply to coverage for durable medical equipment (see "Durable Medical Equipment").

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

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.

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

1. The treatment provided in a clinical trial must either:

   a. Involve a *drug* that is exempt under federal regulations from a new drug application, or

   b. Be approved by (i) one of the National Institutes of Health, (ii) the federal Food and Drug Administration in the form of an investigational new drug application, (iii) the United States Department of Defense, or (iv) the United States Veteran's Administration.

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

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

   Under your Network benefits, if the clinical trial is not provided by or through your *medical group*, your *primary care physician* will refer you to the *physician* or health care provider who provides the clinical trial. Please see "Referral Care" under USING YOUR NETWORK BENEFITS for information about referrals. You will only have to pay your normal copayments for the services you get.

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

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

1. Typically provided absent a clinical trial.

2. Required solely for the provision of the investigational drug, item, device or service.

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

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

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

Routine patient care costs do not include any of the items listed below. You will be responsible for the costs associated with any of the following, in addition to the cost of non-covered services:

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

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

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

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

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

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

Disagreements regarding the coverage or medical necessity of possible clinical trial services may be subject to Independent Medical Review as described in GRIEVANCE PROCEDURES.

Allergy. Allergy testing and treatment.

Mastectomy. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema. Reconstructive surgery performed to restore symmetry following a *medically necessary* mastectomy.

Physical Therapy, Physical Medicine and Occupational Therapy. The following services provided by a *physician* under a treatment plan, including but not limited to:

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 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 unless such care is determined to be *medically necessary*. 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.

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

Outpatient Speech Therapy. Outpatient speech therapy following injury, illness or other medical condition as *medically necessary*.

Hearing Aid Services. The following hearing aid services are covered when provided by or purchased as a result of a written recommendation from an 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 the *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.

Covered charges under 2 and 3 above for hearing aids are limited to 2 hearing aids, every thirty-six (36) months.

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 and Orthotic Devices").

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 and Orthotic Devices").

2. Diabetes education services are covered under your Network Benefits (see "Diabetes Education" under MEDICAL CARE THAT IS COVERED: NETWORK BENEFITS).

3. The following items are covered as medical supplies:

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

    b. Testing strips, lancets, and alcohol swabs.

Special Food Products. Special food products and formulas that are part of a diet prescribed by a *physician* for the treatment of phenylketonuria (PKU). These items will be covered as medical supplies.

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

MEDICAL CARE THAT IS NOT COVERED

No benefits will be provided under this *plan* for services or supplies received 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.)

APPLICABLE TO NETWORK BENEFITS

Not Authorized. Any services not authorized by your *primary care physician* or your *medical group,* except as specifically stated in USING YOUR NETWORK BENEFITS: EMERGENCY CARE and URGENT CARE.

Services Provided by Non-Participating Providers. Any services provided by a *non-participating provider,* except for referral, *emergency services*, and *urgent care* as specifically stated in USING YOUR NETWORK BENEFITS: REFERRAL CARE, EMERGENCY CARE, URGENT CARE, and CARE OUTSIDE OF CALIFORNIA.

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.

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).

Sexual Dysfunction. Treatment of any sexual dysfunction except as stated in the "Sexual Dysfunction" provision of MEDICAL CARE THAT IS COVERED.

Infertility. *Infertility* studies and tests. Artificial insemination or in vitro fertilization procedures, and any related laboratory procedures. *Infertility* treatment.

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 unless the person has been authorized for such test in a *hospital* setting by the attending *primary care physician*.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a *hospital stay* primarily for environmental change or physical therapy unless, in the case of physical therapy, the person has been authorized for such therapy in a *hospital* setting by the attending *primary care physician*. *Custodial care* or rest cures, except as specifically provided under the "Hospice Care" provision of MEDICAL CARE THAT IS COVERED. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a *skilled nursing facility*, except as specifically stated in the "Skilled Nursing Facility" provision of MEDICAL CARE THAT IS COVERED.

Chronic Pain. Treatment of chronic pain, except as specifically provided under the “Hospice Care” provision of MEDICAL CARE THAT IS COVERED.

Routine Examinations. Routine physical or psychological examinations or tests required by employment or government authority, or at the request of a third party such as a school, camp or sport affiliated organization.

Any other routine physical or psychological examination or test which does not directly treat an actual illness, injury or condition, except as specifically stated in the “Preventive Care Services” provision of MEDICAL CARE THAT IS COVERED: HMO BENEFITS.

Immunizations. Immunizations for foreign travel. Immunizations, except as stated in the ”Preventive Care Services” provision of MEDICAL CARE THAT IS COVERED: HMO BENEFITS.

Spinal Manipulation. Services for manual manipulation of the spine to correct subluxation. These services are provided as described in the “Chiropractic Care and Acupuncture Treatment Amendment” at the end of this booklet.

Acupuncture Treatment. Acupuncture treatment is provided as described in the ”Chiropractic Care and Acupuncture Treatment Amendment” at the end of this booklet. 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.

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 your *primary medical group*.

APPLICABLE TO OUT-OF-NETWORK BENEFITS

Not Authorized. Services or supplies that are not authorized (See UTILIZATION REVIEW PROGRAM for details.

Excess Amounts. Any amounts in excess of *covered expense*.

Network Benefits. Services or supplies for which any benefits are authorized, provided and received under your Network Benefits, including any authorized services received for the treatment of an *emergency*. Services and supplies provided by your *primary care physician* or services provided through the Direct Access Program.

Excluded under Network. Services or supplies which are excluded under the Network Benefits, except to the extent that the services of a provider who is not a *participating provider* in the Blue Cross PLUS network are payable under Out-of-Network Benefits.

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.

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 unless the person has been authorized for such test in a *hospital* setting (see UTILIZATION REVIEW PROGRAM).

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a *home health agency, hospice* or *home infusion therapy provider* as specifically stated in the "Home Health Care", "Hospice Care", "Home Infusion Therapy", or "Physical Therapy, Physical Medicine And Occupational Therapy" provisions of MEDICAL CARE THAT IS COVERED.

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

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

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

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a *hospital stay* primarily for environmental change or physical therapy unless, in the case of physical therapy, the person has been authorized for such therapy in a *hospital* setting (see UTILIZATION REVIEW PROGRAM). *Custodial care* or rest cures, except as specifically provided under the "Hospice Care" provision of MEDICAL CARE THAT IS COVERED. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a *skilled nursing facility*, except as specifically stated in the "Skilled Nursing Facility" provision of MEDICAL CARE THAT IS COVERED.

Chronic Pain. Treatment of chronic pain, except as specifically provided under the “Hospice Care” provision of MEDICAL CARE THAT IS COVERED.

Education or Counseling. Any educational treatment or nutritional counseling, or any services that are educational, vocational, or training in nature except as specifically provided or arranged by us. Such services are provided under the "Home Infusion Therapy", "Pediatric Asthma Equipment and Supplies", or "Diabetes" provisions of MEDICAL CARE THAT IS COVERED. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

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.

Any other routine physical examination or test which does not directly treat an actual illness, injury or condition, except as specifically stated in the “Routine Gynecological Examinations for Females”, “Well Baby and Well Child Care”, “Preventive Care”, “Prostate Cancer Screening” or “Other Cancer Screening Tests” provisions of MEDICAL CARE THAT IS COVERED.

Infertility Treatment. In vitro fertilization procedures, and any related laboratory procedures. *Infertility* treatment, except as specifically stated in the "Infertility Treatment” provision of MEDICAL CARE THAT IS COVERED.

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).

Spinal Manipulation. Services for manual manipulation of the spine to correct subluxation.

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

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.

APPLICABLE TO NETWORK AND OUT-OF-NETWORK BENEFITS

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

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.

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 GRIEVANCE PROCEDURES.

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.

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

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

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

Government Treatment. Any services actually given to you by a local, state or federal government agency, or by a public school system or school district, except when payment under this *plan* is expressly required by federal or state law. We will not cover payment for these services if you are not required to pay for them or they are given to you for free.

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

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

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 *member* and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Mental Disorders. Academic or educational testing, counseling, and remediation. *Mental disorders* or *chemical dependency*, including rehabilitative care in relation to these conditions.

Note: Services for treatment of *mental or nervous disorders,* substance abuse and *severe mental disorders* are not covered under this *plan*. They are covered through United Behavioral Health (UBH), the supplemental coverage provided by your employer. The copays paid to UBH do go toward the satisfaction of the out-of-pocket maximum under this *plan*.

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

Outpatient Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specifically stated in the "Home Health Care" and "Prescription Drug for Abortion" provisions of MEDICAL CARE THAT IS COVERED. Non-prescription, over-the-counter patent drugs or medicines. Cosmetics, health or beauty aids.

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth, or treatment to the teeth or gums, except as specifically stated in the “Reconstructive Surgery”, "Dental Care" provision of MEDICAL CARE THAT IS COVERED. Cosmetic dental surgery or other dental services for beautification.

Optometric Services or Supplies. Optometric services, eye exercises, and orthoptics, except for eye examinations to determine the need for vision correction. Eyeglasses or contact lenses, except as specifically stated in the "Prosthetic and Orthotic Devices" provision of MEDICAL CARE THAT IS COVERED. Contact lens fitting.

Outpatient Speech Therapy. Outpatient speech therapy except as stated in the "Outpatient Speech Therapy" provision of MEDICAL CARE THAT IS COVERED.

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.

Sex Transformation. Any procedures to change characteristics of the body to those of the opposite sex except as stated under the TRANSGENDER SURGERY BENEFITS.

Sterilization Reversal. Reversal of sterilization.

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

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

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.

Food or Dietary Supplements. Nutritional and/or dietary supplements, 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 requirement either a written prescription or dispensing by a licensed pharmacist.

Transportation and Travel Expense. Expense incurred for transportation, except as specifically stated in the “Ambulance”, “Transplant Travel Expense” and “Bariatric Travel Expense” provisions of MEDICAL CARE THAT IS COVERED or under the section called TRANSGENDER SURGERY BENEFITS. Charges incurred in the purchase or modification of a motor vehicle. Charges incurred for child care, telephone calls, laundry, postage, or entertainment. Frequent flyer miles; coupons, vouchers or travel tickets; prepayments of deposits.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine.

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.

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

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

Private Duty Nursing. Inpatient services of a private duty nurse. Outpatient private duty nursing services except as specifically stated in “Outpatient Private Duty Nursing” provision under the section MEDICAL CARE THAT IS COVERED.

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

TRANSGENDER SURGERY BENEFITS

This *plan* provides benefits for many of the charges incurred by you or your *family member* for transgender surgery (also known as sex reassignment surgery). Not all charges are eligible and some are only eligible to a limited extent. Transgender surgery must be performed at a facility designated and approved by us for the type of transgender surgery requested and must be authorized prior to being performed. **Charges for services that are not authorized, or which are provided in a facility other than which we have designated and approved for the transgender surgery requested, will not be considered *covered expense*.** See UTILIZATION REVIEW PROGRAM for details.

If the conditions for coverage listed below are met, this *plan* will provide *medically necessary* benefits in connection with transgender surgery.

CONDITIONS FOR COVERAGE

1. The *member* is at least 18 years old;
2. The *member* has criteria for the diagnosis of "true" transsexualism*;
3. The *member* has completed a recognized program at a specialized gender identity treatment center; and
4. The services are authorized (See UTILIZATION REVIEW PROGRAM for details).

*The criteria and requirements are based on the guidelines stated in The Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders. These guidelines may be modified from time to time. For a copy of the current guidelines, contact the *group* or Anthem Customer Service at the phone number of your I.D. card

TRANSGENDER SURGERY CO-PAYMENTS AND MAXIMUMS

After we subtract any applicable Co-Payment, we will pay benefits up to the amount of *covered expense,* not to exceed any applicable Transgender Surgery Maximum. The Co-Payments and Maximums are set forth in the SUMMARY OF BENEFITS.

CO-PAYMENTS

We will subtract your Co-Payment from the amount of *covered expense* remaining.

If your Co-Payment is a percentage, we will apply the applicable percentage to the amount of *covered expense*. This will determine the dollar amount of your Co-Payment.

The Transgender surgery Benefit Co-Payments are set forth in the SUMMARY OF BENEFITS.

TRANSGENDER SURGERY BENEFIT MAXIMUM

We do not make benefit payments for any *member* in excess of the Transgender Surgery Lifetime Maximum. Your Transgender Surgery Lifetime Maximum under this *plan* will be reduced by any Transgender Surgery Benefits we paid to you or on your behalf under any other health plan provided by Anthem, or any of its affiliates, which is sponsored by the *group*.

TRANSGENDER SURGERY CARE THAT IS COVERED

Subject to the Transgender Surgery Lifetime Maximum shown in the SUMMARY OF BENEFITS, the requirements set forth under CONDITIONS OF COVERAGE and the exclusions or limitations listed under TRANSGENDER SURGERY CARE THAT IS NOT COVERED, we will provide benefits for the following services and supplies:

Hospital

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

2. Services in *special care units*.

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

Skilled Nursing Facility. Inpatient services and supplies provided by a *skilled nursing facility,* for up to 240 days. The amount by which your room charge exceeds the prevailing two-bed room rate of the *skilled nursing facility* is not considered *covered expense*.

Skilled nursing facility services and supplies are subject to prior authorization 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.).

Diagnostic Services. Outpatient diagnostic imaging and laboratory services.

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.

Transgender Surgery Travel Expense. The following travel expenses in connection with an authorized, transgender surgery performed at a facility which is designated by us and approved for the transgender surgery requested, provided the expenses are authorized by us (See UTILIZATION REVIEW PROGRAM for details.) for up to six trips:

a. Round trip coach airfare to the facility which is designated by us and approved for the transgender surgery requested, not to exceed **$250** per person per trip.

b. Hotel accommodations, not to exceed **$100** per day for up to 21 days per trip, limited to one room, double occupancy.

c. Other expenses, such as meals, not to exceed **$25** per day for each person, for up to 21 days per trip.

TRANSGENDER SURGERY CARE THAT IS NOT COVERED

No payment will be made under Transgender Surgery Benefit of 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.)

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

Not Authorized. Services or supplies that are not authorized (See UTILIZATION REVIEW PROGRAM for details).

Not Medically Necessary. Services or supplies that are not *medically necessary,* as defined. For the purposes of this Transgender Surgery Benefit, if you meet the Conditions of Coverage (TRANSGENDER SURGERY BENEFITS: CONDITIONS OF COVERAGE), and the services and supplies for your transgender surgery are authorized by us (See UTILIZATION REVIEW PROGRAM for details), this exclusion will not apply.

Excess Amounts. Any amounts in excess of *covered expense* or the Transgender Surgery Lifetime Maximum.

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 transgender surgery.

REIMBURSEMENT FOR ACTS OF THIRD PARTIES

Under some circumstances, a *member* 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.

For the purposes of the Network Benefits only, the provisions of our right of reimbursement are extended to your *medical group*.

USING YOUR NETWORK BENEFITS

The procedures outlined below describe how you can use your Network Benefits. Please note, your *primary care physician* or *medical group* are responsible for authorizing all the care you receive under your Network Benefits, except as specifically stated in this booklet. If you have questions, contact them or your *Anthem Blue Cross PLUS coordinator*.

PRIMARY CARE

Your *primary care physician* is responsible for providing you with primary, or general, medical care. You should consult with him or her first. Your *primary care physician,* and your *medical group,* are also responsible for authorizing referral care and *emergency* care.

You must first select a *primary care physician*. If you have not selected a *primary care physician,* the *medical group* will help you.

To make an appointment with your *primary care physician,* call your *medical group,* in advance, if possible. (If your *medical group* is an *independent practice association,* please call your *primary care physician* directly.)

When you call, identify yourself as an Anthem Blue Cross PLUS *member* and give the following information:

- Your name;
- Your certificate number and *group* number from your ID card (Bring your Anthem Blue Cross PLUS Identification Card when you come in for your appointment. If you do not have your ID card with you, you may be required to sign an Eligibility Certification form);
- A brief explanation of the reason for your visit.

To cancel or reschedule an appointment, please notify your *primary care physician* as far in advance as possible. Your call may allow the *physician* to provide needed medical attention to another person.

To obtain care after normal hours, see URGENT CARE or EMERGENCY CARE sections.

SECOND OPINIONS

Your *medical group* is responsible for arranging second opinions and specialty care with providers within or affiliated with your Anthem Blue Cross PLUS *medical group*. Working with your *medical group* supports and improves the coordination and quality of your medical care.

When you have seen a *specialist* to whom you were referred by your *primary care physician* (called a "group" *specialist*) and want a second opinion, you have the right to a second opinion by an appropriately qualified health care professional within the Anthem Blue Cross PLUS provider network. If there is no appropriately qualified health care professional within the network, we will authorize a second opinion by another appropriately qualified health care professional, taking into account your ability to travel.

Reasons for requesting a second opinion include but are not limited to:

- Questions about the reasonableness or necessity of recommended surgical procedures.
- Questions about the diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including but not limited to a serious chronic condition.
- The clinical indications are unclear or are complex and confusing.

- A diagnosis is in doubt because of conflicting test results.
- The first *physician* is unable to diagnose the condition.
- The treatment plan in progress is not improving your medical condition within an appropriate period of time.
- You have attempted to follow the treatment plan or you have consulted with the *specialist* regarding serious concerns about your diagnosis or plan of care.

To request a second opinion regarding recommendations by your *primary care physician*, call your *primary care physician* or your *Anthem Blue Cross PLUS coordinator* at your *medical group*.

To request a *specialist* second opinion outside your *medical group*, please call the Customer Service number shown on your ID card. The Customer Service Representative will verify your Anthem Blue Cross PLUS membership, obtain preliminary information, and give your request to an RN Case Manager.

A decision is made within five business days of receipt of the information necessary to make a decision. Decisions on urgent requests are made within a time frame appropriate to your medical condition and no later than the next business day.

When approved, your Case Manager assists you with selection of an Anthem Blue Cross PLUS *specialist* within a reasonable travel distance and makes arrangements for your appointment at a time convenient for you and appropriate to your medical condition. If your medical condition is serious, your appointment will be scheduled within no more than seventy-two (72) hours. Your Case Manager will work with you and your *medical group* to make sure the *specialist* has your medical records before your appointment. Except for your usual co-payment, we cover the *specialist's* fee.

An approval letter is sent to you and the *specialist*. The letter includes the services approved and the date of your scheduled appointment. It also includes a toll free number to call your Case Manager if you have questions or need additional assistance. Approval is for the second opinion consultation only. It does not include any other services such as lab, x-ray, or treatment by the *specialist*. You and your *primary care physician* receive a copy of the *specialist's* report, which includes any recommended diagnostic testing or procedures. When you receive the report, you and your *primary care physician* or group *specialist* should work together to determine your treatment options and develop a treatment plan. Your *medical group* must authorize all follow-up care.

Only our *physician* Medical Director may decide when we will not cover the fees for a *specialist* you choose. This may happen when you choose a *specialist* who is not part of the Anthem Blue Cross PLUS network and the same kind of *specialist* is available within the network. If your request is not approved, your letter will include the names of the *specialists* that can be approved.

You may appeal a disapproval decision by following our grievance procedures. Grievance procedures are described later in this booklet (see GRIEVANCE PROCEDURES) and in your denial letter.

If you have questions or need additional information about this program, please contact your *Anthem Blue Cross PLUS coordinator* at your *medical group* or call the Customer Service number shown on your ID card. You may also obtain a second opinion through your Out-of-Network benefits

HOSPITAL STAYS

Your *medical group* or we will review any request by your *primary care physician* that you be admitted to a *hospital* on a non-emergency (elective) basis. If the admission is authorized, you will be directed to a *participating provider hospital*.

For information about *emergency* admissions, see EMERGENCY CARE.

REFERRAL CARE

If your *primary care physician* determines that you need care which he or she cannot provide, he or she will arrange to send you to the type of provider who can furnish that care. In most cases, the provider to whom you are referred will be a member of your *medical group* or will have an arrangement with your *medical group* to provide needed care to its patients.

Your *primary care physician* will give you a completed form which authorizes specific treatment or services.

Take this form to the health care provider you have been referred to. That provider will fill in the appropriate parts and will send it back to your *medical group*.

This form is necessary to coordinate payment for referral services. If you do not receive such a form, please ask your *primary care physician* or *Anthem Blue Cross PLUS coordinator* for it. Please note, only formal referral forms are acceptable. If you receive a prescription pad paper or other casual referral, request an acceptable form.

You should not be billed for referral services. If you mistakenly receive the bill, send it to your Anthem Blue Cross PLUS Coordinator who will see that the appropriate payment is made.

Referrals are made at the sole and absolute discretion of your *primary care physician* and your *medical group*. Payment will only be made for the number of visits and the medical care specifically authorized by your *primary care physician*. Contact your *primary care physician* before obtaining any additional care. **You are responsible for paying for services received but not authorized by your Primary Care Physician.**

EMERGENCY CARE

Please read the definition of "Emergency" in the DEFINITIONS section carefully. This definition will be strictly enforced.

If you need *emergency* care, you should seek medical treatment immediately. You are encouraged to use the 911 emergency response system in areas where it is established and operating if you have an *emergency* medical condition that requires an emergency response.

In Area Emergencies. If you need *emergency* treatment, and you are within 20 miles of your *medical group* (or 20 miles of your *medical group's enrollment area hospital,* if your *medical group* is an *independent practice association*), you should seek medical treatment immediately on your own. You should request your treating provider to contact your *primary care physician* or *medical group* as soon as possible to request *medically necessary* continued care. When your *primary care physician* or *medical group* is contacted, the *physician* will either authorize continued care or will take over your care.

You may choose to call your *primary care physician* or *medical group* first. *Physicians* are available 24 hours a day, seven days a week. If you do, you will be given instructions, which may include the following:

- Your *primary care physician* or *medical group* may ask you to come to the *medical group's* offices;
- Your *primary care physician* or *medical group* may give you the name of a nearby *hospital,* and tell you to go to the emergency room. Any authorized services you receive from that *hospital* will be billed directly to us (remember to bring your Anthem Blue Cross PLUS ID card);
- The *primary care physician* or *medical group* may order an ambulance to take you to a specified *hospital;* or

- Your *primary care physician* or *medical group* may give you the name of another *medical group,* and ask you to go to that group's offices.

But if you think the condition is really serious and a threat to your health, do not delay seeking care.

Out of Area Emergencies. If you need *emergency* treatment and you are more than 20 miles from your *medical group* (or your *medical group's enrollment area hospital* if you are enrolled in an *independent practice association*), you must contact us within 48 hours if you are admitted to the *hospital,* unless extraordinary circumstances (see below) prevent such notification. If your condition requires a *hospital stay* or long-term care we will monitor your progress, and when your condition is stable, facilitate your transfer to your *medical group's enrollment area*.

Non-Participating Providers. If a *physician,* or other type of health care provider not connected with Anthem Blue Cross PLUS provides treatment because of the need for *emergency care,* you will be responsible for any applicable co-payment.

Non-Covered Services. Coverage will not be provided for the following unauthorized emergency care:

- Services which do not meet our definition of "Emergency Services" (see DEFINITIONS); and
- Continuing or *follow-up care* not provided by your *medical group* after your condition has stabilized (unless otherwise authorized).

Once authorization for emergency services is given, it may not be withdrawn by the *medical group*.

URGENT CARE

We provide coverage for *medically necessary* care provided by *non-participating providers* to prevent serious deterioration of your health resulting from an unforeseen illness or injury when you are more than 20 miles from your *medical group* (or your *medical group's enrollment area hospital* if you are enrolled in an *independent practice association)*, and seeking health services cannot be delayed until you return.

If you need *urgent care*, you should seek medical treatment immediately. If you are admitted to a *hospital* for urgently needed care, you should contact us within 48 hours, unless extraordinary circumstances* prevent such notification. Follow-up care will be covered when the care required continues to meet our definition of "Urgent Care" (see DEFINITIONS).

Routine or elective services not authorized by your *primary care physician* and provided by *non-participating providers* are not covered.

CARE OUTSIDE OF CALIFORNIA

We provide *medically necessary* care (follow-up care, *urgent care* and *emergency services*) in many regions of the United States for *members* traveling outside California.

If you are traveling outside of California, and need outpatient care due to an unexpected illness or injury (or follow-up care for an illness or injury) which does not qualify as an *emergency* or as *urgent care*, call the BlueCard Access 800 number, 1-800-810-BLUE (2583).

The BlueCard Access Call Center will give you the names, locations, and telephone numbers of nearby *hospitals* and *physicians* you may call for an appointment.

If your condition is an *emergency*, or if you need *urgent care*, you should seek medical treatment immediately. You, a member of your family or your treating *physician* should contact us as soon as possible after receiving initial *emergency* or *urgent care* services so that we can provide case management.

You may be billed by the health care provider for these services. You should forward these bills to us for processing. We will review all claims to confirm that the services provided were for *emergency care* or *urgent care*.

To obtain Out-of-Network *PPO provider* services while you are outside California, please see the "Out-of-California Providers" provision in the GENERAL PROVISIONS section of this booklet.

EXTRAORDINARY CIRCUMSTANCES

If extraordinary circumstances are present during an *emergency* or when you require *urgent care*, you must notify us as soon as reasonably possible following initial treatment for that condition so we can provide case management.

UTILIZATION REVIEW PROGRAM

The Utilization Review Program described in this section applies to services as specified in this section that are covered under your Out-of-Network benefits.

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.

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

UTILIZATION REVIEW REQUIREMENTS

Utilization reviews are conducted for the following services:

- All inpatient *hospital stays* covered under your Out-of-Network benefits.
- The following services under your Out-of-Network benefits:
    1. Organ and tissue transplants.
    2. Home health care.
    3. Admissions to a *skilled nursing facility*.
    4. Bariatric surgical services performed at a *Centers of Medical Excellence* facility.
    5. Outpatient private duty nursing care services.
    6. Transgender surgical services.

Exceptions: Utilization 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.

The stages of utilization review are:

1. **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 following services:

- Scheduled, non-emergency inpatient *hospital stays* (except inpatient *stays* for maternity care or mastectomy and lymph node dissection).
- Organ and tissue transplants.
- Home health care.
- Admissions to a *skilled nursing facility*.
- Bariatric surgical services performed at a *Centers of Medical Excellence* facility.
- Outpatient private duty nursing care services.
- Transgender surgery services.

Concurrent 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.

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

EFFECT ON BENEFITS

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

1. The appropriate utilization reviews must be performed in accordance with this *plan*. When pre-service review is not performed as required for an inpatient *hospital stay*, the benefits to which you would have been otherwise entitled will be subject to the Non-Certification Deductible shown in the SUMMARY OF BENEFITS.
2. When pre-service review is performed and the admission, procedure or service is determined to be *medically necessary* and appropriate, benefits will be provided for the following:
    - Organ and tissue transplants as follows:
        a. For kidney, bone, skin or cornea transplants if the *physicians* on the surgical team and the facility in which the transplant is to take place are approved for the transplant requested.
        b. For transplantation of liver, heart, heart-lung, lung, kidney-pancreas or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures if the providers of the related preoperative and postoperative services are approved and the transplant will be performed at a *Centers of Medical Excellence (CME)* facility.
    - Home health care services if:
        a. The services can be safely provided in your home, as certified by your attending *physician*;
        b. Your attending *physician* manages and directs your medical care at home; and
        c. Your attending *physician* has established a definitive treatment plan which must be consistent with your medical needs and lists the services to be provided by the *home health agency*.
    - Services provided in a *skilled nursing facility* if you require daily skilled nursing or rehabilitation, as certified by your attending *physician*.

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

  a. The services are to be performed for the treatment of morbid obesity.

  b. The *physicians* on the surgical team and the facility in which the surgical procedure is to take place are approved for the surgical procedure requested; and

  c. The bariatric surgical procedure will be performed at a *Centers of Medical Excellence (CME)* facility.

- Outpatient private duty nursing care services will be provided only if the following criteria are met:

  a. The services are *medically necessary* and appropriate and can be safely provided in the *member's* home, as certified by the attending *physician*.

  b. The attending *physician* manages and directs the *member's* medical care at home.

  c. The attending *physician* must establish a definitive treatment plan which must be consistent with the *member's* medical needs and must list the services to be provided by the licensed nurse (R.N., L.P.N. or L.V.N.).

- Transgender surgery services and related covered services will be provided as follows:

  a. The Surgical Procedure:

     i. You meet the Conditions for Coverage listed for the Transgender Surgery Benefits;

     ii. The services are *medically necessary* and appropriate*;* and

     iii. The *physicians* on the surgical team and the facility in which the surgery is to take place are approved for the transgender surgery requested.

  b. Transgender Surgery Travel Expense:

     i. It is for transgender surgery and related services, authorized by us; and

     ii. The transgender surgery must be performed at a specific facility designated by us which is approved for the transgender surgery requested.

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

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

HOW TO OBTAIN UTILIZATION REVIEWS

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

Pre-service Reviews. Penalties will result for failure to obtain required 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 three working days prior to when you are scheduled to receive services.

2. You must tell your *physician* that this *plan* requires pre-service review. *Physicians* who are *PPO providers* or *participating providers* will initiate the review on your behalf. A non-*PPO provider* or *non-participating provider* may initiate the review for you, or you may call us directly. The toll-free number for pre-service review is printed on your identification card.

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

4. We will determine if services are *medically necessary* and appropriate. For inpatient *hospital stays*, we will, if appropriate, specify a specific length of *stay* for services. You, your *physician* and the provider of the service will receive a written confirmation showing this information.

Concurrent Reviews

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

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

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

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

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

Retrospective Reviews

1. Retrospective review is performed when we are not notified of the service you received, and are therefore unable to perform the appropriate review prior to your discharge from the *hospital* or completion of outpatient treatment. It is also performed when pre-service or concurrent 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 concurrent review was performed.

2. Such services which have been retroactively determined to not be *medically necessary* and appropriate will be retrospectively denied certification. If it is retroactively determined that benefits are not certifiable, the non-certification deductible will apply. (See SUMMARY OF BENEFITS: OUT-OF-NETWORK MEDICAL BENEFITS.)

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 5 business days from receipt of the information reasonably necessary to make the decision, and based on the nature of your medical condition.

2. A decision on the medical necessity of a concurrent 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, concurrent 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. A written confirmation including the specific service determined to be *medically necessary* will be sent to you and your provider no later than 2 business days after the decision, and your provider will be initially notified by telephone within 24 hours of the decision for pre-service and concurrent 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 *agreement* 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;* 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 by your health care professionals. This may include providing benefits not otherwise covered under this plan. A case manager will review your medical records and discuss your treatment with the attending *physician,* you and your family.

We make treatment recommendations only; any decision regarding treatment belong to you and your *physician*. The *group* will not 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 *member,* which alternatives may be offered and the terms of the offer.

2. Our 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 *member*.

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 *member*.

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.

COORDINATION OF BENEFITS

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

DEFINITIONS

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

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

Benefit Reserve. A Benefit Reserve, if any, for a *calendar year* is created for a *member* under This Plan when a *member* is covered by more than one plan and This Plan is not the Principal Plan based on this Coordination of Benefits (COB) provision. The Benefit Reserve is the amount saved by the plan that is not the Principal Plan for the benefit of the *member*.

The following criteria are used to create a Benefit Reserve:

1. 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.
2. The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if you were covered only under This Plan.
3. If This Plan is the Principal Plan, the benefits under This Plan will be determined without taking into account the benefits or services of any Other Plan. When This Plan is the Principal Plan, nothing will be applied to This Plan's Benefit Reserve.

Benefit Reserves for a *member* are not carried forward from one *year* to the next. At the end of each *calendar year*, the Benefit Reserve for a *member* returns to zero and a new Benefit Reserve is created for the next *calendar year*.

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.

EFFECT OF THE BENEFIT RESERVE ON PLAN BENEFITS

The Benefit Reserve provisions will apply if This Plan is not the Principal Plan and the benefits under This Plan and any Other Plan exceed the Allowable Expense for the *calendar year*.

The Benefit Reserve is determined by subtracting the amount the Principal Plan paid from the amount This Plan would have paid had it been the Principal Plan.

When This Plan is not the Principal Plan, the amounts saved, determined on a claim-by-claim basis, are recorded as a benefit reserve and are used to pay Allowable Expenses, not otherwise paid, that are incurred by the *member* during the *calendar year*.

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 provides benefits before a plan which has a Coordination of Benefits provision. This includes Medicare in all cases except when the law requires that This Plan pays before Medicare.
2. A plan which covers you as a *subscriber* pays before a plan which covers you as a dependent. But if you are a Medicare beneficiary, covered as a retired *subscriber* under this *plan*, and also covered as a dependent of an employee with current employment status under another plan, this rule will change. According to Medicare's rules, Medicare pays after a plan that covers you as a dependent (the "active" plan) but before the plan that covers you as a *subscriber* (the "retired" plan). This means the plan that covers you as a dependent will pay before the plan that covers you as a *subscriber*.

   For example: You are covered as a retired *subscriber* under this plan and a Medicare beneficiary (Medicare would pay first, this plan would pay second). You are also covered as a dependent of an active employee under another plan provided by an employer group of 20 or more employees (then, according to Medicare's rules, Medicare would pay second). In this situation, the plan which covers you as a dependent of an active employee will pay first and the plan which covers you as a retired *subscriber* will pay last, after Medicare.
3. For a dependent *child* covered under plans of two parents, the plan of the parent whose birthday falls earlier in the *calendar year* provides benefits before the plan of the parent whose birthday falls later in the *calendar year*. However, 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 provides benefits 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 provided 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 provides benefits first.

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

5. The plan covering the *member* under a continuation of coverage provision in accordance with state or federal law pays after a plan covering the *member* 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 provides benefits 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 the benefits provided under This Plan exceed the maximum amount necessary to satisfy the intent of this provision, the *medical group* and we have the right to recover that excess amount from any persons or organizations to or for whom those payments were made, or from any insurance company or service plan.

BENEFITS FOR MEDICARE ELIGIBLE MEMBERS

UNDER THE NETWORK BENEFITS

For Members Age 65 or More Who Are Eligible for Medicare. If you are age 65 or more, eligible for Part A of Medicare, and are otherwise eligible and enrolled for coverage under this *plan*, you will receive the benefits of this *plan,* without regard to Medicare. But if you have elected Medicare as your primary benefit program, you shall not be entitled to any benefits under this *plan*.

For Other Members Who Are Eligible for Medicare. If you are entitled to Medicare because:

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 current employment status as determined by Medicare rules, and are enrolled under this *plan* through a *group* of 100 or more employees (according to federal OBRA legislation);

Medicare is your primary health plan. You will get the benefits of this *plan* if and only if you have actually enrolled in Medicare and completed any consents, assignments, releases, and other documents needed to get Medicare repayments for this *plan* or its *medical groups*. This applies to services covered by those parts of Medicare that you can enroll in without paying any premium. If you must pay any premium for any part of Medicare, this applies to that part of Medicare only if you are enrolled in that part.

If you are enrolled in Medicare, your Medicare coverage will not affect the services provided or covered under this *plan* except as follows:

1. Medicare must provide benefits first for 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*, that are not prepaid by us, 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 services you received that are covered both by Medicare and under this *plan*, that are prepaid by us, we make no additional payment.

4. For any given claim, the combination of benefits provided by Medicare and the benefits provided under this *plan* will not be more than what is considered allowable expense for the covered services.

UNDER THE OUT-OF-NETWORK BENEFITS

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

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

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

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 *covered expense* for the covered services.

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

Electronic Claims Coordination

If you are covered by Medicare, call us at the Blue Cross Customer Service unit at 1 (888) 209-7975 and tell us your Medicare number. We will load it to the Blue Cross membership system, which will permit us to electronically receive your Medicare EOB. This will allow us to generate your UC benefit without you having to submit a claim to us.

EXTENSION OF BENEFITS

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

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

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

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

    a. You are no longer totally disabled.

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

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

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

HIPAA COVERAGE AND CONVERSION

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

HIPAA Coverage

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

1. You must have a minimum of 18 months of continuous health coverage, most recently under an employer-sponsored health plan, and have had coverage within the last 63 days.
2. Your most recent coverage was not terminated due to nonpayment of subscription charges or fraud.
3. If continuation of coverage under the employer *plan* was available under COBRA, CalCOBRA, or a similar state program including Senior COBRA, such coverage must have been elected and exhausted.
4. You must not be eligible for Medicare, Medi-Cal, or any group medical coverage and cannot have other medical coverage.

You must apply for HIPAA coverage within 63 days of the date your coverage under the employer's *plan* ends. Any carrier or health plan that offers individual medical coverage must make HIPAA coverage available to qualified persons without regard to health status. If you decide to enroll in HIPAA coverage, you will no longer qualify for conversion coverage.

Conversion Coverage

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

1. You are not eligible if your coverage under this *plan* ends because the *agreement* between the *group* and us terminates and is replaced by another group plan within 15 days.
2. You are not eligible if your coverage under this *plan* ends because subscription charges are not paid when due because you (or the *subscriber* who enrolled you as a dependent) did not contribute your part, if any.
3. You are not eligible for a conversion plan if you are eligible for health coverage under another group plan when your coverage ends.
4. You are not eligible for a conversion plan if you are eligible for Medicare coverage when your coverage under this *plan* ends, whether or not you have actually enrolled in Medicare.
5. You are not eligible for a conversion plan if you are covered under an individual health plan.
6. You are not eligible for a conversion plan if you were not covered for medical benefits under the *plan* for three consecutive months immediately prior to the termination of your coverage.

   The three-month period of coverage requirement does not apply to a *member* who has been covered under another UC plan then switches to this *plan* during Open Enrollment and needs to convert prior to being covered for three consecutive months under this *plan*.

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

Important: The intention of conversion coverage is not to replace the coverage you have under this *plan,* but to make available to you a specified amount of coverage for medical benefits until you can find a replacement. The conversion plan provides lesser benefits than this *plan* and the provisions and rates differ.

When coverage under your employer's group *plan* ends, you will receive more information about how to apply for HIPAA coverage or conversion, including a postcard for requesting an application and a telephone number to call if you have any questions.

CERTIFICATION OF CREDITABLE COVERAGE

In accordance with the statutory requirements of the Health Insurance Portability and Accountability Act of 1996 and Section 1357.51 of the California Health and Safety Code, we will provide certifications of periods of creditable coverage for *members* whose coverage under the *plan* terminates.

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.

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. *Medical groups, 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* or *PPO providers*.

Out-of-California Providers –

In-Network Benefits Only. We can provide you with *medically necessary* care (follow-up care, *urgent care* and *emergency services*) while you are outside of California. For more information about this arrangement, see CARE OUTSIDE OF CALIFORNIA.

Both In-Network and Out-of-Network Medical Benefits. The Blue Cross and Blue Shield Association, of which we are a member, has a program (called the "BlueCard Program") which allows our *members* to have the reciprocal use of participating providers contracted under other states' Blue Cross and/or Blue Shield Licensees. If you are outside of California and require medical care or treatment, you may use a local Blue Cross and/or Blue Shield provider. If you use one of these providers, your out-of-pocket expenses may be lower than those incurred when using a provider that does not participate in the BlueCard Program. The rules for the BlueCard Program, including those described below, are set by The Blue Cross and Blue Shield Association. In order for you to receive access to whatever discounts may be available, we must abide by those rules.

When you obtain covered health care services through the BlueCard Program outside of California, your co-payment for such services, if it is not a flat dollar amount, is usually calculated on the lower of the:

- Billed charges for your covered services, or
- Negotiated price that the on-site Blue Cross and/or Blue Shield Licensee ("Host Blue") passes on to us.

Often, the "negotiated price," referred to above, will consist of a simple discount, which reflects the actual price paid by the Host Blue. But, sometimes it is an estimated price that factors in expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect **average** expected savings with your health care provider or with a specified group of providers. If the negotiated price reflects average expected savings, it may result in greater variation (more or less) from the actual price paid than will the estimated price. The estimated or average price may be adjusted in the future to correct for over- or underestimation of past prices. Regardless of how the negotiated price is determined, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating *member* liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate *member* liability calculation methods that differ from the usual BlueCard Program method noted above in the second paragraph of this section, or require a surcharge, we would then calculate your co-payment for any covered health care services using the methods outlined by the applicable state statute in effect at the time you received your care.

Providers available to you through the BlueCard Program have not entered into contracts with Anthem Blue Cross. 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 *agreement,* both the *agreement* and your coverage under the *agreement* 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 *agreement* is subject to amendment, modification or termination according to the provisions of the *agreement* without your consent or concurrence.

Medical Group Termination

1. You must live or work within the *enrollment area* of your *medical group*. If you change your permanent residence or employment location, and your new residence or employment location is not within the *enrollment area* of your current *medical group*, your coverage at that *medical group* ends as of the date of your move. You must request a transfer to another *medical group*, by calling the Customer Service number shown on your ID card or by properly filing a membership change form with the *group* within 31 days of your move.

   The change in your *medical group* will take effect on the first day of the month following the date we receive the request.

2. If you fail to establish a satisfactory member-provider relationship (as set forth below), you may be terminated at your *medical group*.

3. If you fail to pay the required co-payment within 31 days of the date the provider bills you or otherwise requests payment, your coverage will be cancelled at that *medical group*.

4. Additional reasons for which you could be terminated at a *medical group* include: abusive behavior; acting in a disruptive manner; providing incorrect, or materially incomplete, information; or initiating arbitration or other legal action against the *medical group*.

If you are terminated at your *medical group*, you may be allowed to choose another *medical group* within the *enrollment area* in which you live or work. Whether or not you will be allowed to enroll at another *medical group* will be at our sole and absolute discretion.

In addition, if you move outside the Blue Cross PLUS service area, you will not be eligible for Blue Cross PLUS.

Member-Provider Relationship. You may refuse to accept procedures or treatments by your *medical group's primary care physician*. Your *physician* may regard this action as incompatible with continuing the doctor-patient relationship and the providing of proper medical care.

If you refuse to follow a recommended treatment or procedure, and the *physician* believes that no professionally acceptable alternative exists, we will give you written notice of that fact. If you continue to refuse to follow the recommended treatment or procedure, your coverage will be cancelled. Neither the *medical group, hospitals,* nor any *physician* associated with us will have any further responsibility to provide care.

We retain the right to transfer a *member* to another *medical group* if the *member*-provider relationship has deteriorated to the point that the *medical group* does not feel it can render health care objectively and in the best interest of the *member*.

Protection of Coverage. We do not have the right to cancel your coverage under this *plan* while:

1. This *plan* is in effect; and
2. You are eligible; and
3. Your subscription charges are paid according to the terms of the *agreement;* and
4. You live or work within the *medical group enrollment area;* and
5. With respect to your Network benefits, you accept procedures or treatments by the *primary care physician* and *medical group* staff and maintain a satisfactory doctor-patient relationship within the *medical group;* and
6. With respect to your Network benefits, you pay all co-payments due, within 31 days of notification of amounts due.

Unfair Termination of Coverage. Your coverage may not be terminated because of your health status or requirements for health care services. If you believe that your coverage has been terminated for either of these reasons, you may request a review of the matter by the Director of the Department of Managed Health Care.

Transition Assistance for New *Members*: Transition Assistance is a process that allows for completion of covered services for new *members* receiving services from a *medical group* or *physician* that does not have a Blue Cross PLUS Provider Agreement or Prudent Buyer Plan Participating Provider Agreement in effect with us. If you are a new *member*, you may request Transition Assistance if any one of the following conditions applies:

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 Blue Cross in consultation with you and the *non-participating provider* (under your Network benefits) or *non-PPO provider* (under your Out-of-Network benefits) and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time you enroll with Blue Cross.
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 time the *child* enrolls with Blue Cross.
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 time you enroll with Blue Cross.

Please contact customer service at the telephone number listed on your ID card to request Transition Assistance or to obtain a copy of the written policy. Eligibility is based on your clinical condition and is not determined by diagnostic classifications. Transition Assistance 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 Transition Assistance is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the *plan*. Financial arrangements with *non-participating providers* (under your Network benefits) and *non-PPO providers* (under your Out-of-Network benefits) are negotiated on a case-by-case basis. We will request that the *non-participating provider* (under your Out-of-Network benefits) or *non-PPO provider* (under your Out-of-Network benefits) agree to accept reimbursement and contractual requirements that apply to *PPO providers*, including payment terms. If the *non-participating provider* or *non-PPO provider* does not agree to accept said reimbursement and contractual requirements, we are not required to continue that provider's services. If you do not meet the criteria for Transition Assistance, you are afforded due process including having a *physician* review the request.

Continuity of Care after Termination of Provider: Subject to the terms and conditions set forth below, Blue Cross will provide benefits for covered services (subject to applicable copayments, coinsurance, deductibles and other terms) at the level for (a) *participating providers* (under your Network benefits) for services received from a *medical group* at the time the *medical group's* contract with us terminates or (b) *PPO providers* (under your Out-of-Network benefits) for services received from a *physician* at the time the *physician's* contract with us terminates (unless the *medical group's* or *physician's* contract terminates for reasons of medical disciplinary cause or reason, fraud, or other criminal activity).

You must be under the care of the *medical group* or *physician* at the time the contract terminates. The terminated *medical group* or *physician* must agree in writing to provide services to you in accordance with the terms and conditions of the agreement with Blue Cross prior to termination. The *medical group* or *physician* must also agree in writing to accept the terms and reimbursement rates that apply to *PPO providers*. If the *medical group* or *physician* does not agree with these contractual terms and conditions, we are not required to continue the *medical group's* or *physician's* services beyond the contract termination date.

Blue Cross will provide such benefits for the completion of covered services by a terminated *medical group* or *physician* 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 Blue Cross in consultation with you and the terminated *medical group* or *physician* and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the date the *medical group's* or *physician'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 *medical group's* or *physician'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 *medical group's* or *physician's* contract terminates.

Such benefits will not apply to *medical groups* or *physicians* who have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity.

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 the *member's* 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 *medical groups* and *physicians* are negotiated on a case-by-case basis. We will request that the terminated *medical group* or *physician* agree to accept reimbursement and contractual requirements that apply to *PPO providers*, including payment terms. If the terminated *medical group* or *physician* does not agree to accept these 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 grievance with us by following the procedures described in the section entitled GRIEVANCE PROCEDURES.

This provision also applies if the contractual or employment relationship between your *medical group* or us and the *primary care physician* or *specialist* from whom you are receiving care terminates. In this situation, please request continuity of care through your *Anthem Blue Cross PLUS coordinator*.

Provider Reimbursement. For medical services provided under your Network benefits, participating *medical groups* are generally paid a capitation fee, a set and agreed to dollar amount per *member* each month, for medical services. Participating *medical groups* may also receive additional reimbursement for certain types of specialty care or for overall efficiency. *Medical groups* may also receive additional compensation related to the management of services and referrals. The terms of these arrangements may vary by *medical group*. *Hospitals* and other health care facilities are paid negotiated fixed fees or on the basis of a negotiated discount from their standard fee-for-service rates. For additional information you may contact us at the telephone number listed on your identification card or your *medical group*.

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

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

Medical Necessity. The benefits of this *plan* are provided only for services that are considered to be *medically necessary*. The services must be ordered by the *primary care physician* for the direct care and treatment of a covered condition except as specifically stated in this booklet. They must be standard medical practice where received for the condition being treated and must be legal in the

United States. The process used to authorize or deny health care services under this *plan* is available to you upon request.

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

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

Notice of Claim. If the submission of a claim form is required to receive benefits under this *plan,* you or the provider of service must send properly and fully completed claim forms to us within 90 days of the date you receive the service or supply for which a claim is made. Services received and charges for the services must be itemized, and clearly and accurately described. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed. We are not liable for the benefits of the *agreement* if you do not file claims within the required time period. Claim forms must be used; cancelled checks or receipts are not acceptable.

Payment to Providers. We will pay the benefits of this *plan* directly to PPO *providers, CMEs* and medical transportation providers. We will pay non-contracting hospitals and other providers of service directly when *emergency* services and care are provided to you or one of your *family members*. We will continue such direct payment until the *emergency* care results in stabilization. Also, we will pay other providers of service directly when you assign benefits in writing. If you are a Medi-Cal beneficiary and you assign benefits in writing to the State Department of Health Services, we will pay the benefits of this *plan* to the State Department of Health Services. These payments will fulfill our obligation to you for those covered services.

Right of Recovery. If the amount we paid exceeds the amount for which we are liable under this *plan,* or the reasonable cash value of benefits provided under this *plan* exceed the maximum amount for which we are liable, the *medical group* and Anthem Blue Cross have the right to recover the excess amount. This amount may be recovered from you, the person to whom payment was made or from any other plan.

Plan Administrator. In no event will we be plan administrator for the purposes of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA). 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 *agreement* does not affect any requirement for coverage by workers' compensation insurance. It also does not replace that insurance.

Prepayment Fees. Your employer is responsible for paying subscription charges to us for all coverage provided to you and your *family members*. Your employer may require that you contribute all or part of the costs of these subscription charges. Please consult your employer for details.

Liability of Subscriber to Pay Providers. In accordance with California law, you will not be required to pay any *participating provider* or *PPO provider* any amounts we owe to that provider (not including co-payments or deductibles), even in the unlikely event that we fail to pay that provider. You may be liable to pay *non-PPO providers* or *other health care providers* any amounts not paid to them by us. You are, however, liable for services which are not covered by this *plan*.

Renewal Provisions. Your employer's health plan agreement with us is subject to renewal at certain intervals. We may change the subscription charges or other terms of the *plan* from time to time.

Public Policy Participation. We have established a Public Policy Committee (that we call our Consumer Relations Committee) to advise our Board of Directors. This Committee advises the

Board about how to assure the comfort, dignity, and convenience of the people we cover. The Committee consists of members covered by our health plan, participating providers and a member of our Board of Directors. The Committee may review our financial information and information about the nature, volume, and resolution of the complaints we receive. The Consumer Relations Committee reports directly to our Board.

Financial Arrangements with Providers. Blue Cross 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 *subscribers* and *members*/insured persons entitled to health care benefits under individual certificates and group policies or contracts to which Blue Cross or an affiliate is a party, including all persons covered under the *agreement*.

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

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, may be based on aggregate payments made by Blue Cross or an affiliate in respect to all health care services rendered to all persons who have coverage through a program provided or administered by Blue Cross 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 Blue Cross or an affiliate in determining its fees or subscription charges or premiums.

Confidentiality and Release of Medical Information. We will use reasonable efforts, and take the same care to preserve the confidentiality of the *member's* medical information. We may use data collected in the course of providing services hereunder for statistical evaluation and research. If such data is ever released to a third party, it shall be released only in aggregate statistical form without identifying the *member*. Medical information may be released only with the written consent of the *member* or as required by law. It must be signed, dated and must specify the nature of the information and to which persons and organizations it may be disclosed. *Members* may access their own medical records.

We may release your medical information to professional peer review organizations and to the *group* for purposes of reporting claims experience or conducting an audit of our operations, provided the information disclosed is reasonably necessary for the *group* to conduct the review or audit.

A statement describing our policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request.

Medical Policy and Technology Assessment. Anthem Blue Cross reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria is used to determine the investigational status or medical necessity of new technology. Guidance and external validation of Anthem Blue Cross' medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 physicians from various medical specialties including Anthem Blue Cross' medical directors, physicians in academic medicine and physicians in private practice. Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to *medical necessity* criteria used to determine whether a procedure, service, supply or equipment is covered.

GRIEVANCE PROCEDURES

Network Benefits

1. If you have questions or inquiries regarding services under this *plan*, contact your *Anthem Blue Cross PLUS coordinator* at your *medical group* or Anthem Blue Cross Customer Service at the number printed on your ID card.

   If you are dissatisfied and wish to file a grievance, you may request a "Member Issue Form" from your *medical group* or Anthem Blue Cross. Complete the form and send it to us, or you may call Customer Service and ask the customer service representative to complete the form for you. You may also submit a grievance to us online or print the Member Issue Form through the Anthem Blue Cross website at **www.anthem.com/uc**. You must include all pertinent information from your Anthem Blue Cross PLUS Identification Card and the details and circumstances of your concern or problem. You must submit your grievance to us no later than 180 days following the date you receive a denial notice from us or your *medical group* or any other action or incident with which you are dissatisfied. Your issue will then become part of our formal grievance process and will be resolved accordingly. If your condition is acute or urgent, you have the right to request an expedited review of an appeal for service which has been denied by your *medical group*. Expedited appeals must be resolved within three days.

2. To request a review, you may telephone us at the telephone number listed on your I.D. card, or you may write to us at the following address:

   Anthem Blue Cross PLUS
   Grievance and Appeal Management
   P.O. Box 4310
   Woodland Hills, CA 91367

   You must document the circumstances surrounding your grievance/appeal, and submit this information along with any medical documents, including bills or records. After we have reviewed your grievance/appeal we will send you a written statement on its resolution within 30 days. If your case involves an imminent threat to your health, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, review of your grievance/appeal will be expedited and resolved within three days.

3. For issues pertaining to *medical necessity* or appropriateness of service, you or your appointed representative has the option of appearing in person before the committee reviewing your appeal. If you request to appear in person, a meeting will be scheduled with you or your representative. You also have the option of a telephone conference with the committee if you are unable to appear in person.

Out-of-Network Benefits

If you have a question or complaint regarding your Out-of-Network benefits, such as your eligibility, your benefits under this *plan*, or concerning a claim, please call the telephone number listed on your identification card, or you may write to us (please address your correspondence to Anthem Blue Cross, 21555 Oxnard Street, Woodland Hills, CA 91367 marked to the attention of the Customer Service Department listed on your identification card). Our customer service staff will answer your questions or assist you in resolving your issue.

If you are not satisfied with the resolution based on your initial inquiry, you may request a copy of the Plan Grievance Form from the customer service representative. You may complete and return the form to us, or ask the customer service representative to complete the form for you over the telephone. You may also submit a grievance to us online or print the Plan Grievance Form through the Anthem Blue Cross website at **www.anthem.com/uc**. You must submit your grievance to us no later than 180 days following the date you receive a denial notice from us or any other incident or action with which you are dissatisfied. Your issue will then become part of our formal grievance

process and will be resolved accordingly. All grievances received by us will be acknowledged in writing, together with a description of how we propose to resolve the grievance.

Resolving Your Grievance (Network and Out-of-Network Benefits)

If you are dissatisfied with the resolution of your issue, or if your grievance has not been resolved after at least 30 days, you also have the option of submitting your grievance to the California Department of Managed Health Care for review. If your case involves an imminent threat to your health, as described above, you are not required to complete our grievance/appeal process or to wait at least 30 days, but may immediately submit your grievance to the Department of Managed Health Care for review. You may at any time request binding arbitration (see BINDING ARBITRATION).

Independent Medical Review of Denials of Experimental or Investigative Treatment

If coverage for a proposed treatment is denied because we or your *medical group* 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 Department of Managed Health Care ("DMHC"). Your request for this review may be submitted to the DMHC. 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. You will receive 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 one of the following addresses:

- If we deny the proposed treatment, send your request to us at Anthem Blue Cross, 21555 Oxnard Street, Woodland Hills, CA 91367.
- If proposed treatment is denied by your *medical group*, send your request to us at Anthem Blue Cross PLUS Grievance and Appeals Management, P.O. Box 4310, Woodland Hills, CA 91367.

To qualify for this review, all of the following conditions must be met:

- You have a life-threatening or seriously debilitating condition, described as follows:
    - ♦ A life-threatening condition is a condition or disease where the likelihood of death is high unless the course of the disease is interrupted or a condition or disease with a potentially fatal outcome where the end point of clinical intervention is the patient's survival.
    - ♦ A seriously debilitating condition is a disease or condition that causes major, irreversible morbidity.
- Your *medical group* or *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* or *PPO 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 must request this review within six months of the date you receive a denial notice 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 DMHC for good cause.

Within three business days of receiving notice from the DMHC 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 *medical group* or *PPO provider*. Any newly developed or discovered relevant medical records identified by us or by a *participating provider* or *PPO 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 *medical group* 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.

Please note: If you have a terminal illness (an incurable or irreversible condition that has a high probability of causing death within one year or less) and proposed treatment is denied because the treatment is determined to be *experimental*, you may also meet with our review committee to discuss your case as part of the grievance process (see GRIEVANCE PROCEDURES).

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 Department of Managed Health Care ("DMHC") if you believe that we or your *medical group* 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 or your *medical group*, 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 DMHC will review your application for IMR to confirm that:

1. One or more of the following conditions has been met:

   (a) Your provider has recommended a health care service as *medically necessary*,

   (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 or your *medical group*, 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 or your *medical group* 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 DMHC 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 or your *medical group* 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 DMHC 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 the health care service.

For non-urgent cases, the IMR organization designated by the DMHC 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.

Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at the **telephone number listed on your identification card** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-HMO-**

2219) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's Internet Web site (**http://www.hmohelp.ca.gov**) has complaint forms, IMR applications forms and instructions online.

BINDING ARBITRATION

THIS PROVISION DOES NOT APPLY TO CLASS ACTIONS

ALL DISPUTES INLCUDING, BUT NOT LIMITED TO, DISPUTES RELATING TO THE DELIVERY OF SERVICES UNDER THE *PLAN* OR ANY OTHER ISSUES RELATED TO THE *PLAN* AND CLAIMS OF MEDICAL MALPRACTICE MUST BE RESOLVED BY BINDING ARBITRATION IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. California Health & Safety Code section 1363.1 requires specific disclosures in this regard including the following notice: "It is understood that any dispute as to medical malpractice, that is, whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, acknowledge that they are giving up their constitutional right to have any and all disputes, including medical malpractice claims, decided in a court of law before a jury, and instead are accepting the use of arbitration." THE *MEMBER* AND ANTHEM AGREE TO BE BOUND BY THIS BINDING ARBITRATION PROVISION AND ACKNOWLEDGE THAT THE RIGHT TO A JURY TRIAL IS WAIVED FOR BOTH DISPUTES RELATING TO THE DELIVERY OF SERVICES UNDER THE *PLAN* OR ANY OTHER ISSUES RELATED TO THE *PLAN* AND MEDICAL MALPRACTICE CLAIMS.

The Federal Arbitration Act will 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 will apply.

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

The arbitration is initiated by the *member* making written demand on Anthem. 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 *member* and Anthem, or by order of the court, if the *member* and Anthem 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 will assume all or a portion of the costs of the arbitration.

Please send all Binding Arbitration demands in writing to Anthem Blue Cross, 21555 Oxnard Street, Woodland Hills, CA 91367 marked to the attention of the Customer Service Department listed on your identification card.

DEFINITIONS

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

Agreement is the Group Benefit Agreement issued by Anthem Blue Cross to the *group*.

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.

Anthem Blue Cross (Anthem) is a health care service plan, regulated by the California Department of Managed Health Care.

Anthem Blue Cross PLUS coordinator means the representative of your *medical group* who will help you with your Anthem Blue Cross PLUS benefits, and provide any information you may need about Anthem Blue Cross PLUS services and procedures.

Anthem Blue Cross PLUS hospital is a *hospital* which has a Blue Cross PLUS Provider Agreement in effect at the time services are rendered.

Authorized referral occurs when you, because of your medical needs, are referred to a *non-PPO provider* for medical care under your Out-of-Network Benefits, but only when:

1. There is no *PPO provider* or *participating provider* who practices in the appropriate specialty, provides the required services, or which has the necessary facilities within 15 miles of, or 30 minutes normal travel time from, your residence or place of work;

2. You are referred in writing to the *non-PPO provider* or *non-participating provider* by a *physician* who is a *PPO provider* or *participating provider;* and

3. The referral has been authorized by us 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-PPO provider* or *non-participating provider*.

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

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

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

Child meets the *plan's* eligibility requirements for children outlined in the UNIVERSITY OF CALIFORNIA ELIGIBILITY, ENROLLMENT, TERMINATION AND PLAN ADMINISTRATION PROVISIONS insert attached to this booklet.

Covered expense is the expense you incur for a covered service or supply, but not more than the maximum amounts described in YOUR MEDICAL BENEFITS: OUT-OF-NETWORK BENEFITS: HOW COVERED EXPENSE IS DETERMINED. Expense is incurred on the date you receive the service or supply.

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, administration of medicine which is usually self-administered or any other care which does not require continuing services of medical personnel.

Customary and reasonable charge, as determined annually by us, is a charge which falls within the common range of fees billed by a majority of *physicians* for a procedure in a given geographic region. If it exceeds that range, the expense must be justified based on the complexity or severity of treatment for a specific case.

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

Emergency is a sudden, serious, and unexpected acute illness, injury, medical or psychiatric condition (including without limitation sudden and unexpected severe pain) which the *member* reasonably perceives, could permanently endanger health if medical treatment is not received immediately. Medical emergency includes being in active labor when there is inadequate time for a safe transfer to another *hospital* prior to delivery, or when such a transfer would pose a threat to the health and safety of the *member* or her unborn *child*. Final determination as to whether services were rendered in connection with an emergency will rest solely with us or your *medical group*.

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

Employee meets the *plan's* eligibility requirements for active employees outlined in the UNIVERSITY OF CALIFORNIA ELIGIBILITY, ENROLLMENT, TERMINATION AND PLAN ADMINISTRATION PROVISIONS insert attached to this booklet.

Enrollment area is the geographical area within a 30-mile radius of the *medical group* selected by the *subscriber*.

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

Family member meets the *plan's* eligibility requirements for family members as outlined in the UNIVERSITY OF CALIFORNIA ELIGIBILITY, ENROLLMENT, TERMINATION AND PLAN ADMINISTRATION PROVISIONS insert attached to this booklet.

Follow-up care is care which is provided to the *member* following *emergency services*.

Group refers to the business entity to which we have issued this *agreement*. The name of the group is UNIVERSITY OF CALIFORNIA.

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

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

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

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

Independent practice association is a *medical group,* incorporated as a medical partnership, corporation or association of *physicians* who practice in private offices, and are usually organized around a *hospital* with which they are associated.

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.

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

Medical group is a group of *physicians,* organized as a legal entity, which has an Anthem Blue Cross PLUS Provider Agreement in effect with us at the time services are rendered.

Medically necessary procedures, supplies, services or equipment are those that Anthem Blue Cross determines 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, equipment, service or supply are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and
    b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
    c. For *hospital stays*, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received by you as an outpatient or in a less intensified medical setting.

Member is the *subscriber* or *family member*. A member may enroll under only one health plan provided by Anthem, or any of its affiliates, which is sponsored by the *group*.

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

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

Negotiated rate is the amount PPO *providers* agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by Prudent Buyer Plan Participating Provider Agreements. Note: If Medicare is the primary payor, the negotiated rate may be determined by Medicare’s approved amount (see HOW COVERED EXPENSE IS DETERMINED)

Non-participating providers are licensed health care providers which are not *participating providers*. They do not have an Anthem Blue Cross PLUS Provider Agreement in effect with us at the time services are rendered.

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

1. A *hospital;*
2. A *physician;*
3. An *ambulatory surgical center;*
4. A *home health agency;*
5. A facility which provides diagnostic imaging services;
6. A durable medical equipment outlet;
7. A *skilled nursing facility*;
8. A clinical laboratory; or
9. A *home infusion therapy provider*.

Other health care provider is one of the following providers:

1. A certified registered nurse anesthetist;
2. A blood bank;
3. A licensed ambulance company; or
4. A *hospice*.

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

Participating providers are licensed health care providers which have an Anthem Blue Cross PLUS Provider Agreement in effect with us at the time services are rendered.

Physician means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided, or
2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license and such license is required to render that service, is providing a service for which benefits are specified in this booklet, and when benefits would be provided if the services were provided by a physician as defined in 1 above:

    a. A dentist (D.D.S. or D.M.D.)
    b. An optometrist (O.D.)
    c. A dispensing optician
    d. A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
    e. A licensed clinical psychologist
    f. A chiropractor (D.C.)
    g. An acupuncturist (A.C.)
    h. A licensed clinical social worker (L.C.S.W.)
    i. A marriage and family therapist (M.F.T.)
    j. A physical therapist (P.T. or R.P.T.)*
    k. A speech pathologist*
    l. An audiologist*
    m. An occupational therapist (O.T.R.)*
    n. A respiratory care practitioner (R.C.P.)*
    o. A *psychiatric mental health nurse**
    p. A nurse midwife**
    q. A nurse practitioner
    r. A physician assistant
    s. A registered dietitian (R.D.)* for the provision of diabetic medical nutrition therapy only

Note: (1) With respect to Network benefits, the providers listed in 2 above are covered when such providers are available within the selected *medical group*, or by referral of the *primary care physician* if not available within the selected *medical group*; and (2) with respect to Out-of-Network benefits, the providers indicated by asterisks (*)are covered only by referral of a physician as defined in 1 above.

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

Plan is the set of benefits described in this booklet and in the amendments to this booklet (if any). This plan is subject to the terms and conditions of the *agreement* issued to the *group* by us. (If any

changes are made to the plan, an amendment or a revised booklet will be issued to the *group* for distribution to each *subscriber* affected by the change.)

PPO provider is one of the following providers which has a Prudent Buyer Plan Participating Provider Agreement in effect with us at the time services are rendered:

1. A *hospital;*
2. A *physician;*
3. An *ambulatory surgical center;*
4. A *home health agency;*
5. A facility which provides diagnostic imaging services;
6. A durable medical equipment outlet;
7. A *skilled nursing facility*;
8. A clinical laboratory; or
9. A *home infusion therapy provider*.

PPO providers agree to accept the *negotiated rate* as payment for covered services. A directory of *PPO providers* is available upon request.

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

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

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

http://www.healthcare.gov/center/regulations/prevention.html

http://www.ahrq.gov/clinic/uspstfix.htm

http://www.cdc.gov/vaccines/recs/acip/

Primary care physician is a *physician* who is a member of the *medical group* the *subscriber* has chosen to provide health care. Primary care physicians include general and family practitioners, internists and pediatricians and such other *specialists* as we may approve to be designated primary care physicians.

Primary medical group is a *medical group,* staffed by a team of *physicians,* nurses, and other health professionals, and organized as a group medical practice.

Prior Plan is a plan sponsored by the *group* which was replaced by this *plan* within 60 days. A member is considered covered under the prior plan if that member: (1) was 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.

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

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

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

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

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

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

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

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

Specialist is a *physician* who is not a general practitioner, internist, family practitioner, pediatrician, gynecologist, or obstetrician.

Spouse meets the *plan's* eligibility requirements for spouses outlined in the UNIVERSITY OF CALIFORNIA ELIGIBILITY, ENROLLMENT, TERMINATION AND PLAN ADMINISTRATION PROVISIONS insert attached to this booklet.

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

Subscriber is the person who, by meeting the *plan's* eligibility requirements for subscribers, is allowed to choose membership under this *plan* for himself or herself and his or her eligible *family members*. Such requirements are outlined in the UNIVERSITY OF CALIFORNIA ELIGIBILITY, ENROLLMENT, TERMINATION AND PLAN ADMINISTRATION PROVISIONS insert attached to this booklet.

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

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

Urgent care is the services received for a sudden, serious, or unexpected illness, injury or condition including pregnancy, for which treatment cannot be delayed until the *member* returns to the *plan's* service area, which requires immediate care for the relief of severe pain or diagnosis and treatment of such condition. “Urgent care,” includes maternity services necessary to prevent serious deterioration of the health of the *member's* fetus, based on her reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the she returns to the *plan's* service area.

We (us, our) refers to Anthem Blue Cross.

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 *subscribers* and *family members* who are enrolled for benefits under this *plan*.

CHIROPRACTIC CARE AND ACUPUNCTURE TREATMENT AMENDMENT

Anthem agrees to modify your Network Benefits under your Anthem Blue Cross PLUS Combined Evidence of Coverage and Disclosure (Evidence of Coverage) Form by this amendment. All other provisions of the Network Benefits under your Anthem Blue Cross PLUS Evidence of Coverage Form that are not inconsistent with this amendment remain in effect.

The benefits described in this amendment are provided through a Health Care Services Agreement between Anthem and the American Specialty Health Plans (ASHP). **The services described in this amendment are covered only if provided by an ASHP Chiropractor and/or ASHP Acupuncturist.**

These benefits are provided in addition to the benefits described in the "Physical Therapy, Physical Medicine and Occupational Therapy: provision in YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED: NETWORK AND OUT-OF-NETWORK BENEFITS section of your Blue Cross PLUS Evidence of Coverage Form. **However, when expenses are incurred for treatment received from an ASHP Chiropractor, no other benefits other than the benefits described in this amendment will be paid.**

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 SECTIONS OF YOUR BLUE CROSS PLUS EVIDENCE OF COVERAGE FORM, AND IN THIS AMENDMENT, ENTITLED DEFINITIONS.

SUMMARY OF BENEFITS

CO-PAYMENTS

- For each office visit **$20**

HOW TO USE YOUR CHIROPRACTIC AND ACUPUNCTURE CARE BENEFITS

The Initial Examination. You must make an appointment with an *ASHP chiropractor* or *ASHP acupuncturist* for an initial examination of your condition. You do not need a referral from your Anthem Blue Cross PLUS Network *primary care doctor* to see an *ASHP chiropractor* or *ASHP acupuncturist*.

You must bring in your Anthem Blue Cross PLUS I.D. card, and fill out an ASHP Eligibility Guarantee and Assignment of Benefits form.

Authorization. The *ASHP chiropractor* or *ASHP acupuncturist* will evaluate your condition and request an authorization of additional services if such services are required.

The *ASHP chiropractor* or *ASHP acupuncturist* is responsible for obtaining authorization for any additional services. A new reevaluation is required for each new treatment program. You are required to pay only your co-payment for each visit.

Unauthorized Services. The *ASHP chiropractor* or *ASHP acupuncturist* may provide services prior to receiving the necessary authorization. However, unless you agree in writing, prior to receiving those services, to self-pay for those services, the *ASHP chiropractor* or *ASHP acupuncturist* is financially responsible for any services received for which authorization is not obtained.

How to locate an *ASHP* Chiropractor or ASHP Acupuncturist. We will provide you with a directory listing *ASHP chiropractors* or *ASHP acupuncturists* in your area. In addition, you may call **1-**

800-678-9133 to locate an *ASHP chiropractor* or *ASHP acupuncturist* or to confirm that a *chiropractor* is an *ASHP chiropractor* or an *acupuncturist* is an *ASHP acupuncturist*.

MEDICAL CARE THAT IS COVERED

Chiropractor Services. An initial examination by an *ASHP chiropractor* for evaluation of disorders of the neuro-musculoskeletal system.

The following services are covered, if authorized as *medically necessary* by ASHP.

1. Diagnostic services, other than diagnostic scanning, when provided during an initial examination or re-examination;
2. Adjustments;
3. Radiological x-rays and laboratory tests; and
4. *Medically necessary* therapy when provided in conjunction with the visit specifically for spinal or joint adjustment.

Your *ASHP chiropractor* is responsible for obtaining the necessary authorization.

Chiropractic Appliances. We will also pay for support type devices which are ordered by an *ASHP chiropractor*, and authorized as *medically necessary* by ASHP.

Such medical equipment includes: (1) elbow, back, thoracic, lumbar, rib or wrist supports; (2) cervical collars or pillows; (3) ankle, knee, lumbar, or wrist braces; (4) heel lifts; (5) hot or cold packs; (6) lumbar cushions; (7) orthotics; and (8) home traction units for treatment of the cervical or lumbar regions.

Acupuncture Services. An initial examination by an *ASHP acupuncturist*. The following services are covered, if authorized as *medically necessary* by ASHP.

1. Acupuncture. Acupuncture treatment must be provided during each visit, after the initial visit;
2. Radiological x-rays and laboratory tests;
3. *Medically necessary* therapy when provided in conjunction with the visit specifically for acupuncture.

If a *member* would like a second opinion with regard to covered services provided by an *ASHP chiropractor* or *acupuncturist*, the *member* will have direct access to another *ASHP chiropractor* or *acupuncturist*. The *member's* visit for purposes of obtaining a second opinion will count as one visit, for purposes of any maximum benefit, and the *member* must pay any co-payment that applies for an office visit.

If ASHP determines that an additional period of rehabilitative care is both *medically necessary* and likely to result in a significant improvement to your condition by measurably reducing your physical impairment during that period of additional care, ASHP will authorize a specific number of additional visits.

MEDICAL CARE THAT IS NOT COVERED

ASHP Chiropractors and ASHP Acupuncturists. Any services provided by an *ASHP chiropractor* or *ASHP Acupuncturist* not authorized by ASHP except for an initial examination. The *ASHP chiropractor* or *ASHP acupuncturist* is responsible for obtaining the necessary authorization.

Any services of an *ASHP chiropractor* or *ASHP acupuncturist* not specifically stated in the "Chiropractor Services" or "Acupuncture Services" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED. Any service or supply provided in connection with:

1. Diagnostic scanning, such as magnetic resonance imaging (MRI) or computerized axial tomography (CAT) scans. Diagnostic services for acupuncture;
2. Thermography;
3. Hypnotherapy;
4. Behavior training;
5. Sleep therapy;
6. Any non-medical program or service;
7. Pre-employment examinations, any non-*medically necessary* chiropractic or acupuncture services that may be required by an employer, or any other non-*medically necessary* examination not intended for diagnosis or treatment of a condition for which there are signs or symptoms;
8. Any office visit other than the initial visit during which a manipulation is not provided;
9. Any service or supply for the examination or treatment of a non-neuro-musculoskeletal condition, or physical therapy not provided in conjunction with a spinal or joint adjustment;
10. Any service or supply excluded elsewhere in the YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS NOT COVERED section of your Anthem Blue Cross PLUS Evidence of Coverage Form;
11. Transportation costs including local ambulance charges;
12. Education programs, non-medical self-care or self-help, or any self-help physical exercise training or any related diagnostic testing;
13. Hospitalization, anesthesia, manipulation under anesthesia or other related services;
14. All auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephone compatible with hearing aids;
15. Adjunctive therapy not associated with spinal, muscle or joint manipulation.

Non-ASHP chiropractors or non-ASHP acupuncturists. The services of *non-ASHP chiropractor* or *non-ASHP acupuncturist*.

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

If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to worker's compensation, we will provide the benefits of this *plan* for such conditions, subject to a right of recovery and reimbursement under California Labor Code Section 4903, and as described in the section entitled REIMBURSEMENT FOR ACTS OF THIRD PARTIES.

Government Treatment. Any services provided by a local, state, or federal government agency, except when payment under this *plan* is expressly required by federal or state law.

Chiropractic Appliances. Chiropractic appliances or devices not authorized by ASHP, and as specifically stated in the YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED section of your Anthem Blue Cross PLUS Evidence of Coverage Form.

Herbal Supplement. Vitamins, minerals, or other similar products and any nutritional supplements which are herbal supplements.

Air Conditioners. Air purifiers, air conditioners, humidifiers.

Personal Items. Any supplies for comfort, hygiene or beautification, including therapeutic mattresses.

Out-of-Area and Emergency Care. Out-of-area and *emergency* care are not covered under this chiropractic and acupuncture care benefit. Please follow the procedures outlined in the USING YOUR NETWORK BENEFITS section of your Anthem Blue Cross PLUS Evidence of Coverage Form to obtain *emergency* care or out-of-area care.

REIMBURSEMENT FOR ACTS OF THIRD PARTIES

Under some circumstances, a *member* 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, but, not more than the amount allowed by California Civil Code Section 3040.

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

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

DEFINITIONS

ASHP chiropractor means a *chiropractor* who has an agreement, in effect on the date services are rendered, with the American Specialty Health Plans (ASHP), to provide chiropractic services under this *plan*.

ASHP acupuncturist means an *acupuncturist* who has an agreement in effect on the date services are rendered, with the American Specialty Health Plans (ASHP), to provide acupuncture services under this *plan*.

Acupuncturist means a doctor of acupuncture (L.A.C.), qualified and licensed by state law.

Chiropractor means a doctor of chiropractic (D.C.), qualified and licensed by state law.

Medically necessary services or supplies, for the purposes of this amendment only, are those that ASHP or Blue Cross determines to be:

1. Appropriate and necessary for the diagnosis or treatment of the injury, illness or condition;

2. Provided for the diagnosis or direct care and treatment of the injury, illness or condition, and without which your condition would be adversely affected;

3. Within standards of accepted chiropractic or acupuncture treatment standards; and

4. The most appropriate supply or level of service which can safely be provided.

Non-ASHP acupuncturist means an *acupuncturist* who does not have an agreement with the ASHP, to provide acupuncture services under this *plan*.

Non-ASHP chiropractor means a *chiropractor* who does not have an agreement with the ASHP, to provide chiropractic services under this *plan*.

FOR YOUR INFORMATION

ORGAN DONATION

Each year, organ transplantation saves thousands of lives. The success rate for transplantation is rising but there are far more potential recipients than donors. More donations are urgently needed.

Organ donation is a singular opportunity to give the gift of life. Anyone age 18 or older and of sound mind can become a donor when he or she dies. Minors can become donors with parental or guardian consent.

Organ and tissue donations may be used for transplants and medical research. Today it is possible to transplant more than 25 different organs and tissues; this can save the lives of as many as eight people and improve the lives of another 50 people. Your decision to become a donor could someday save or prolong the life of someone you know, perhaps even a close friend or family member.

If you decide to become a donor, please discuss it with your family. Let your physician know your intentions as well. You may register as a donor by obtaining a donor card from the Department of Motor Vehicles. Be sure to sign the donor card and keep it with your driver's license or identification card. In California, you may also register online at:

www.donatelifecalifornia.org/

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

ANTHEM BLUE CROSS WEB SITE

Information specific to your benefits and claims history are available by calling the 800 number on your identification card or on the Anthem Blue Cross web site at **www.anthem.com/uc**. To access benefit information, claims payment status, benefit maximum status, participating providers or to order an ID card, simply log on to the web site, 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. You may also submit a grievance online or print the Plan Grievance form through the website.

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IMPORTANT INFORMATION ABOUT YOUR MENTAL HEALTH BENEFITS

Benefits for *mental or nervous disorders* and substance abuse are provided by United Behavioral Health (the BHP), a health care service plan licensed by the California Department of Managed Health Care (the "DMHC"), through a direct arrangement with the *group*. Benefits are provided at the same level, including any deductibles and copayments, as we provide for all other medical conditions. If you believe that United Behavioral Health is not providing these services according to these guidelines, please contact us at the telephone number listed on your ID card and the DMHC as described in this booklet under "Department of Managed Health Care".