Dear Plan Member:

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

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

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

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

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

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

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

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

ANTHEM BLUE CROSS

on behalf of

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY
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TYPES OF PROVIDERS

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

Participating Providers. The plan has made available to the members a network of various types of “Participating Providers”. These providers are called “participating” because they have agreed to participate in the claims administrator’s preferred provider organization program (PPO), called the Prudent Buyer Plan. Participating providers have agreed to a rate they will accept as reimbursement for covered services. The amount of benefits payable under this plan will be different for non-participating providers than for participating providers. See the definition of “Participating Providers” in the DEFINITIONS section for a complete list of the types of providers which may be participating providers.

A directory of participating providers is available upon request. The directory lists all participating providers in your area, including health care facilities such as hospitals and skilled nursing facilities, physicians, laboratories, and diagnostic x-ray and imaging providers. You may call the customer service number listed on your ID card and request for a directory to be sent to you. You may also search for a participating provider using the “Provider Finder” function on the claims administrator’s website at www.anthem.com/ca. The listings include the credentials of participating providers such as specialty designations and board certification.

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

Contracting and Non-Contracting Hospitals. Another type of provider is the "contracting hospital". This is different from a hospital which is a participating provider. As a health care service plan, the claims administrator has traditionally contracted with most hospitals to obtain certain advantages for patients covered by the plan. While only some hospitals are participating providers, all eligible California hospitals are invited to be contracting hospitals and most--over 90%--accept. For those which do not (called non-contracting hospitals), there is a significant benefit penalty in your plan.
Physicians. “Physician” means more than an M.D. Certain other practitioners are included in this term as it is used throughout the plan. This doesn't mean they can provide every service that a medical doctor could; it just means that the plan will cover expense you incur from them when they're practicing within their specialty the same as if the care were provided by a medical doctor. As with the other terms, be sure to read the definition of "Physician" to determine which providers' services are covered. Only providers listed in the definition are covered as physicians. Please note also that certain providers' services are covered only upon referral of an M.D. (medical doctor) or D.O. (doctor of osteopathy). Providers for whom referral is required are indicated in the definition of "physician" by an asterisk (*).

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

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

Centers of Medical Excellence. The claims administrator is providing access to the Centers of Medical Excellence (CME) network. The facilities included in this CME network are selected to provide services for the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. Subject to any applicable co-payments or deductibles, CME have agreed to a rate they will accept as payment in full for covered services. These procedures are covered only when performed at a CME.

A participating provider in the Prudent Buyer Plan network is not necessarily a CME facility.
Care Outside the United States—BlueCard Worldwide

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

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

Payment Information

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

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

Claim Filing

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

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

- International claim forms are available from the claims administrator, from the BlueCard Worldwide Service Center, or online at:
  
  www.bcbs.com/bluecardworldwide.

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

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

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

For your convenience, this summary provides a brief outline of your benefits. You need to refer to the entire benefit booklet for more complete information, and the exact terms and conditions of your coverage.

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

Triage or Screening Services. If you have questions about a particular health condition or if you need someone to help you determine whether or not care is needed, triage or screening services are available to you by telephone. Triage or screening services are the evaluation of your health by a physician or a nurse who is trained to screen for the purpose of determining the urgency of your need for care. Please contact the 24/7 NurseLine at the telephone number listed on your identification card 24 hours a day, 7 days a week.

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

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

DEDUCTIBLES

Calendar Year Deductibles

- Member Deductible:
  - Participating providers and other health care providers.................................$150
  - Non-participating providers............................................................................$350

- Family Deductible:
  - Participating providers and other health care providers.................................$300
  - Non-participating providers............................................................................$700

Additional Deductibles

- Inpatient Deductible (non-participating providers).................................$300
- Non-Certification Deductible.............................................................................$250

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

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

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

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

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

- The Calendar Year Deductible will not apply to inpatient hospital services provided by a non-participating provider.

- The Calendar Year Deductible will not apply to Skilled Nursing services provided by a non-participating provider.
- The Calendar Year Deductible will not apply to services under the Hospice Care benefit.
- The Calendar Year Deductible will not apply to services provided by a participating provider under the Home Health Care benefit.
- The Calendar Year Deductible will not apply to inpatient visits by a physician who is a non-participating provider or facility-based care for the treatment of mental or nervous disorders and substance abuse provided by a facility that is a non-participating provider.
- The Calendar Year Deductible will not apply to transplant travel expenses authorized by the claims administrator in connection with a specified transplant procedure provided at a designated CME.
- The Calendar Year Deductible will not apply to emergency services.
- The Inpatient Deductible will not apply to emergency admissions, nor to the services provided by a participating provider.
- The Non-Certification Deductible will not apply to emergency admissions or services, nor to services provided by a participating provider. See UTILIZATION REVIEW PROGRAM.

CO-PAYMENTS

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

- Participating Providers..................................................................................................................10%
- Other Health Care Providers........................................................................................................10%
- Non-Participating Providers.........................................................................................................50%

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

*Exceptions:
- There will be no Co-Payment for any covered services provided by a participating provider under the Preventive Care benefit.
- Your Co-Payment for emergency room visits will be $100. This Co-Payment will not apply if you are admitted as a hospital inpatient immediately following emergency room treatment. This Co-Payment will not apply toward the satisfaction of any deductible, nor will it apply toward satisfaction of the Out-of-Pocket Amount.
There will be no Co-Payment for any covered services provided by a participating provider under the Hospice Care benefit.

There will be no Co-Payment for any covered services provided by a participating provider under the Home Health Care benefit.

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

a. All emergency services;

b. An authorized referral from a physician who is a participating provider to a non-participating provider;

c. Charges by a type of physician not represented in the Prudent Buyer Plan network; or

d. Cancer Clinical Trials.

Your Co-Payment for office visits to a physician who is a participating provider will be $20. This Co-Payment will not apply toward the satisfaction of any deductible, nor will it apply toward satisfaction of the Out-of-Pocket Amount.

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

Your Co-Payment for office visits to a physician who is a non-participating provider will be 50% after a $40 office visit Co-Payment. The $40 office visit Co-Payment will not apply toward satisfaction of the Out-of-Pocket Amount.

Your Co-Payment for diabetes education program services provided by a physician who is a participating provider will be $20. This Co-Payment will not apply toward the satisfaction of any deductible, nor will it apply toward satisfaction of the Out-of-Pocket Amount.

Your Co-Payment for diabetes education program services provided by a physician who is a non-participating provider will be 50% after a $40 office visit Co-Payment. The $40 office visit Co-Payment will not apply toward satisfaction of the Out-of-Pocket Amount.

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

**NOTE:** No Co-Payment will be required for the transplant travel expenses authorized by the *claims administrator* in connection with a specified transplant performed at a designated CME. Transplant travel expense coverage is available when the closest CME is 75 miles or more from the recipient’s or donor’s residence.

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

Per member:
- *Participating providers and other health care providers* $2,500
- *Non-participating providers* None

Per family
- *Participating providers and other health care providers* $5,000**
- *Non-participating providers* None

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

*Exceptions:*
- Your $20 Co-Payment for office visits to a *physician* who is a participating provider will not be applied toward the satisfaction of your Out-of-Pocket Amount. In addition, you will be required to continue to pay your Co-Payment for such visits even after you have reached that amount.
- Your $40 Co-Payment for office visits to a *physician* who is a non-participating provider will not be applied toward the satisfaction of your Out-of-Pocket Amount. In addition, you will be required to continue to pay your Co-Payment for such visits even after you have reached that amount.
— Your $20 Co-Payment for diabetes education program services provided by a physician who is a participating provider will not be applied toward the satisfaction of your Out-of-Pocket Amount. In addition, you will be required to continue to pay your Co-Payment for such services even after you have reached that amount.

— Your $40 Co-Payment for diabetes education program services provided by a physician who is a non-participating provider will not be applied toward the satisfaction of your Out-of-Pocket Amount. In addition, you will be required to continue to pay your Co-Payment for such services even after you have reached that amount.

— Your $100 Co-Payment for emergency room visits will not be applied toward the satisfaction of your Out-of-Pocket Amount. In addition, you will be required to continue to pay your Co-Payment for such visits even after you have reached that amount.

— Any Co-Payments you make for donor searches for transplants will not be applied toward the satisfaction of your Out-of-Pocket Amount.

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

**Non-Contracting Hospital Penalty.** The maximum allowed amount is reduced by 25% for services and supplies provided by a non-contracting hospital. This penalty will be deducted from the maximum allowed amount prior to calculating your Co-Payment amount, and any benefit payment will be based on such reduced maximum allowed amount. You are responsible for paying this extra expense. This reduction will be waived only for emergency services. To avoid this penalty, be sure to choose a contracting hospital.
MEDICAL BENEFIT MAXIMUMS

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

Skilled Nursing Facility
- For covered skilled nursing facility care.................................100 days per calendar year

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

Hearing Aid Services
- For covered charges for hearing aids.................................One hearing aid per ear every three years

Acupuncture
- For all covered services.........................................................34 visits per calendar year

Transplant Travel Expense
- For all travel expense authorized by the claims administrator in connection with a specified transplant performed at a designated CME...........$10,000 per transplant

Unrelated Donor Searches
- For all charges for unrelated donor searches for covered bone marrow/stem cell transplants.........................$30,000 per transplant

Lifetime Maximum
- For all medical benefits.........................................................Unlimited
YOUR MEDICAL BENEFITS

MAXIMUM ALLOWED AMOUNT

General

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

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

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

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

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

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

Provider Network Status

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

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

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

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

Non-Participating Providers and Other Health Care Providers.* For covered services you receive from a non-participating provider or other
health care provider the maximum allowed amount will be based on the applicable non-participating provider rate or fee schedule for this plan, an amount negotiated by the claims administrator or a third party vendor which has been agreed to by the non-participating provider, an amount derived from the total charges billed by the non-participating provider, or an amount based on information provided by a third party vendor.

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

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

*Exceptions:

- Emergency Services Provided by Non-Participating Providers

  For emergency services provided by non-participating providers or at non-contracting hospitals, reimbursement is based on the reasonable and customary value. You will not be responsible for any amounts in excess of the reasonable and customary value for emergency services rendered within California.

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

- If Medicare is the primary payor, the maximum allowed amount does not include any charge:

  1. By a hospital, in excess of the approved amount as determined by Medicare; or

  2. By a physician who is a participating provider who accepts Medicare assignment, in excess of the approved amount as determined by Medicare; or
3. By a physician who is a non-participating provider or other health care provider who accepts Medicare assignment, in excess of the lesser of maximum allowed amount stated above, or the approved amount as determined by Medicare; or

4. By a physician or other health care provider who does not accept Medicare assignment, in excess of the lesser of the maximum allowed amount stated above, or the limiting charge as determined by Medicare.

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

MEMBER COST SHARE

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

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

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

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

WARNING! Reduction of Covered Expense for Non-Contracting Hospitals. A small percentage of hospitals which are non-participating providers are also non-contracting hospitals. Except for emergency care, the maximum allowed amount is reduced by 25% for all services and supplies provided by a non-contracting hospital. You will be responsible for paying this amount. You are strongly encouraged to avoid this additional expense by seeking care from a contracting hospital. You can call the customer service number on your identification card to locate a contracting hospital.

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

After any applicable deductible is subtracted and your Co-Payment, the plan will pay benefits up to the maximum allowed amount, (or the reasonable and customary value for emergency services provided by a non-participating provider), not to exceed any applicable Medical Benefit Maximum. The Deductible amounts, Co-Payments, Out-Of-Pocket Amounts and Medical Benefit Maximums are set forth in the SUMMARY OF BENEFITS.

DEDUCTIBLES

Each deductible under this plan is separate and distinct from the other. Only the covered charges that make up the maximum allowed amount (or the reasonable and customary value for emergency services provided by a non-participating provider) will apply toward the satisfaction of any deductible except as specifically indicated in this booklet.
Calendar Year Deductibles. Each year, you will be responsible for satisfying the member's Calendar Year Deductible before we begin to pay benefits. If members of an enrolled family pay deductible expense in a year equal to the Family Deductible, the Calendar Year Deductible for all family members will be considered to have been met.

Participating Providers and Other Health Care Providers. Covered expense for the services of participating providers and other health care providers will be applied to the participating provider Calendar Year and Family Deductibles. When these deductibles are met, however, the plan will pay benefits only for the services of participating providers and other health care providers. The plan will not pay any benefits for non-participating providers unless the separate non-participating provider Calendar Year or Family Deductible (as applicable) is met.

Non-Participating Providers. Covered expense for the services of non-participating providers will be applied to the non-participating provider Calendar Year and Family Deductibles. The plan will pay benefits for the services of non-participating providers only when the applicable non-participating provider deductible is met.

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

Additional Deductibles

1. Each time you are admitted to a hospital or residential treatment center which is a non-participating provider, you are responsible for paying the Inpatient Deductible. This deductible will not apply to an emergency admission.

2. Each time you are admitted to a hospital or residential treatment center without properly obtaining certification, you are responsible for paying the Non-Certification Deductible. This deductible will not apply to an emergency admission or procedure, nor to services provided at a participating provider. Certification is explained in UTILIZATION REVIEW PROGRAM.

CO-PAYMENTS

After you have satisfied any applicable deductible, your Co-Payment will be subtracted from the remaining maximum allowed amount (or from the remaining amount of reasonable and customary value for emergency services provided by a non-participating provider).
If your Co-Payment is a percentage, the plan will apply the applicable percentage to the maximum allowed amount remaining after any deductible has been met. This will determine the dollar amount of your Co-Payment.

OUT-OF-POCKET AMOUNTS

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

If enrolled members of a family pay Co-Payments in a year equal to the Out-of-Pocket Amount per family, the Out-of-Pocket Amount for all members of that family will be considered to have been met. Once the family Out-of-Pocket Amount is satisfied, no member of that family will be required to make Co-Payments for any additional covered services or supplies during the remainder of that year, except as specifically stated under Charges Which Do Not Apply Toward the Out-of-Pocket Amount below. However, any expense previously applied to the Out-of-Pocket Amount per member in the same year will not be credited for any other member of that family.

Participating Providers, CMEs and Other Health Care Providers.

Only covered charges up to the maximum allowed amount for the services of a participating provider, CME or other health care provider will be applied to the participating provider and other health care provider Out-of-Pocket Amount.

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

Charges Which Do Not Apply Toward the Out-Of-Pocket Amount.

The following charges will not be applied toward satisfaction of an Out-Of-Pocket Amount:

- Charges for services or supplies not covered under this plan;
- Charges which exceed the maximum allowed amount;
- Dollar Co-Payments for emergency room visits;
• Dollar Co-Payments for office visits to a physician;
• Dollar Co-Payments for diabetic education program services provided by a physician;
• Any expense applied to a deductible; and
• Any Co-Payments you make for donor searches for transplants.

MEDICAL BENEFIT MAXIMUMS

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

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

CONDITIONS OF COVERAGE

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

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

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

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

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

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

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

7. All services and supplies must be ordered by a physician.
MEDICAL CARE THAT IS COVERED

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

Hospital

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

2. Services in special care units.

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

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

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

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

If covered charges are applied toward the Calendar Year Deductible and payment is not provided, those days will be included in the 100 days for that year.

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

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

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

3. Services of a medical social service worker.

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

5. Medically necessary supplies provided by the home health agency.

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

If covered charges is applied toward the Calendar Year Deductible and payment is not provided, those visits will be included in the 100 visits for that year.

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

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

Hospice Care. The services and supplies listed below are covered when provided by a hospice for the palliative treatment of pain and other symptoms associated with a terminal disease. You must be suffering from a terminal illness as certified by your physician and submitted to the claims administrator. Covered services are available on a 24-hour basis for the management of your condition.

1. Interdisciplinary team care with the development and maintenance of an appropriate plan of care.

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

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

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

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

6. Physical therapy, occupational therapy, speech therapy, and respiratory therapy provided by a licensed therapist.
7. Volunteer services provided by trained hospice volunteers under the direction of a hospice staff member.

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

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

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

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

Infusion Therapy. The following services and supplies, when provided in your home by a home infusion therapy provider or in any other outpatient setting by a qualified health care provider, for the intravenous administration of your total daily nutritional intake or fluid requirements, medication related to illness or injury, chemotherapy, antibiotic therapy, aerosol therapy, tocolytic therapy, special therapy, intravenous hydration, or pain management:

1. Medication (specialty drugs must be obtained through the specialty drug program (see the “Specialty Drugs,” provision of this section MEDICAL CARE THAT IS COVERED)), ancillary medical supplies and supply delivery, (not to exceed a 14-day supply); but medication which is delivered but not administered is not covered;

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

3. Hospital and home clinical visits related to the administration of infusion therapy, including skilled nursing services including those provided for: (a) patient or alternative caregiver training; and (b) visits to monitor the therapy;
4. Rental and purchase charges for durable medical equipment (as shown below); maintenance and repair charges for such equipment;

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

Infusion therapy services are subject to pre-service review to determine medical necessity. (See UTILIZATION REVIEW PROGRAM.)

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

**Professional Services**

1. Services of a physician.

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

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

**Ambulance.** The following ambulance services:

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

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

3. Base charge, mileage and non-reusable supplies of a licensed air ambulance company to transport you from the area where you are first disabled to the nearest hospital where appropriate treatment is provided if, and only if, such services are medically necessary and ground ambulance service is inadequate. Pre-service review is required for air ambulance in a non-medical emergency. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.
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.

The majority of ambulance companies are non-participating providers. If you receive services from an ambulance company that is a non-participating provider, you may be responsible for charges which exceed the maximum allowed amount.

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

Radiation Therapy
Chemotherapy
Hemodialysis Treatment
Prosthetic Devices
1. Breast prostheses following a mastectomy.
2. Prosthetic devices to restore a method of speaking when required as a result of a covered medically necessary laryngectomy.
3. The plan will pay for other medically necessary prosthetic devices, including:
   a. Surgical implants;
   b. Artificial limbs or eyes;
   c. The first pair of contact lenses or eye glasses when required as a result of a covered medically necessary eye surgery;
   d. Therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications; and
e. Orthopedic footwear used as an integral part of a brace; shoe inserts that are custom molded to the patient.

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

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

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

**Pediatric Asthma Equipment and Supplies.** The following items 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.

**Dental Care**

1. **Admissions for Dental Care.** Listed inpatient hospital services for up to three days during a hospital stay, when such stay is required for dental treatment and has been ordered by a physician (M.D.) and a dentist (D.D.S. or D.M.D.). The claims administrator will make the final determination as to whether the dental treatment could have been safely rendered in another setting due to the nature of the procedure or your medical condition. Hospital stays for the purpose of administering general anesthesia are not considered necessary and are not covered except as specified in #2, below.
2. **General Anesthesia.** General anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a hospital or ambulatory 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. or D.M.D.) solely to treat an accidental injury to natural teeth. Coverage shall be limited to only such services that are medically necessary to repair the damage done by accidental injury and/or restore function lost as a direct result of the accidental injury. Damage to natural teeth due to chewing or biting is not accidental injury.

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

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

**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 a subscriber, an enrolled spouse, or a domestic partner.
3. Certain services are covered under the “Preventive Care Services” benefit. Please see that provision for further details.

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

1. The recipient; or
2. The donor.

If you are the recipient, an organ or tissue donor who is not an enrolled member is also eligible for services as described. Benefits are reduced by any amounts paid or payable by that donor's own coverage. The maximum allowed amount for a donor, including donor testing and donor search, is limited to expense incurred for medically necessary medical services only. The maximum allowed amount for services incident to obtaining the transplanted material from a living donor or a human organ transplant bank will be covered. Such charges, including complications from the donor procedure for up to six weeks from the date of procurement, are covered. Services for treatment of a condition that is not directly related to, or a direct result of, the transplant are not covered. The plan's payment for unrelated donor searches for bone marrow/stem cell transplants will not exceed $30,000 per transplant.

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

Specified Transplants

You must obtain the claims administrator's prior authorization for all services including, but not limited to, preoperative tests and postoperative care related to the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. Specified transplants must be performed at Centers of Medical Excellence (CME). Charges for services provided for or in connection with a specified transplant performed at a facility other than a CME will not be 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

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

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

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

The Calendar Year Deductible will not apply and no co-payments will be required for transplant travel expenses authorized in advance by the claims administrator. The plan will provide benefits for lodging and ground transportation, up to the current limits set forth in the Internal Revenue Code.

Expense incurred for the following is not covered: interim visits to a medical care facility while waiting for the actual transplant procedure; travel expenses for a companion and/or caregiver for a transplant donor; return visits for a transplant donor for treatment of a condition found during the evaluation; rental cars, buses, taxis or shuttle services; and mileage within the city in which the medical transplant facility is located.

Details regarding reimbursement can be obtained by calling the customer service number on your identification card. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.
Mental or Nervous Disorders or Substance Abuse. Covered services shown below for the medically necessary treatment of mental or nervous disorders or substance abuse.

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

2. Physician visits during a covered inpatient stay.

3. Physician visits for outpatient psychotherapy or psychological testing or outpatient rehabilitative care (such as physical therapy, occupational therapy, or speech therapy) for the treatment of mental or nervous disorders or substance abuse.

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

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

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

2. Immunizations prescribed by a examining physician.

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

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

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

6. Counseling and risk factor reduction intervention services for sexually transmitted infections, human immunodeficiency virus (HIV), contraception, tobacco use, and tobacco use-related diseases.
7. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:

a. Women’s contraceptives, sterilization procedures, and counseling. This includes generic and single source brand drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUD)s, and implants are also covered.

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

c. Gestational diabetes screening.

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

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

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

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

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 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.
Benefits are provided for one hearing aid per ear every three years.

No benefits will be provided for the following:

1. Charges for a hearing aid which exceeds specifications prescribed for the correction of hearing loss, or for more than one hearing aid per ear every three years.

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

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

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

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

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

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

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

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

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

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

1. Typically provided absent a clinical trial.
2. Required solely for the provision of the investigational drug, item, device or service.
3. Clinically appropriate monitoring of the investigational item or service.
4. Prevention of complications arising from the provision of the investigational drug, item, device, or service.
5. Reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

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

1. Drugs or devices not approved by the federal Food and Drug Administration that are associated with the clinical trial.
2. Services other than health care services, such as travel, housing, companion expenses and other nonclinical expenses that you may require as a result of the treatment provided for the purposes of the clinical trial.
3. Any item or service provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient.
4. Health care services that, except for the fact they are provided in a clinical trial, are otherwise specifically excluded from the plan.
5. Health care services customarily provided by the research sponsors free of charge to members enrolled in the trial.

Note: You will be financially responsible for the costs associated with non-covered services.
Physical Therapy, Physical Medicine and Occupational Therapy.
The following services provided by a physician under a treatment plan:

1. Physical therapy and physical medicine provided on an outpatient basis for the treatment of illness or injury including the therapeutic use of heat, cold, exercise, electricity, ultra violet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care which are customarily provided by 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. For the purposes of this benefit, the term "visit" shall include any visit by a physician in that physician's office, or in any other outpatient setting, during which one or more of the services covered under this limited benefit are rendered, even if other services are provided during the same visit.

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

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

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

Certain contraceptives are covered under the "Preventive Care Services" benefit. Please see that provision for further details.
Outpatient Speech Therapy. Outpatient speech therapy following injury or organic disease.

Acupuncture. The services of a physician for acupuncture treatment to treat a disease, illness or injury, including a patient history visit, physical examination, treatment planning and treatment evaluation, electroacupuncture, cupping and moxibustion. The plan will pay for up to 34 visits during a calendar year.

If covered charges is applied toward the Calendar Year Deductible and payment is not provided, that visit is included in the visit maximum (34 visits) for that year.

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

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

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

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

Diabetes education services are covered under plan benefits for office visits to physicians.
3. The following items are covered as medical supplies:
   a. Insulin syringes, disposable pen delivery systems for insulin administration. Charges for insulin and other prescriptive medications are not covered.
   b. Testing strips, lancets, and alcohol swabs.

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

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

**Special Food Products.** Special food products and formulas that are part of a diet prescribed by a physician for the treatment of phenylketonuria (PKU). 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.

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

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

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

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

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

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

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

- As soon as the claims administrator can, based on your medical condition, as medically necessary, within 5-business days after they have all the information they need to decide if they will approve benefits, the claims administrator will tell you and your physician what has been decided in writing - by fax to your physician and by mail to you.

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

**MEDICAL CARE THAT IS NOT COVERED**

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

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

**Experimental or Investigative.** Any experimental or investigative procedure or medication. But, if you are denied benefits because it is determined that the requested treatment is experimental or investigative, you may request an independent medical review. (See your right to appeals at the end of this plan.)

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

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

**Not Covered.** Services received before your effective date or after your coverage ends, except as specifically stated under extension of benefits.

**Non-Licensed Providers.** Treatment or services rendered by non-licensed health care providers and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed provider under the supervision of a licensed physician, except as specifically provided or arranged by the claims administrator.

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

**Work-Related.** Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if you do not claim those benefits.
If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, benefits will be provided subject to the claims administrator's right of recovery and reimbursement under California Labor Code Section 4903, and as described in SUBROGATION AND REIMBURSEMENT.

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

**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 "Infusion Therapy" provision of MEDICAL CARE THAT IS COVERED.

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

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

**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.

**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.
Mental or Nervous Disorders or Substance Abuse. Academic or educational testing, counseling, and remediation. Any treatment of mental or nervous disorders or substance abuse, including rehabilitative care in relation to these conditions, except as specifically stated in the “Mental or Nervous Disorders or Substance Abuse” provision of MEDICAL CARE THAT IS COVERED. Any educational treatment or any services that are educational, vocational, or training in nature except as specifically provided or arranged by the claims administrator.

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

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

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

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

This exclusion does not apply to the following:

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

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

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

Outpatient Occupational Therapy. Outpatient occupational therapy, except as specifically stated in the “Infusion Therapy” provision of MEDICAL CARE THAT IS COVERED, or when provided by a home health
agency or hospice, as specifically stated in the “Home Health Care”, “Hospice Care” or “Physical Therapy, Physical Medicine and Occupational Therapy” provisions of that section.

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

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

**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.

**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.

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

**Sterilization Reversal.** Reversal of sterilization.

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

**Surrogate Mother Services.** For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
Orthopedic Supplies. Orthopedic shoes (other than shoes joined to braces) or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications as specifically stated in the "Prosthetic Devices" provision of MEDICAL CARE THAT IS COVERED.

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

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Custodial care, rest cures, except as specifically provided under the "Hospice Care" or "Infusion Therapy" 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" or "Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED.

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

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

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 the claims administrator. Such services are provided under the "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.

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 require either a written prescription or dispensing by a licensed pharmacist.

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

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those
required by employment or government authority, except as specifically stated in the "Well Baby and Well Child Care", "Physical Exam", "Adult Preventive Services", "Breast Cancer" or "Screening For Blood Lead Levels" provisions of MEDICAL CARE THAT IS COVERED.

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

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

**Physical Therapy or Physical Medicine.** Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement, or as specifically stated in the "Home Health Care", "Hospice Care", "Infusion Therapy" or "Physical Therapy, Physical Medicine and Occupational Therapy" provisions of MEDICAL CARE THAT IS COVERED.

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

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

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

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

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

PRE-EXISTING CONDITION EXCLUSION

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

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

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

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

Subrogation

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

- The *plan* has first priority from any Recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.

- You and your legal representative must do whatever is necessary to enable the *plan* to exercise the *plan*'s rights and do nothing to prejudice those rights.

- In the event that you or your legal representative fail to do whatever is necessary to enable the *plan* to exercise its subrogation rights, the *plan* shall be entitled to deduct the amount the *plan* paid from any future benefits under the *plan*.

- The *plan* has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the *plan*.

- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the *plan*'s subrogation claim and any claim held by you, the *plan*'s subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.

- The *plan* is not responsible for any attorney fees, attorney liens, other expenses or costs you incur without the *plan*'s prior written
consent. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the plan.

Reimbursement

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

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

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

- You and your legal representative must hold in trust for the plan the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the plan immediately upon your receipt of the Recovery. You must reimburse the plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the plan.

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

  1. The amount the plan paid on your behalf is not repaid or otherwise recovered by the plan; or
  2. You fail to cooperate.

- In the event that you fail to disclose the amount of your settlement to the plan, the plan shall be entitled to deduct the amount of the plan's lien from any future benefit under the plan.
• The *plan* shall also be entitled to recover any of the unsatisfied portion of the amount the *plan* has paid or the amount of your Recovery, whichever is less, directly from the Providers to whom the *plan* has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the *plan* will not have any obligation to pay the Provider or reimburse you.

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

Your Duties

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

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

• You must not do anything to prejudice the *plan*’s rights.

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

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

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

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

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

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

**COORDINATION OF BENEFITS**

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

**Note:** The prescription drug plan administered by Medco will coordinate benefits for prescription drugs for husband-wife teams who work for the City of Long Beach. Reimbursement is limited to the prescription drug co-payments. Members must submit a prescription drug receipt to Medco showing the co-payment paid by the member for reimbursement.

**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 plan member under This Plan when a plan 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 plan 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 plan member are not carried forward from one year to the next. At the end of each calendar year, the Benefit Reserve for a plan 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 trusted plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.

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

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

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

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

EFFECT ON BENEFITS

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. The member should submit the claim first to the claims administrator for This Plan. When the explanation of benefits is received from the claims administrator, send it, along with the claim and itemized bills, to the 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. The member should submit the claim first to the Principal Plan. After the other plan has determined its benefits, send the explanation of benefits from the other plan, along with the member’s claim, the claims administrator for This Plan.

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 pays before a plan which has a Coordination of Benefits provision. This would include Medicare in all cases, except when the law requires that This Plan pays before Medicare.

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

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

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

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

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

b. If the parent with custody of that child for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:
   i. The plan which covers that child as a dependent of the parent with custody.
   ii. The plan which covers that child as a dependent of the stepparent (married to the parent with custody).
   iii. The plan which covers that child as a dependent of the parent without custody.
   iv. The plan which covers that child as a dependent of the stepparent (married to the parent without custody).

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

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

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

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

OUR RIGHTS UNDER THIS PROVISION

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

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

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

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

BENEFITS FOR MEDICARE ELIGIBLE MEMBERS

For Active Employees and Family Members. If you are a full-time employee or a family member of a full-time employee, and entitled to Medicare, you will receive the full benefits of this plan, except as listed below:

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

2. You are entitled to Medicare benefits as a disabled person, unless you have a current employment status as determined by Medicare rules through a group of 100 or more employees (according to federal OBRA legislation).
In cases where exceptions 1 or 2 apply, our payment will be determined according to the provisions in the section entitled COORDINATION OF BENEFITS and the provision “Coordinating Benefits With Medicare”, below.

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

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

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

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

**UTILIZATION REVIEW PROGRAM**

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

No benefits are payable, however, unless your coverage is in force at the time services are rendered, and the payment of benefits is subject to all the terms and requirements of this plan.
Important: The Utilization Review Program requirements described in this section do not apply when coverage under this plan is secondary to another plan providing benefits for you or your dependents.

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 the claims administrator has 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 the claims administrator and monitored so that you know when it is no longer medically necessary and appropriate to continue those services.

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

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

UTILIZATION REVIEW REQUIREMENTS

Utilization reviews are conducted for the following services:

- All inpatient hospital stays and residential treatment center admissions.
- Specific outpatient services, including diagnostic treatment and other services.
- Facility-based care for the treatment of mental or nervous disorders and substance abuse.
- Organ and tissue transplants.
- Air ambulance in a non-medical emergency.
- Infusion therapy.
- Home health care.
- Admissions to a skilled nursing facility.
- Specific diagnostic procedures, including but not limited to: Magnetic Resonance Imaging (MRI), Computerized Tomography (CT scan), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography and Nuclear Cardiac Imaging. You may call the toll-free customer service telephone number on your identification card to find out if an imaging procedure requires pre-service review.

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 and residential treatment center admissions (except inpatient stays for maternity care or mastectomy and lymph node dissection).

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

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

   - Organ and tissue transplants.

   - Air ambulance in a non-medical emergency.

   - Infusion therapy.

   - Home health care.

   - Admissions to a skilled nursing facility.

   - Specific diagnostic procedures, including but not limited to: Magnetic Resonance Imaging (MRI), Computerized Tomography (CT scan), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography and Nuclear Cardiac Imaging.
2. Concurrent review determines whether services are medically necessary and appropriate when the claims administrator is 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 or residential treatment center admission, specific outpatient services, including diagnostic treatment and other services, or a doctor's office or for facility-based care for the treatment of mental or nervous disorders and substance abuse, 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:
   - Transplant services as follows:
     a. For bone, skin or cornea transplants, if the physicians on the surgical team and the facility in which the transplant is to take place are approved for the transplant requested.
     b. For transplantation of heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney or bone marrow/stem cell and similar procedures, if the providers of the related preoperative and postoperative services are approved and the transplant will be performed at a Centers of Medical Excellence (CME) facility.
   - Air ambulance in a non-medical emergency.
   - Services of a home infusion therapy provider if the attending physician has submitted both a prescription and a plan of treatment before services are rendered.
● Home health care services if:
   a. The services can be safely provided in your home, as certified by your attending physician;
   b. Your attending physician manages and directs your medical care at home; and
   c. Your attending physician has established a definitive treatment plan which must be consistent with your medical needs and lists the services to be provided by the home health agency.

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

● Specific diagnostic procedures, including, but not limited to: Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography and Nuclear Cardiac Imaging.

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 five working days prior to when you are scheduled to receive services.
2. You must tell your *physician* that this *plan* requires pre-service review. *Physicians* who are *participating providers* will initiate the review on your behalf. A *non-participating provider* may initiate the review for you, or you may call the *claims administrator* 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. The *claims administrator* will determine if services are *medically necessary* and appropriate. For inpatient *hospital* and *residential treatment center* stays, the *claims administrator* will, if appropriate, specify a specific length of *stay* for services. For *facility-based care* for the treatment of *mental or nervous disorders* and substance abuse the *claims administrator* will, if appropriate, specify the type and level of services, as well as their duration. You, your *physician* and the provider of the service will receive a written confirmation showing this information.

**Concurrent Reviews**

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

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

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

4. If the *claims administrator* determines that the service is not *medically necessary* and appropriate, your *physician* will be notified by telephone no later than 24 hours following their decision. The *claims administrator* will send written notice to you and your *physician* within two business days following their 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", the claims administrator may take into account whether or not your condition was severe enough to prevent you from notifying them, or whether or not a member of your family was available to notify them 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 the claims administrator is 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.

THE MEDICAL NECESSITY REVIEW PROCESS

The claims administrator works 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, the claims administrator is committed to ensuring that reviews are performed in a timely and professional manner. The following information explains the claims administrator's 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 the claims administrator does not have the information they need, they will make every attempt to obtain that information from you or your physician. If the claims administrator is unsuccessful, and a delay is anticipated, they will notify you and your physician of the delay and what they need to make a decision. The claims administrator 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 the claims administrator’s medical policy. These criteria and policies are developed and approved by practicing providers not employed by the claims administrator, 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 the claims administrator chooses at their 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. The claims administrator discloses their 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 plan with the plan administrator 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 the claims administrator 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, the claims administrator has 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 does the claims administrator have an obligation to provide it; the claims administrator provides these services at their 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 the claims administrator’s claims reports. You or your family may also call the claims administrator.

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. The claims administrator anticipates that such treatment utilizing services or supplies covered under this plan will result in considerable cost;

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

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

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

The claims administrator makes treatment recommendations only; any decision regarding treatment belong to you and your physician. The plan administrator will, in no way, compromise your freedom to make such decisions.
EFFECT ON BENEFITS

1. Benefits are provided for an alternative treatment plan on a case-by-case basis only. The claims administrator has 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. The claims administrator’s authorization of services in lieu of benefits in a particular case in no way commits them to do so in another case or for another member.

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

Note: The claims administrator reserves 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 the claims administrator.

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. The claims administrator’s Board of Directors is responsible for medical necessity review processes through its oversight committees including the Strategic Planning Committee, Quality Management Committee, and Physician Relations Committee. Oversight includes approval of policies and procedures, review and approval of self-audit tools, procedures, and results. Monthly process audits measure the performance of reviewers and Peer Clinical Reviewers against approved written policies, procedures, and timeframes. Quarterly reports of audit results and, when needed, corrective action plans are reviewed and approved through the committee structure.

HOW COVERAGE BEGINS AND ENDS

HOW COVERAGE BEGINS

ELIGIBLE STATUS

1. **Subscribers.** You are in an eligible status if you are a permanent full-time employee or a retired employee. A full-time employee is one who works at least 80 hours per pay period in the conduct of the business of THE CITY OF LONG BEACH. A retired employee is a) less than age 65, b) not eligible for Medicare, c) retired from active full-time employment, and d) was covered under a group sponsored plan immediately prior to retirement.

2. **Dependents.** The following are eligible to enroll as dependents: (a) Either the subscriber’s spouse or domestic partner; and (b) A child.

Definition of Dependent

1. **Spouse** is the subscriber’s spouse under a legally valid marriage. A person may be covered as both a subscriber and a spouse, if eligible as both. However, the total amount of benefits paid shall not exceed the maximum allowed amount.

2. **Domestic partner** is the subscriber’s domestic partner under a legally registered and valid domestic partnership. A person may be covered as both a subscriber and a domestic partner, if eligible as both. However, the total amount of benefits paid shall not exceed the maximum allowed amount.
3. **Child** is the subscriber's or spouse's natural child, stepchild, legally adopted child, or a child for whom the subscriber, spouse or domestic partner has been appointed legal guardian by a court of law, subject to the following:

a. The child is under 26 years of age.

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

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

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

d. A child for whom the subscriber, spouse or domestic partner is a legal guardian is considered eligible on the date of the court decree (the "eligibility date"). We must receive legal evidence of the decree.
e. If both parents are covered as subscribers, their children may be covered as the dependents of both. However, the total amount of benefits paid shall not exceed the maximum allowed amount.

ELIGIBILITY DATE

1. For subscribers, you become eligible for coverage on the first day of the month coinciding with or following the date you complete 30 days of continuous, active full-time employment. (This is your “waiting” period.)

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

Exceptions to the Waiting Period

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

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

ENROLLMENT

To enroll as a subscriber, or to enroll dependents, the subscriber must properly file an application. An application is considered properly filed, only if it is personally signed, dated, and given to the plan administrator within 31 days from your eligibility date. If any of these steps are not followed, your coverage may be denied.

EFFECTIVE DATE

Your effective date of coverage is subject to the timely payment of required monthly contributions. The date you become covered is determined as follows:

1. Timely Enrollment: If you enroll for coverage before, on, or within 31 days after your eligibility date, then your coverage will begin as follows: (a) for subscribers, on your eligibility date; and (b) for dependents, on the later of (i) the date the subscriber’s coverage begins, or (ii) the first day of the month after the dependent becomes eligible. If you become eligible before the plan takes effect, coverage begins on the effective date of the plan, provided the enrollment application is on time and in order.
2. **Late Enrollment:** If you enroll more than 31 days after your eligibility date, you must wait until the next Open Enrollment Period to enroll.

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

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

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

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

**Special Enrollment Periods**

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

1. You have met all of the following requirements:
   a. You were covered as an individual or dependent under either:
      i. Another employer group health plan or health insurance coverage, including coverage under COBRA continuation; or
ii. A state Medicaid plan or under a state child health insurance program (SCHIP), including the Healthy Families Program or the Access for Infants and Mothers (AIM) Program.

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

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

i. If the other health plan was another employer group health plan or health insurance coverage, including coverage under COBRA continuation, coverage ended because you lost eligibility under the other plan, your coverage under COBRA continuation was exhausted, or employer contributions toward coverage under the other plan terminated. You must properly file an application with the plan administrator within 31 days after the date your coverage ends or the date employer contributions toward coverage under the other plan terminate.

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

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

2. A court has ordered coverage be provided for a spouse, domestic partner or dependent child under your employee health plan and an application is filed within 31 days from the date the court order is issued.
3. The claims administrator does not have a written statement from the plan administrator stating that prior to declining coverage or disenrolling, you received and signed acknowledgment of a written notice specifying that if you do not enroll for coverage within 31 days after your eligibility date, or if you disenroll, and later file an enrollment application, your coverage may not begin until the first day of the month following the end of the plan administrator's next open enrollment period.

4. You have a change in family status through either marriage or domestic partnership, or the birth, adoption, or placement for adoption of a child:
   a. If you are enrolling following marriage or domestic partnership, you and your new spouse or domestic partner must enroll within 31 days of the date of marriage or domestic partnership. Your new spouse or domestic partner's children may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above.
   b. If you are enrolling following the birth, adoption, or placement for adoption of a child, your spouse (if you are already married) or domestic partner, who is eligible but not enrolled, may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above. Application must be made within 31 days of the birth or date of adoption or placement for adoption.

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

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

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

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

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

OPEN ENROLLMENT PERIOD

There is an open enrollment period once each year, during the months of October and November. During that time, an individual who meets the eligibility requirements as a subscriber under this plan may enroll. A subscriber may also enroll any eligible dependents at that time. Persons eligible to enroll as dependents may enroll only under the subscriber’s plan.

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

HOW COVERAGE ENDS

Your coverage ends without notice as provided below:

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

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

3. Coverage for dependents ends when subscriber’s coverage ends.

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

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

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

a. **Leave of Absence.** If you are a *subscriber* and the required monthly contributions are paid, your coverage may continue during an approved temporary leave of absence.

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

**Note:** If a marriage or domestic partnership terminates, the *subscriber* must give or send to the *plan administrator* written notice of the termination. Coverage for a former *spouse* or *domestic partners*, and their dependent *children*, if any, ends according to the "Eligible Status" provisions. Failure to provide written notice to the *plan administrator* will not delay or prevent termination of the marriage or domestic partnership. If the *subscriber* notifies the *plan administrator* in writing to cancel coverage for a former *spouse or domestic partner* and the *children* of the *spouse or domestic partner*, if any, immediately upon termination of the *subscriber’s* marriage or domestic partnership, such notice will be considered compliance with the requirements of this provision.

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

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

DEFINITIONS

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

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

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

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

1. For Subscribers and Dependents:
   a. The subscribers termination of employment, for any reason other than gross misconduct; or
   b. A reduction in the subscriber’s work hours.

2. For Retired Employees and their Dependents. Cancellation or a substantial reduction of retiree benefits under the plan due to the plan’s filing for Chapter 11 bankruptcy, provided that:
   a. The plan expressly includes coverage for retirees; and
   b. Such cancellation or reduction of benefits occurs within one year before or after the plan’s filing for bankruptcy.
3. **For Dependents:**
   a. The death of the subscriber;
   b. The spouse’s divorce or legal separation from the subscriber;
   c. The end of a domestic partner’s partnership with the subscriber;
   d. The end of a child’s status as a dependent child, as defined by the plan; or
   e. The subscriber’s entitlement to Medicare.

**ELIGIBILITY FOR COBRA CONTINUATION**

A subscriber or dependent may choose to continue coverage under the plan if his or her coverage would otherwise end due to a Qualifying Event.

**TERMS OF COBRA CONTINUATION**

**Notice.** We will notify either the subscriber or dependent of the right to continue coverage under COBRA, as provided below:

1. For Qualifying Events 1, or 2, the plan administrator will notify the subscriber of the right to continue coverage.
2. For Qualifying Events 3(a) or 3(e) above, a dependent will be notified of the COBRA continuation right.
3. You must inform the plan administrator within 60 days of Qualifying Events 3(b), 3(c), or 3(d) above, if you wish to continue coverage. The plan administrator, in turn, will promptly give you official notice of the COBRA continuation right.

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

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

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

**Additional Dependents.** A spouse, domestic partner or child acquired during the COBRA continuation period is eligible to be enrolled as a dependent. The standard enrollment provisions of the plan apply to enrollees during the COBRA continuation period.
Cost of Coverage. The plan administrator may require that you pay the entire cost of your COBRA continuation coverage. This cost, called the “required monthly contribution”, must be remitted to the plan administrator each month during the COBRA continuation period in order to maintain the coverage in force.

Besides applying to the subscriber, the subscriber’s rate will also apply to:

1. A spouse whose COBRA continuation began due to divorce, separation or death of the subscriber;
2. A domestic partner whose COBRA continuation began due to the end of the domestic partnership or death of the subscriber;
3. A child, if neither the subscriber nor the spouse has enrolled for this COBRA continuation coverage (if more than one child is so enrolled, the required monthly contribution will be the two-party or three-party rate depending on the number of children enrolled); and
4. A child whose COBRA continuation began due to the person no longer meeting the dependent child definition.

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

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

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

For dependents properly enrolled during the COBRA continuation, coverage begins according to the enrollment provisions of the plan.
When the COBRA Continuation Ends. This COBRA continuation will end on the earliest of:

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

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

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

4. The date the plan terminates;

5. The end of the period for which required monthly contributions are last paid;

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

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

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

Subject to the plan remaining in effect, a retired employee whose COBRA continuation coverage began due to Qualifying Event 2 may be covered for the remainder of his or her life; that person's covered dependents may continue coverage for 36 months after the subscriber's death. However, coverage could terminate prior to such time for either subscriber or dependent in accordance with items 4, 5 or 6 above.
If your COBRA continuation under this plan ends in accordance with items 1, 2 or 3, you may be eligible for medical conversion coverage. If your COBRA continuation under this plan ends in accordance with items 1, 2, 3, or 4 you may be eligible for HIPAA coverage. The plan administrator will provide notice of these options within 180 days prior to your COBRA termination date. Please see HIPAA COVERAGE AND CONVERSION in this booklet for more information.

EXTENSION OF CONTINUATION DURING TOTAL DISABILITY

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

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

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

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

1. The date of the Social Security Administration's determination of the disability;
2. The date on which the original Qualifying Event occurs;
3. The date on which the Qualified Beneficiary loses coverage; or
4. The date on which the Qualified Beneficiary is informed of the obligation to provide the disability notice.
**Cost of Coverage.** For the 19th through 29th months that the total disability continues, the cost for the extended continuation coverage must be remitted to us. This cost (called the "required monthly contribution") shall be subject to the following conditions:

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

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

3. You may be required to pay the entire cost of the extended continuation coverage.

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

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

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

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

3. The date the *plan* terminates;

4. The end of the period for which required monthly contributions are last paid;

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

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

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

EXTENSION OF BENEFITS

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

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

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

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

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

HIPAA Coverage

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

1. You must have a minimum of 18 months of continuous health coverage, most recently under an employer-sponsored health plan, and have had coverage within the last 63 days.
2. Your most recent coverage was not terminated due to nonpayment of premium charges or fraud.
3. If continuation of coverage under the employer plan was available under COBRA or a similar state program, 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 the claims administrator and make the first premium 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 plan terminates and is replaced by another group plan within 15 days.
2. You are not eligible if your coverage under this plan ends because premium 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.

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

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

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

**GENERAL PROVISIONS**

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

**Independent Contractors.** The claims administrator’s relationship with providers is that of an independent contractor. Physicians, and other health care professionals, hospitals, skilled nursing facilities and other community agencies are not the claims administrator’s agents nor is the claims administrator, or any of the employees of the claims administrator, an employee or agent of any hospital, medical group or medical care provider of any type.
Non-Regulation of Providers. The benefits of this plan do not regulate the amounts charged by providers of medical care, except to the extent that rates for covered services are regulated with participating providers.

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

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

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

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

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

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

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

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

Providers available to you through the BlueCard Program have not entered into contracts with the claims administrator. If you have any questions or complaints about the BlueCard Program, please call 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 plan, both the plan and your coverage under the plan must be in effect on the date the expense giving rise to a claim for benefits is incurred.

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

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

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

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

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

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

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

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

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

**Notice of Claim.** You or the provider of service must send the claims administrator properly and fully completed claim forms within 90 days of the date you receive the service or supply for which a claim is made. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed. The plan administrator is not liable for the benefits of the plan if you do not file claims within the required time period. The plan administrator will not be liable for benefits if the claims administrator does not receive written proof of loss on time.

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

**Payment to Providers.** The benefits of this plan will be paid directly to contracting hospitals, participating providers, CME and medical transportation providers. If you or one of your dependents receives services from non-contracting hospitals or non-participating providers, payment will be made directly to the subscriber and you will be responsible for payment to the provider. The plan will pay non-contracting hospitals and other providers of service directly when emergency services and care are provided to you or one of your dependents. The plan will continue such direct payment until the emergency care results in stabilization. If you are a MediCal beneficiary
and you assign benefits in writing to the State Department of Health Services, the benefits of this *plan* will be paid to the State Department of Health Services. These payments will fulfill the *plan*'s obligation to you for those covered services.

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

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

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

The *claims administrator* has established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses, and whether to settle or compromise recovery amounts. The *claims administrator* will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. The *claims administrator* may not provide you with notice of overpayments made by the *plan* or you if the recovery method makes providing such notice administratively burdensome.
Plan Administrator - COBRA and ERISA. In no event will the claims administrator be plan administrator for the purposes of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) or the Employee Retirement Income Security Act (ERISA). The term "plan administrator" refers to THE CITY OF LONG BEACH or to a person or entity other than the claims administrator, engaged by THE CITY OF LONG BEACH to perform or assist in performing administrative tasks in connection with the plan. The plan administrator is responsible for satisfaction of notice, disclosure and other obligations of administrators under ERISA. In providing notices and otherwise performing under the CONTINUATION OF COVERAGE section of this benefit booklet, the plan administrator is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as your agent.

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

Prepayment Fees. The plan administrator may require that you contribute all or part of the costs of these required monthly contributions. Please consult your plan administrator for details.

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

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

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

Transition Assistance for New Members: Transition Assistance is a process that allows for completion of covered services for new members receiving services from a non-participating provider. 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 the claims administrator in consultation with you and the non-participating provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time you enroll in this plan.

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 in this plan.

6. Performance of a surgery or other procedure that the claims administrator 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 in this plan.

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.

You will be notified 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 are negotiated on a case-by-case basis. The non-participating provider will be asked to agree to
accept reimbursement and contractual requirements that apply to participating providers, including payment terms. If the non-participating provider does not agree to accept said reimbursement and contractual requirements, the non-participating provider’s services will not be continued. 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, benefits will be provided at the participating provider level for covered services (subject to applicable copayments, coinsurance, deductibles and other terms) received from a provider at the time the provider’s contract with the claims administrator terminates (unless the provider’s contract terminates for reasons of medical disciplinary cause or reason, fraud, or other criminal activity).

You must be under the care of the participating provider at the time the provider’s contract terminates. The terminated provider must agree in writing to provide services to you in accordance with the terms and conditions of his or her agreement with the claims administrator prior to termination. The provider must also agree in writing to accept the terms and reimbursement rates under his or her agreement with the claims administrator prior to termination. If the provider does not agree with these contractual terms and conditions, the provider’s services will not be continued beyond the contract termination date.

Benefits for the completion of covered services by a terminated provider will be provided 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 the claims administrator in consultation with you and the terminated provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the date the provider’s contract terminates.
3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

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

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

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

Such benefits will not apply to providers 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 your clinical condition and is not determined by diagnostic classifications. Continuity of care does not provide coverage for services not otherwise covered under the plan.

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

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

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

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

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

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

The arbitration is begun by the member making written demand on the plan administrator. The arbitration will be conducted by Judicial Arbitration and Mediation Services (“JAMS”) according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the member and the plan administrator, or by order of the court, if the member and the plan administrator cannot agree.

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

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

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

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

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

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

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

3. The *claims administrator* has authorized the referral before services are rendered.

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

**Benefit Booklet (benefit booklet)** is this written description of the benefits provided under the *plan*.

**Centers of Medical Excellence (CME)** are health care providers designated by the *claims administrator* as a selected facility for specified medical services. A provider participating in a CME network has an agreement in effect with the *claims administrator* at the time services are rendered or is available through their affiliate companies or their relationship with the Blue Cross and Blue Shield Association. CME agree to accept the *maximum allowed amount* as payment in full for covered services. A *participating provider* in the Prudent Buyer Plan network is not necessarily a *CME*. 
Child meets the plan's eligibility requirements for children as outlined under HOW COVERAGE BEGINS AND ENDS.

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

Contracting hospital is a hospital which has a Standard Hospital Contract in effect with the claims administrator to provide care to members. A contracting hospital is not necessarily a participating provider. A list of contracting hospitals will be sent on request.

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

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

If your prior coverage was not through an employer, you will receive credit for that coverage if any lapse between the date that coverage ended and the date you become eligible under this plan is no more than 63 days (not including any waiting period imposed under this plan).
Custodial care is care provided primarily to meet your personal needs. This includes help in walking, bathing or dressing. It also includes: preparing food or special diets; feeding by utensil, tube or gastrostomy; suctioning and administration of medicine which is usually self-administered or any other care which does not require continuing services of medical personnel.

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

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

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

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

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

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

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

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

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

Full-time employee meets the plan’s eligibility requirements for full-time employees as outlined under HOW COVERAGE BEGINS AND ENDS.
Home health agencies are home health care providers which are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in your home, and recognized as home health providers under Medicare and/or accredited by a recognized accrediting agency such as the Joint Commission on the Accreditation of Healthcare Organizations.

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

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

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

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

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

Investigative procedures or medications are those that have progressed to limited use on humans, but which are not widely accepted as proven and effective within the organized medical community.
**Maximum allowed amount** is the maximum amount of reimbursement the *claims administrator* will allow for covered medical services and supplies under this *plan*. See YOUR MEDICAL BENEFITS: MAXIMUM ALLOWED AMOUNT.

**Medically necessary** procedures, supplies equipment or services are those the *claims administrator* determines to be:

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

**Member** is the *subscriber* or *dependent*. 

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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.

Non-contracting hospital is a hospital which does not have a Standard Hospital Contract in effect with the claims administrator at the time services are rendered.

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

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

- A hospital
- A physician
- An ambulatory surgical center
- A home health agency
- A facility which provides diagnostic imaging services
- A durable medical equipment outlet
- A skilled nursing facility
- A clinical laboratory
- A home infusion therapy provider
- An urgent care center
- A retail health clinic;
- A hospice
- A licensed ambulance company
They are not participating providers. Remember that the maximum allowed amount may only represent a portion of the amount which a non-participating provider charges for services. See YOUR MEDICAL BENEFITS: MAXIMUM ALLOWED AMOUNT.

Other health care provider is one of the following providers:

- A certified registered nurse anesthetist;
- A blood bank; or

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

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

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

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

Pharmacy means a licensed retail pharmacy.

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 above:

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

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

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

Plan is the set of benefits described in this benefit booklet and in the amendments to this benefit booklet, if any. These benefits are subject to the terms and conditions of the plan. If changes are made to the plan, an amendment or revised benefit booklet will be issued to each subscriber affected by the change. (The word "plan" here does not mean the same as "plan" as used in ERISA.)
Plan administrator refers to THE CITY OF LONG BEACH, the entity which is responsible for the administration of the plan.

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

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

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

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

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

http://www.healthcare.gov/center/regulations/prevention.html
http://www.ahrq.gov/clinic/uspstfix.htm
http://www.cdc.gov/vaccines/recs/acip/
Prior plan is a plan sponsored by us which was replaced by this plan within 60 days. You are considered covered under the prior plan if you:
(1) were covered under the prior plan on the date that plan terminated;
(2) properly enrolled for coverage within 31 days of this plan’s Effective Date; and (3) had coverage terminate solely due to the prior plan’s termination.

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

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

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

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

Benefits provided for treatment in a psychiatric health facility which does not have a Standard Hospital Contract in effect with the claims administrator will be subject to the non-contracting hospital penalty in effect at the time of service.

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

Reasonable and customary value is (1) for professional non-participating providers, the reasonable and customary value is determined by using a percentile of billed charges from a database of a third-party that takes into consideration various factors, such as the amounts billed for same or similar services, and the geographic locations in which the services were rendered; and (2) for facility non-participating providers and non-contracting hospitals, the reasonable and customary
value is determined by using a percentile of billed charges from a database of the claims administrator’s actual claims experience, subject to certain thresholds based on each provider’s cost-to-charge ratio as reported by the provider to a California governmental agency and the actual claim submitted to the claims administrator.

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

**Retail Health Clinic** - A facility that provides limited basic medical care services to members on a “walk-in” basis. These clinics normally operate in major pharmacies or retail stores.

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

**Severe mental disorders** include the following psychiatric diagnoses specified in California 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.

**Specialty drugs** are high-cost, injectable, infused, oral or inhaled medications that generally require close supervision and monitoring of their effect on the patient by a medical professional. These drugs which often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail *pharmacies*.

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

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

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

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

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

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

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

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

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

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

**We (us, our)** refers to THE CITY OF LONG BEACH.

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

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

**YOUR RIGHT TO APPEALS**

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

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

If your claim is denied:

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

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

**Notice of Adverse Benefit Determination**

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

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
a reference to the specific plan provision(s) on which the claims administrator's determination is based;

- a description of any additional material or information needed to perfect your claim;

- an explanation of why the additional material or information is needed;

- a description of the plan's review procedures and the time limits that apply to them, including a statement of your right to bring a civil action under ERISA (if applicable) if you appeal and the claim denial is upheld;

- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision;

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

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

For claims involving urgent/concurrent care:

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

- the claims administrator may notify you or your authorized representative within 24 hours orally and then furnish a written notification.

**Appeals**

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

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

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

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

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

Anthem Blue Cross Life and Health Insurance Company
ATTN: Appeals
P.O. Box 54159, Los Angeles, CA 90054

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

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly-situated claimants; or

- is a statement of the plan’s policy or guidance about the treatment or benefit relative to your diagnosis.

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

**How Your Appeal will be Decided**

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

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

**Notification of the Outcome of the Appeal**

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

**If you appeal any other pre-service claim,** the claims administrator will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.
If you appeal a post-service claim, the claims administrator will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

Appeal Denial

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

Voluntary Second Level Appeals

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

External Review

If the outcome of the mandatory first level appeal is adverse to you, you may be eligible for an independent External Review pursuant to federal law.

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

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

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

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

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

Anthem Blue Cross Life and Health Insurance Company
ATTN: Appeals
P.O. Box 54159, Los Angeles, CA 90054

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

Requirement to file an Appeal before filing a lawsuit

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

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

ANTHEM BLUE CROSS WEB SITE

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

LANGUAGE ASSISTANCE PROGRAM

Anthem Blue Cross Life and Health introduced its Language Assistance Program to provide certain written translation and oral interpretation services to California members with limited English proficiency.

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

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

- Spanish
- Chinese
- Vietnamese
- Korean
- Tagalog

Oral interpretation services are available in additional languages.

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

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