



**PEPPERDINE UNIVERSITY  
HEALTH & WELFARE PLAN**

*September 1, 2011*



***Anthem Blue Cross PLUS Plan***

**COMBINED EVIDENCE OF COVERAGE  
AND DISCLOSURE FORM**

**Anthem Blue Cross  
21555 Oxnard Street  
Woodland Hills, California 91367**

**This Combined Evidence of Coverage and Disclosure (Evidence of Coverage) Form is a summary of the important terms of your health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage. If you have special health care needs, you should read those sections of the Evidence of Coverage that apply to those needs. Your employer will provide you with a copy of the health plan contract upon request.**





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## INTRODUCTION TO ANTHEM BLUE CROSS PLUS

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

The Anthem Blue Cross PLUS Plan is a managed care health plan that combines the comprehensive, cost-saving coverage of a health maintenance organization (HMO) with the flexibility and freedom of choice of a preferred provider organization (PPO).

With the Anthem Blue Cross PLUS Plan, you have access to both the Anthem Blue Cross PLUS network of HMO providers, plus Anthem Blue Cross' Prudent Buyer Plan network of PPO providers. You may choose any licensed provider, including the thousands of providers who participate in the extensive statewide Prudent Buyer Plan network.

The type of provider you choose, however, will determine the benefits that will be provided for services covered by your Anthem Blue Cross PLUS Plan. **You will be entitled to the maximum benefits (the HMO coverage) only when services are received from or authorized by your Primary Care Physician or Medical Group.** You may "opt out" of the HMO, and under your PLUS benefits, use a *Prudent Buyer Plan provider* or a *non-Prudent Buyer Plan provider* for selected services, however, your out-of-pocket costs will be greater. By choosing a *Prudent Buyer Plan provider*, you can reduce your out-of-pocket costs. However, you may not "opt out" of your HMO to your own *primary care physician*, or for Direct Access program services provided by a *physician* who works with your *medical group* (see "Direct Access" later in this section).

When you enroll for the plan, you must choose a *medical group* and *primary care physician*. You must also follow our rules when obtaining care from the HMO. However, you do not need a referral from your *primary care physician* or *medical group* when you are using your PLUS benefits. You simply choose any *Prudent Buyer Plan provider* or *non-Prudent Buyer Plan provider*.

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

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

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

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

**Contracting and Non-Contracting Hospitals.** As a health care service plan, we have traditionally contracted with most *hospitals* to obtain certain advantages for patients covered by us. While only some *hospitals* are *Prudent Buyer Plan 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*.**

**Your ID Card.** Your identification card not only identifies you, but this card also shows the *medical group* to which you belong and gives your *medical group's* address and telephone number. Be sure to keep this card with you at all times and to present it whenever you receive care.

You will also need to present this card when you receive care from a *Prudent Buyer Plan provider* through your PLUS benefits.

**Your Medical Group and Primary Care Physician.** When a *subscriber* enrolls, he or she chooses an Anthem Blue Cross PLUS *medical group* for himself or herself, plus all covered *family members*. Not every *member* in that family must be enrolled at the same *medical group*. You may choose any *medical group* that is accepting new patients. However, each *member* must live or work within the *enrollment area* of the *medical group* chosen by him or her.

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

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

Obstetrical and gynecological services may be received without obtaining referral or approval from your *primary care physician* or from us, from an obstetrician, gynecologist or family practice physician who is a member of your *medical group* or who has an arrangement with your *medical group* to provide care for its patients, and who has been identified by your *medical group* as available for providing obstetrical and gynecological care. A *participating provider* who specializes in obstetrical and gynecological care may refer you to another *physician* or health care provider and order related obstetrical and gynecological items and services if you need additional *medically necessary* care. The conditions for a referral from a *participating provider* who specializes in obstetrical and gynecological care are the same conditions for referral

from your *primary care physician* (see the “Referral Care” provision under USING YOUR HMO BENEFITS). All other terms and conditions of this *plan* apply to covered services received from a *participating provider* who specializes in obstetrical and gynecological care.

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

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

**Care for Mental or Nervous Disorders or Substance Abuse.** Services for the treatment of *mental or nervous disorders* and substance abuse may be received directly, without obtaining referral from your *primary care physician*, from a *participating provider*. Some services may require that we evaluate and approve treatment in advance. Please see UTILIZATION REVIEW PROGRAM for more information.

An Anthem Blue Cross Behavioral Health Network directory of *participating providers* who specialize in the treatment of *mental or nervous disorders* and substance abuse is available to you from your plan administrator (usually your employer) or from us, as follows:

- You may call the telephone number shown on your ID card or you may write to us and ask that we send you a directory. Ask for the Behavioral Health Network directory.
- You may also search for a *participating provider* using the “Provider Finder” function on our website at [www.anthem.com/ca](http://www.anthem.com/ca). Be sure to select the “Behavioral Health Professionals” option on the next screen following your selection of plan category.

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

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

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

- Allergy
- Dermatology
- Ear/Nose/Throat

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

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

**Revoking or Modifying a Referral or Authorization.** A referral or authorization for services or care that was approved by your *medical group*, your *primary care physician*, or by us may be revoked or modified prior to the services being rendered for reasons including but not limited to the following:

- Your coverage under this *plan* ends;
- The *agreement* with the *group* terminates;
- You reach a benefit maximum that applies to the services in question;
- Your benefits under the *plan* change so that the services in question are no longer covered or are covered in a different way.

**Reproductive Health Care Services.** Some *hospitals* and other providers do not provide one or more of the following services that may be covered under your *plan* contract and that you or your family member

might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call us at the customer service telephone number listed on your ID card to ensure that you can obtain the health care services that you need.

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

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

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

3. Under special circumstances, you can request a transfer, by calling the Customer Service number shown on your ID card or by properly filing a membership change form with the *group* within 31 days of the special circumstance prompting your request. You must include the reasons for your request. We must approve your request for the transfer to become effective.

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

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

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

**Your Anthem Blue Cross PLUS Coordinator.** If you need help selecting a *primary care physician* from the staff of your *medical group* or need information including financial arrangements and any incentives about the *physicians* in your *medical group*, contact the *Anthem Blue Cross PLUS coordinator*, located at your *medical group*. Your *Anthem*

*Blue Cross PLUS coordinator* will also provide you with any information you may need about Anthem Blue Cross PLUS services and procedures. You may contact your *Anthem Blue Cross PLUS coordinator* by phone or by letter.

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

Anthem Blue Cross is committed to:

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

**Member Rights.** You have the right to:

- Participate with your health care professionals and providers in making decisions about your health care;
- Receive the benefits for which you have coverage;
- Be treated with respect and dignity;
- Privacy of your personal health information, consistent with state and federal laws, and our policies;
- Receive information about our organization and services, our network of health care professionals and providers, and your rights and responsibilities;
- Candidly discuss with your *physicians* and providers appropriate or *medically necessary* care for your condition, regardless of cost or benefit coverage;
- Make recommendations regarding the organization's *members'* rights and responsibilities policies;

- Voice complaints or appeals about our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided;
- Refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by your *physician(s)* of the medical consequences;
- Participate in matters of the organization's policy and operations.

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

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

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

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

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

## SUMMARY OF BENEFITS

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

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

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

**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, please contact your *primary care physician*. In addition, triage or screening services are available to you from us 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.

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

The benefits of this <i>plan</i> may be subject to the REIMBURSEMENT FOR ACTS OF THIRD PARTIES section.
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## HMO MEDICAL BENEFITS

### CO-PAYMENT LIST

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

#### Hospital Services

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

#### Skilled Nursing Facility Services

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

#### Home Health Care

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

#### Hospice

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

#### Ambulatory Surgical Center

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

#### Physician

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

- Physical Therapy, Physical Medicine and Occupational Therapy ..... \$20
- Visit to a *specialist* ..... \$20

**General Medical Care**

- Ambulance ..... **No charge**
- Hemodialysis ..... **No charge**
- Durable medical equipment ..... **No charge**
- Medical social services ..... **No charge**
- *Prosthetic devices* ..... **No charge**
- Chemotherapy and radiation therapy ..... **No charge**
- Diagnostic x-ray and laboratory procedures\*:
  - CT or CAT scan, MRI or nuclear cardiac scan, PET scan ..... \$100 per test
  - all other x-ray and laboratory tests ..... **No charge**
- Allergy testing and treatment ..... **No charge**
- Diabetes education programs ..... \$20
- Organ and tissue transplants ..... **The applicable co-payment specified herein**

\* When performed in a non-*hospital*-based facility.

**Emergency Services**

- Professional services ..... **No charge**
- *Hospital* emergency room ..... **\$100\***
- *Hospital* inpatient services ..... **No charge**

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

**Pregnancy and Maternity Care**

- Office visit (including therapeutic abortions)..... **\$20**
- *Physician's* services for normal delivery or cesarean section ..... **No charge**
- *Hospital* services (including therapeutic abortions):
  - Inpatient services ..... **No charge**
  - Outpatient services ..... **No charge**
- Elective abortions including Mifeprestone (abortion *drug*) when administered in the *physician's* office ..... **\$150**
- Genetic testing..... **No charge**

**Infertility and Birth Control**

- *Infertility* services (not including family planning or medication) ..... **50%\***
- Sterilization for females ..... **\$150**
- Sterilization for males ..... **\$75**
- Family planning (counseling and consultation) ..... **No charge**

**\*Note:** Any co-payment made for *infertility* services will not be applied to the "Maximum Co-Payment Limits".

**Mental or Nervous Disorders and Substance Abuse**

- Inpatient *stay* ..... **No charge**
- Inpatient *physician's* visit ..... **No charge**
- Outpatient *physician's* visit ..... **No charge**

**Preventive Care Services**

- Routine physical examinations ordered by your *primary care physician*..... **No Charge**
- Immunizations prescribed by your *primary care physician*..... **No Charge**
- Routine x-ray and laboratory tests in connection with a routine physical examination ordered by your *primary care physician*..... **No Charge**

- Medically accepted routine cancer screening tests.....**No Charge**
- HIV testing .....**No Charge**
- Routine vision or hearing examinations .....**No Charge**
- Health education programs other than diabetes education .....**Selected programs at no charge**
- Preventive counseling and risk factor reduction intervention services related to tobacco use .....**No Charge**

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

**MAXIMUM CO-PAYMENT LIMITS**

Member .....	<b>\$1,500</b>
Family.....	<b>\$3,000</b>

**Exception.** Any co-payment made for the initial consultation and testing for diagnosis of *infertility* will not be applied to the Maximum Co-Payment Limits.

## PLUS MEDICAL BENEFITS

### DEDUCTIBLES

#### Applicable to Prudent Buyer Plan providers:

- Member Deductible ..... \$350
- Family Deductible ..... \$700

#### Applicable to Non-Prudent Buyer Plan providers:

- Member Deductible ..... \$750
- Family Deductible ..... \$1,500

#### Additional Deductibles

- Emergency Room Deductible..... \$100
- Inpatient Deductible..... \$500
- 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 services provided by a *Prudent Buyer Plan provider* under the Physical Therapy, Physical Medicine and Occupational Therapy benefit.
- The Calendar Year Deductible will not apply to transplant travel expenses authorized by us in connection with a specified transplant procedure provided at a designated *CME*.
- The Calendar Year Deductible will not apply to bariatric travel expense in connection with an authorized bariatric surgical procedure provided at a designated *CME*.
- The Emergency Room Deductible will not apply if you are admitted as a *hospital* inpatient immediately following emergency room treatment.
- The Inpatient Deductible will not apply to *emergency* admissions, nor to the services provided by a *Prudent Buyer Plan provider*.
- The Non-Certification Deductible will not apply to *emergency* admissions or services, nor to the services provided by a *Prudent Buyer Plan provider*. See UTILIZATION REVIEW PROGRAM.

## CO-PAYMENTS AND OUT-OF-POCKET AMOUNTS

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

- *Prudent Buyer Plan Providers and Other Health Care Providers* .....**20%**
- *Non-Prudent Buyer Plan Providers* .....**30%**

**Note:** In addition to the Co-Payment shown above, you will be required to pay any amount in excess of *covered expense* for the services of an *other health care provider* or *non-Prudent Buyer Plan provider*.

Any co-payment shown above will not apply to services for the treatment of *mental or nervous disorders*, and *substance abuse* if covered services are received from a *Prudent Buyer Plan provider*. When you receive these services from a *Prudent Buyer Plan provider*, your co-payments will be the same as those listed under HMO MEDICAL BENEFITS.

### **\*Exceptions:**

- Your Co-Payment for the following services will be **50%**, plus charges in excess of *covered expense*:
  - Sterilization for males;
  - Sterilization for females; and
  - Family planning (counseling and visit).
- Your Co-Payment for *Prudent Buyer Plan providers* and *non-Prudent Buyer Plan providers* will be the same as for *participating providers* for all *emergency services*. You may be responsible for charges which exceed *covered expense*.
- Your Co-Payment for *non-Prudent Buyer Plan providers* will be the same as for *Prudent Buyer Plan providers* for the following services. You may be responsible for charges which exceed *covered expense*.
  - a. An *authorized referral* from a *physician* who is a *Prudent Buyer plan provider* to a *non-Prudent Buyer Plan provider*;
  - b. Charges by a type of *physician* not represented in the Prudent Buyer Plan network; or
  - c. Cancer Clinical Trials.

- Your Co-Payment for office visits to a *Prudent Buyer Plan provider* for services provided under the Physical Therapy, Physical Medicine and Occupational Therapy benefit will be **\$20**.
- Your Co-Payment for specified transplants (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures) determined to be *medically necessary* and performed at a designated *CME* will be the same as for *participating providers*. **Services for specified transplants are not covered when performed at other than a designated *CME***. See UTILIZATION REVIEW PROGRAM.

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

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

**NOTE:** Co-Payments do not apply to bariatric travel expenses authorized by us. Bariatric travel expense coverage is available when the closest *CME* is 50 miles or more from the *member's* residence.

**Out-of-Pocket Amount\*.** After each *member* has made the following total out-of-pocket payments for *covered expense* incurred during a *calendar year*, each *member* will no longer be required to pay a Co-Payment for the remainder of that *year*, but will remain responsible for costs in excess of *covered expense*.

- *Participating providers and other health care providers*..... **\$2,000**
- *Non-participating providers* ..... **\$3,000**

**Note.** The amount of out-of-pocket payments you or your family have made for services rendered by a *participating provider* or *non-participating provider* are combined for purposes of calculating the maximum out-of-pocket payments required until you will no longer have to pay a Co-Payment. For example, if your out-of-pocket payments for services rendered by a *participating provider* equals \$2,000 and you

incur expenses for services rendered by a *non-participating provider*, you will only need to make an additional \$1,000 in out-of-pocket payments in order to satisfy the out-of-pocket maximum for *non-participating providers* (\$3,000).

**\*Exceptions:**

- You will be required to continue to pay your Co-Payment for the following services even after you have reached your Out-of-Pocket Amount. In addition, any Co-Payments you make for such services will not be applied toward reaching that amount.
  - Sterilization for males;
  - Sterilization for females; and
  - Family planning (counseling and visit).
- 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 amount of *covered expense*, will not be applied toward your Out-of-Pocket Amount.

**Non-Contracting Hospital Penalty.** *Covered expense is reduced by 25% for services and supplies provided by a non-contracting hospital. This penalty will be deducted from covered expense prior to calculating your Co-Payment amount, and any benefit payment by us will be based on such reduced covered expense. 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**

**PLUS MEDICAL BENEFIT MAXIMUMS**

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

**Ambulatory Surgical Center**

- For all covered services and supplies ..... **\$350\***  
*\*Non-Prudent Buyer Plan providers only*

**Outpatient Hemodialysis**

- For all covered services and supplies ..... **\$350\***  
per visit  
*\* Non-Prudent Buyer Plan providers only*

**Acupuncture**

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

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

- For covered outpatient services ..... **30**  
visits per *calendar year*,  
additional visits as authorized  
by us if *medically necessary*
- For each covered visit when provided  
by a *non-participating provider* ..... **\$25**  
per visit

**Transplant Travel Expense**

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

**Unrelated Donor Searches**

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

**Bariatric Travel Expense**

- For the *member* (limited to three (3) trips – one pre-surgical visit, the initial surgery and one follow-up visit)
  - For transportation to the *CME*.....up to **\$130**  
per trip
- For the companion (limited to two (2) trips – the initial surgery and one follow-up visit)
  - For transportation to the *CME*.....up to **\$130**  
per trip
- For the *member* and one companion (for the pre-surgical visit and the follow-up visit)
  - Hotel accommodations .....up to **\$100**  
per day, for up to 2 days per trip,  
limited to one room,  
double occupancy
- For one companion (for the duration of the *member's* initial surgery stay)
  - Hotel accommodations .....up to **\$100**  
per day, for up to 4 days,  
limited to one room,  
double occupancy
  - For other reasonable expenses  
(excluding, tobacco, alcohol, drug  
and meal expenses).....up to **\$25**  
per day,  
for up to 4 days per trip

**Lifetime Maximum**

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

## HMO MEDICAL BENEFIT MAXIMUMS

### Physical Therapy, Physical Medicine and Occupational Therapy

- For all services combined.....**up to a 60 day period**  
for each illness or injury,  
additional visits as authorized  
by your *medical group* or Anthem  
if *medically necessary*

## COMBINED HMO AND PLUS MEDICAL BENEFIT MAXIMUMS

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

### Skilled Nursing Facility

- For covered *skilled nursing facility* care .....**100 days**  
per *calendar year*

### Home Health Care

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

### Hearing Aid Services

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

## PRESCRIPTION DRUG BENEFITS

**PRESCRIPTION DRUG CO-PAYMENTS.** The following co-payments apply for each *prescription*:

**Retail Pharmacies:** The following co-payments apply for a 30-day supply of medication. **Note:** Unless an exception is made, after the first two month supply of a *specialty drug* is obtained through a retail *pharmacy*, the *drug* is available only through the specialty drug program, see Specialty Drug Prescriptions below.

### Participating Pharmacies

- *Generic Drugs* ..... **\$10**
- *Brand Name Drugs:*
  - *Formulary drugs* ..... **\$25**
  - *Non-formulary drugs* ..... **\$45**
- *Compound medications* ..... **\$45**
- Self-administered injectable drugs, except insulin ..... **20%**  
of *prescription drug covered expense*  
to a maximum copayment of **\$100**  
for each *prescription*

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

**Non-Participating Pharmacies\***

- *Generic Drugs* ..... **\$10**  
plus **50%** of the remaining *prescription drug covered expense*
  
- *Brand Name Drugs:*
  - *Formulary drugs* ..... **\$25**  
plus **50%** of the remaining *prescription drug covered expense*
  
  - *Non-formulary drugs* ..... **\$45**  
plus **50%** of the remaining *prescription drug covered expense*
  
- Self-administered injectable drugs, except insulin ..... **20%**  
of *prescription drug covered expense*  
to a maximum copayment of **\$100** for each *prescription*  
plus **50%** of the remaining *prescription drug covered expense*

**Mail Order Prescriptions:** The following co-payments apply for a 90-day supply of medication. **Note:** *Specialty drugs* are not available through the mail service program, see Specialty Drug Prescriptions below.

- *Generic Drugs* ..... **\$10**
  
- *Brand Name Drugs:*
  - *Formulary drugs* ..... **\$25**
  
  - *Non-formulary drugs* ..... **\$45**
  
- Self-administered injectable drugs, except insulin ..... **20%**  
of *prescription drug covered expense*  
to a maximum copayment of **\$100**  
for each *prescription*

**Specialty Drug Prescriptions:** The following co-payments apply for a 30-day supply of medication obtained from the specialty drug program.

- *Generic Drugs* ..... **\$10**
- *Brand Name Drugs:*
  - *Formulary drugs*..... **\$25**
  - *Non-formulary drugs* ..... **\$45**
- Self-administered injectable drugs, except insulin.....**20%**  
of *prescription drug covered expense*  
to a maximum copayment of **\$100**  
for each *prescription*

**\*Important Note About Prescription Drug Covered Expense and Your Co-Payment.**

- The *prescription drug formulary* is a list of outpatient *prescription drugs* which may be particularly cost-effective, therapeutic choices. Your co-payment amount for *non-formulary drugs* is higher than for *formulary drugs*. Any *participating pharmacy* can assist you in purchasing a *formulary drug*. You may also get information about covered formulary drugs by calling 1-800-700-2541 (or TTY/TDD 1-800-905-9821) or going to our internet website [www.anthem.com/ca](http://www.anthem.com/ca).
- What we allow for *prescription drug covered expense* for *non-participating pharmacies* is usually significantly lower than what those providers customarily charge, so you will almost always have a higher out-of-pocket expense for your drugs when you use a *non-participating pharmacy* to fill your prescription.

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

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

## Preferred Generic Program

Prescription drugs will always be dispensed by a *pharmacist* as prescribed by your *physician*. Your *physician* may order a *brand name drug* or a *generic drug* for you. You may request your *physician* to prescribe a *brand name drug* for you or you may request the *pharmacist* to give you a *brand name drug* instead of a *generic drug*. Under this *plan*, if a *generic drug* is available, and it is not determined that the *brand name drug* is *medically necessary* for you to have (see PRESCRIPTION DRUG FORMULARY: Prior Authorization below), you will have to pay the co-payment for the *generic drug* plus the difference in cost between the *prescription drug maximum allowed amount* for the *generic drug* and the *brand name drug*, but, not more than **\$120**. If your *physician* specifies “dispense as written,” in lieu of paying the co-payment for the *generic drug* plus the difference, as previously stated, you will pay just the applicable co-payment shown for the *brand name drug* you get.

## Special Programs

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

## Half-tab Program

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

## YOUR MEDICAL BENEFITS

### HMO BENEFIT CO-PAYMENTS

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

If you do not make required co-payments within 31 days from the date you are notified of payment due, your coverage may be cancelled as shown in HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE ENDS.

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

### MAXIMUM CO-PAYMENT LIMITS\*

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

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

**The Maximum Co-Payment Limits are shown in the SUMMARY OF BENEFITS: HMO PLAN.**

**\*Exception:** Any co-payment made for the treatment of *infertility* will not be applied toward the Maximum Co-Payment Limits. In addition, any co-payment under the "Plus" benefits will not be applied toward the Maximum Co-Payment Limits.

### PLUS BENEFITS: HOW COVERED EXPENSE IS DETERMINED

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

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

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

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

The maximum *covered expense* for *non-Prudent Buyer Plan providers* for services and supplies provided in connection with Cancer Clinical Trials will be the lesser of the billed charge or the amount that ordinarily applies when services are provided by a *Prudent Buyer Plan provider*.

**Exception:** If Medicare is the primary payor, *covered expense* does not include any charge:

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

2. By a *physician* who is a *Prudent Buyer Plan provider* who accepts Medicare assignment, in excess of the approved amount as determined by Medicare; or
3. By a *physician* who is a *non-Prudent Buyer Plan provider* or *other health care provider* who accepts Medicare assignment, in excess of the lesser of maximum *covered expense* stated above, or the approved amount as determined by Medicare; or
4. By a *physician* or *other health care provider* who does not accept Medicare assignment, in excess of the lesser of maximum *covered expense* 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*.**

**WARNING! Reduction of Covered Expense for Non-Contracting Hospitals.** A small percentage of *hospitals* which are *non-Prudent Buyer Plan providers* are also *non-contracting hospitals*. Except for *emergency care*, *covered expense* **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*.**

#### **PLUS BENEFITS: MEDICAL DEDUCTIBLES, CO-PAYMENTS, OUT-OF-POCKET AMOUNTS AND BENEFIT MAXIMUMS**

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

#### **DEDUCTIBLES**

Each deductible under this *plan* is separate and distinct from the other. Charges that are considered *covered expense* will apply toward 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 the *members* of an enrolled family pay deductible expense in a *year* equal to the Family Deductible, the Calendar Year Deductible for all family members will be considered to have been met. For the purposes of the Family Deductible, *covered expense* over an individual *member's* Calendar Year Deductible will not be counted toward the Family Deductible.

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

**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 your PLUS Benefits; provided that, such payments were for charges that would be *covered expense* under your PLUS Benefits.

### **Additional Deductibles**

1. Each time you visit an emergency room for treatment you will be responsible for paying the Emergency Room Deductible. But this deductible will not apply if you are admitted as a *hospital* inpatient from the emergency room immediately following emergency room treatment.
2. Each time you are admitted to a *hospital* or *residential treatment center* which is a *non-Prudent Buyer Plan provider*, you are responsible for paying the Inpatient Deductible per admission. This deductible will not apply to an *emergency* admission.
3. 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 *Prudent Buyer Plan provider*. Certification is explained in UTILIZATION REVIEW PROGRAM.

### **PLUS CO-PAYMENTS**

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

## **PLUS OUT-OF-POCKET AMOUNT**

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

- Charges which are not considered *covered expense*
- Any expense applied to a deductible
- Any Co-Payments you make for donor searches for transplants
- Sterilization for males
- Sterilization for females
- Family planning (counseling and visit)

Only charges that are considered *covered expense* will apply toward satisfaction of the PLUS Out-of-Pocket Amount. In addition, any charges applied to a deductible or to the services listed above will not be applied toward satisfaction of the PLUS Out-of-Pocket Amount.

## **PLUS MEDICAL BENEFIT MAXIMUMS**

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

**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.

### **COMBINED HMO AND PLUS MEDICAL BENEFIT MAXIMUMS**

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

**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 benefits to be provided under this *plan* for a medical service or supply.

1. You must receive this service or supply while you are covered under this *plan*.
2. The service or supply must be furnished to you as a result of illness or injury or pregnancy, unless a specific exception is made.
3. The service or supply must be included in YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.
4. The service or supply must not be listed in YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS NOT COVERED. If the service or supply is partially excluded, then only benefits for the portion which is not excluded will be provided.
5. The service or supply must not exceed any of the maximum benefits or limitations of this *plan*. For covered services or supplies obtained from a *Prudent Buyer Plan provider*, expense incurred must not exceed the amount of *covered expense*.

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

6. Any services received must be those which are regularly provided and billed by the provider. In addition, those services must be consistent with the illness, injury, degree of disability and your medical needs. Benefits are provided only for the number of days required to treat your illness or injury.
7. All services and supplies must be authorized by a *physician*. If care is obtained through the HMO Benefits, all care must be authorized by your *primary care physician*, or *medical group* except as specifically stated in this booklet.

## MEDICAL CARE THAT IS COVERED

### HMO BENEFITS

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

#### Hospital

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

#### Professional Services

1. Services of a *physician*, including: (a) office visits for a covered illness, injury or condition; and (b) visits to the *member's* home within the *medical group* area, by a *primary care physician*, at that *physician's* discretion.
2. Services of an anesthesiologist (M.D.) or anesthetist (C.R.N.A.).

**Diagnostic Services.** Outpatient diagnostic radiology and laboratory services.

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

#### Dental Care

1. **Admissions for Dental Care.** Listed inpatient *hospital* services for up to three days during a *hospital stay*, when such *stay* is required for dental treatment, has been ordered by a *physician* (M.D.) and a dentist (D.D.S. or D.M.D.), and is authorized by your *medical group*. *Hospital stays* for the purpose of administering general anesthesia are not considered necessary and are not covered except as specified in #2, below.

2. **General Anesthesia.** General anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a *hospital* or *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.** Initial *emergency* care by a *physician* (M.D.) or dentist (D.D.S. or D.M.D.) solely to treat an *accidental injury* to natural teeth. Coverage shall be limited to only such services that are *medically necessary* to repair the damage done by the *accidental injury* and/or restore function lost as a direct result of the *accidental injury*. Damage to natural teeth due to chewing or biting is not *accidental injury*.
4. **Cleft Palate.** *Medically necessary* dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. "Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

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

### **Pregnancy and Maternity Care**

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

**Infertility And Birth Control.** Family planning services, counseling and planning for problems of fertility and *infertility*, as *medically necessary*. Artificial insemination, in vitro fertilization, and any related laboratory procedures are not covered.

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

**Organ and Tissue Transplants.** Services provided in connection with a non-investigative organ or tissue transplant, if you are: (1) the organ or tissue recipient; or (2) the organ or tissue donor, provided the recipient is also an enrolled Anthem Blue Cross PLUS *member*.

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

**Preventive Care Services.**

1. A *physician's* services for routine physical examinations.
2. Immunizations given as standard medical practice.
3. Routine x-ray and laboratory tests in connection with a routine physical examination when ordered by a *physician*.
4. All generally medically accepted cancer screening tests, including mammograms, pap tests, human papillomavirus (HPV) screening, prostate cancer screening, and colorectal cancer screening.
5. Human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.
6. Routine vision or hearing examinations. This includes a vision check provided as part of a routine physical examination to determine if it is *medically necessary* for you to have a complete vision exam by a *specialist*. Hearing screenings include tests to diagnose and correct hearing problems.
7. Health education programs other than diabetes education provided by your *primary care physician* or *medical group*.
8. Preventive counseling and risk factor reduction intervention services in connection with tobacco use and tobacco use-related diseases.

*Preventive care services* are provided on an outpatient basis or in a *physician's* office. Physical exams, tests, and screenings are covered as *preventive care services* when you have no current symptoms or prior history of any medical condition associated with the service provided. See the definition of "Preventive Care Services" in the DEFINITIONS section for more information about services that are covered by this *plan* as *preventive care services*.

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

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

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

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

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

**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.

Up to a 60 day period of care for each illness or injury will be provided, beginning with the first treatment for that illness or injury.

Under your HMO Benefits, your *primary care physician* makes the decision as to when each new illness or injury began. At the request of your *primary care physician*, additional periods of care may be approved, but only if we determine that an additional period of physical therapy, physical medicine or occupational therapy is *medically necessary*. We will specify a specific number of additional visits. See UTILIZATION REVIEW PROGRAM.

### **PLUS BENEFITS**

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

#### **Hospital**

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

*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.

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

1. Medication, (*specialty drugs* must be obtained through the specialty drug program (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); however, medication which is delivered but not administered is not covered;
2. Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications (if outpatient prescription drug benefits are provided under this *plan*, *compound medications* must be obtained from a *participating pharmacy*);
3. *Hospital* and home clinical visits related to the administration of infusion therapy, including skilled nursing services including those provided for: (a) patient or alternative caregiver training; and (b) visits to monitor the therapy;
4. Rental and purchase charges for durable medical equipment; maintenance and repair charges for such equipment;
5. Laboratory services to monitor the patient's response to therapy regimen.

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

### **Professional Services**

1. Services of a *physician*.
2. Services of an anesthetist (M.D. or C.R.N.A.).

**Diagnostic Services.** Outpatient diagnostic imaging and laboratory services. 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), 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.

## **Dental Care**

1. **Admissions for Dental Care.** Listed inpatient *hospital* services for up to three days during a *hospital stay*, when such *stay* is required for dental treatment and has been ordered by a *physician* (M.D.) and a dentist (D.D.S. or D.M.D.). We will make the final determination as to whether the dental treatment could have been safely rendered in another setting due to the nature of the procedure or your medical condition. *Hospital stays* for the purpose of administering general anesthesia are not considered necessary and are not covered except as specified in #2, below.
2. **General Anesthesia.** General anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a *hospital* or *ambulatory surgical center*. This applies only if (a) the *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 *Prudent Buyer plan provider* who is a dentist may charge you his or her usual and customary rate for those services. Prior to providing you with dental services that are not a covered benefit, the dentist should provide a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about the dental services that are covered under this *plan*, please call us at the customer service telephone number listed on your ID card. To fully understand your coverage under this *plan*, please carefully review this Evidence of Coverage 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*.

### **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.

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

Up to 30 visits in a *year* for all covered services are payable. But, if it is determined that an additional period of physical therapy, physical medicine or occupational therapy is *medically necessary*, we will specify a specific number of additional visits.

Such additional visits are not payable if pre-service review is not obtained, and remain limited to **\$25** for each specified additional visit to a *non-participating provider*. (See UTILIZATION REVIEW PROGRAM.)

If we apply *covered expense* toward the Calendar Year Deductible and do not provide payment, that visit will be included in the visit maximum (30 visits) for that *year*.

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

1. The recipient; or
2. The donor.

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

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

## Specified Transplants

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

## Transplant Travel Expense

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

- Ground transportation to and from the *CME* when the designated *CME* is 75 miles or more from the recipient's or donor's place of residence.
- Coach airfare to and from the *CME* when the designated *CME* is 300 miles or more from the recipient's or donor's residence
- Lodging, limited to one room, double occupancy
- Other reasonable expenses. Tobacco, alcohol, drug, 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 us. We will provide benefits for lodging and ground transportation, up to the current limits set forth in the Internal Revenue Code.

Expense incurred for the following is not covered: interim visits to a medical care facility while waiting for the actual transplant procedure; travel expenses for a companion and/or caregiver for a transplant donor;

return visits for a transplant donor for treatment of a condition found during the evaluation; rental cars, buses, taxis or shuttle services; and mileage within the city in which the medical transplant facility is located.

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

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

You must obtain pre-service review for all bariatric surgical procedures.

**Charges for services provided for or in connection with a bariatric surgical procedure performed at a facility other than a *CME* will not be considered covered expense.**

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

- Transportation for the *member* to and from the *CME* up to **\$130** per trip for a maximum of three (3) trips (one pre-surgical visit, the initial surgery and one follow-up visit).
- Transportation for one companion to and from the *CME* up to **\$130** per trip for a maximum of two (2) trips (the initial surgery and one follow-up visit).
- Hotel accommodations for the *member* and one companion not to exceed **\$100** per day for the pre-surgical visit and the follow-up visit, up to two (2) days per trip or as *medically necessary*. Limited to one room, double occupancy.
- Hotel accommodations for one companion not to exceed **\$100** per day for the duration of the *member's* initial surgery stay, up to four (4) days. Limited to one room, double occupancy.
- Other reasonable expenses not to exceed **\$25** per day, up to four (4) days per trip. Tobacco, alcohol, drug and meal expenses are excluded from coverage.

Customer service will confirm if the "Bariatric Travel Expense" benefit is available in connection with access to the selected bariatric *CME*.

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

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

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

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

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

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

**Specialty Drugs.** **You can only have your *prescription* for a *specialty drug* filled through the specialty drug program unless you qualify for an exception.** The Anthem Blue Cross - Specialty Drug Program only fills *specialty drug prescriptions*. The specialty drug program will deliver up to a 30-day supply of your medication to you by mail or common carrier (you cannot pick up your medication at Anthem Blue Cross). If your *physician* orders the *specialty drug* to be administered in their office, only the medication needed for the visit will be delivered.

Non-duplication of benefits applies to *specialty drugs* under this *plan*. When benefits are provided for *specialty 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 *specialty drugs* under YOUR PRESCRIPTION DRUG BENEFITS, if included, they will not be provided under the *plan's* medical benefits.

To obtain a *specialty drug* for home use, you must have a *prescription* for the *drug* that states the *drug* name, dosage, directions for use, quantity, the *physician's* name and phone number, the patient's name and address, that is signed by a *physician*. Your *physician* will be responsible for ordering the *specialty drug* for administration in their office.

You or your *physician* may order your *specialty drug* from specialty drug program by calling 1-800-870-6419. When you or your *physician* call Anthem Blue Cross – Specialty Drug Program, a Dedicated Care Coordinator will guide you or your *physician* through the process up to and including actual delivery of your *specialty drug* to you or your *physician*. (If you order your *specialty drug* by telephone, you will need to use a credit card to debit card to pay for it.) If you order a *specialty drug* for home use, you may also submit your *specialty drug* prescription with the appropriate payment for the amount of the purchase (you can pay by check, money order, credit card or debit card), and a properly completed order form to Anthem Blue Cross – Specialty Drug Program at the address shown below. Once you have met your deductible, if any, you will only have to pay the cost of your Co-Payment, if any. If your *physician* orders the *specialty drug* for administration in their office, you will be responsible for any applicable Co-Payments.

If you order a *specialty drug* for home use, the first time you get a *prescription* for a *specialty drug* you must complete an Intake Referral Form. The Intake Referral Form is completed by telephone by calling 1-800-870-6419. You need only enclose the *prescription* or refill notice, and the appropriate payment for any subsequent *specialty drug prescriptions*, or call the toll-free number, 1-800-870-6419. Co-payments can be made by check, money order, credit card or debit card.

You or your *physician* may obtain a list of *specialty drugs* available through specialty drug program or order forms by contacting Member Services at the number shown below or online at [www.anthem.com/ca](http://www.anthem.com/ca).

**Specialty Pharmacy Program**  
**Attn: Claims Department**  
**P.O. Box 66583**  
**St. Louis, MO. 63166-6583**

**Prior Authorization.** Certain *specialty 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 established guidelines. You may need to try a *drug* other than the one originally prescribed if we determine that it should be clinically effective for you. However, if we determine through prior authorization that the *drug* originally prescribed is *medically necessary*, you will be provided the *drug* originally requested. (If, when you first become a *member*, you are already being treated for a medical condition by a *drug* that has been appropriately prescribed and is considered safe and effective for your medical condition, we will not require you to try a *drug* other than the one you are currently taking.) If approved, *specialty drugs* requiring prior authorization for benefits will be provided to you after you make the required co-payment.

In order for you to get a *specialty drug* that requires prior authorization, your *physician* must make a request to us for you to get it. The request may be made by either telephone or facsimile to us. At the time the request is initiated, specific clinical information will be requested from your *physician* based on Anthem's 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 drug*.

If the request is for urgently needed *drugs*, after we get the request:

- We will review it and decide if we will approve benefits within 72-hours. (As soon as we can, based on your medical condition, as *medically necessary*, we may take less than 72-hours to decide if we will approve benefits.) We will tell you and your *physician* what we have decided - by telephone and in writing by facsimile to your *physician*, and in writing by mail to you.
- If more information is needed to make a decision, or we cannot make a decision for any reason, we will tell your *physician*, within 24-hours after we get the request, what information is missing and why we cannot make a decision. If, for reasons beyond our control, we cannot tell your *physician* what information is missing within 24-hours, we will tell your *physician* that there is a problem as soon as we know that we cannot respond within 24-hours. In either event, we will tell you and your *physician* that there is a problem – in writing by facsimile, and by telephone, to your *physician*, and in writing by mail to you.
- As soon as we can, based on your medical condition, as *medically necessary*, but, not more than 48-hours after we have all the information we need to decide if we will approve benefits, we will tell you and your *physician* what we have decided in writing - by fax to the *physician* and by mail to you.

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

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

While we are reviewing the request for a *specialty drug*, a 72-hour emergency supply of medication may be dispensed to you if your *physician* determines that it is appropriate and *medically necessary*. You may have to pay the applicable co-payment, if any, shown in SUMMARY OF BENEFITS: PLUS MEDICAL BENEFITS: CO-PAYMENTS for the 72-hour supply of your *drug*. If we approve the request for the *specialty drug* after you have received a 72-hour supply, you will receive the remainder of the 30-day supply of the *drug* after payment of any applicable additional co-payment that could apply.

If you have any questions regarding whether a *specialty drug* requires prior authorization, please call us at 1-800-274-7767.

If we deny a request for prior authorization of a *specialty drug*, you or your prescribing *physician* may appeal our decision by calling us at 1-800-274-7767. If you are not satisfied with the resolution based on your inquiry, you may file a grievance with us by following the procedures described in the section entitled GRIEVANCE PROCEDURES.

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

- a. The first two months supply of a *specialty drug* which is available through a participating retail *pharmacy*;

- b. *Drugs*, which due to medical necessity, must be obtained immediately; or
- c. A *member* who is unable to pay for delivery of their medication (i.e., no credit card).

**How to obtain an exception to the specialty drug program.** If you believe that you should not be required to get your medication through the specialty drug program, for any of the reasons listed above, you must complete an Exception to Specialty Drug Program form to request an exception and send it to us. The form can be faxed or mailed to us. If you need a copy of the form, you may call us at 1-800-274-7767 to request one. You can also get the form on-line at [www.anthem.com/ca](http://www.anthem.com/ca). If we have given you an exception, it will be in writing and will be good for twelve months from the time it is given. After twelve months, if you believe that you should still not be required to get your medication through the specialty drug program, you must again request an exception. If we deny your request for an exception, it will be in writing and will tell you why we did not approve the exception.

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

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

**Unless you qualify for an exception, if you don't get your *specialty drug* through the specialty drug program, you will not receive any benefits under this *plan* for them.**

## HMO AND PLUS BENEFITS

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

**Skilled Nursing Facility.** Inpatient services and supplies provided by a *skilled nursing facility*, for up to 100 days per *calendar year*. Under your HMO Benefits, benefits will not be provided for any amount exceeding the prevailing two-bed room rate of the *skilled nursing facility*. Under your PLUS Benefits, the amount by which your room charge exceeds the prevailing two-bed room rate of the *skilled nursing facility* is not considered *covered expense*.

*Skilled nursing facility* services and supplies under your PLUS Benefits are subject to prior authorization to determine medical necessity. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

Under your PLUS Benefits, if we apply *covered expense* toward the Calendar Year Deductible and do not provide payment, those days will be included in the 100 days for that *year*.

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

1. Services of a registered nurse or licensed vocational nurse under the supervision of a registered nurse or a *physician*.
2. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy, or respiratory therapy.
3. Services of a medical social service worker.
4. Services of a health aide who is employed by (or who contracts with) a *home health agency*. Services must be ordered and supervised by a registered nurse employed by the *home health agency* as professional coordinator. These services are covered only if you are also receiving the services listed in 1 or 2 above.
5. *Medically necessary* supplies provided by the *home health agency*.

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

Under your PLUS Benefits, if we apply *covered expense* toward the Calendar Year Deductible and do not provide payment, those visits will be included in the 100 visits for that *year*.

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

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

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

1. Interdisciplinary team care with the development and maintenance of an appropriate plan of care.
2. Short-term inpatient *hospital* care when required in periods of crisis or as respite care. Coverage of inpatient respite care is provided on an occasional basis and is limited to a maximum of five consecutive days per admission.
3. Skilled nursing services provided by or under the supervision of a registered nurse. Certified home health aide services and homemaker services provided under the supervision of a registered nurse.
4. Social services and counseling services provided by a qualified social worker.
5. Dietary and nutritional guidance. Nutritional support such as intravenous feeding or hyperalimentation.
6. Physical therapy, occupational therapy, speech therapy, and respiratory therapy provided by a licensed therapist.
7. Volunteer services provided by trained *hospice* volunteers under the direction of a *hospice* staff member.
8. Pharmaceuticals, medical equipment, and supplies necessary for the management of your condition. Oxygen and related respiratory therapy supplies.
9. Bereavement services, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following the *subscriber's* or the *family member's* death. Bereavement services are available to surviving members of the immediate family for a period of one year after the death. Your immediate family means your spouse, children, step-children, parents, and siblings.

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

Under your HMO Benefits, you must be suffering from a terminal illness as certified to your *medical group* by your *primary care physician* and submitted to us. Covered services are available on a 24-hour basis for the management of your condition. Your *primary care physician* must consent to your care by the *hospice* and must be consulted in the development of your treatment plan. The *hospice* must submit a written treatment plan to your *medical group* every 30 days.

Under your PLUS Benefits, you must be suffering from a terminal illness as certified by your *physician* and submitted to us. Covered services are available on a 24-hour basis for the management of your condition. Your *physician* must consent to your care by the *hospice* and must be consulted in the development of your treatment plan. The *hospice* must submit a written treatment plan to us every 30 days.

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

Under your PLUS benefits, for the services of a *non-Prudent Buyer Plan provider* facility only, our maximum payment is limited to **\$350** each time you have outpatient surgery at an *ambulatory surgical center*.

**Hemodialysis Treatment.** Under your PLUS benefits, outpatient hemodialysis treatment provided by a *non-Prudent Buyer Plan provider* is limited to **\$350** per visit.

**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.

### **Radiation Therapy**

### **Chemotherapy**

### **Prosthetic Devices**

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

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

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

We will determine whether the item satisfies the conditions above.

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

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

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

**Mental or Nervous Disorders or Substance Abuse.** Covered services shown below for the *medically necessary* treatment of *mental or nervous disorders* or substance abuse. Services shown in #1 below must be reviewed and approved by us in advance (please see UTILIZATION REVIEW PROGRAM). We will provide benefits, or pay benefits under PLUS, for the following covered services provided:

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.

**Note:** If covered services are provided by either a *participating provider* or a *Prudent Buyer Plan provider*, benefits are provided as shown in “HMO Medical Benefits” under SUMMARY OF BENEFITS.

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

*Medically necessary* marriage, family, or group counseling is covered. Each *member* attending the session is responsible for his or her own co-payment, and each session will count as a visit toward that *member's* visit maximum.

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

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

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

1. The treatment provided in a clinical trial must either:
  - a. Involve a *drug* that is exempt under federal regulations from a new drug application, or
  - b. Be approved by (i) one of the National Institutes of Health, (ii) the federal Food and Drug Administration in the form of an investigational new drug application, (iii) the United States Department of Defense, or (iv) the United States Veteran’s Administration.
2. You must be diagnosed with cancer to be eligible for participation in these clinical trials.
3. Participation in such clinical trials must be recommended by your *physician* after determining participation has a meaningful potential to benefit the *member*.

Under your HMO benefits, if the clinical trial is not provided by or through your *medical group*, your *primary care physician* will refer

you to the *physician* or health care provider who provides the clinical trial. Please see "Referral Care" under USING YOUR HMO BENEFITS for information about referrals. You will only have to pay your normal copayments for the services you get.

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

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

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

Routine patient care costs do not include 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.

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

**Allergy.** Allergy testing and *physician's* services.

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

**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*.

**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, auditory bone conduction devices). *Medically necessary* surgically implanted hearing devices may be covered under your *plan's* benefits for prosthetic devices (see "Prosthetic Devices").

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

**Outpatient Speech Therapy.** Outpatient speech therapy following injury or organic disease.

**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 services are covered under your HMO benefits (see "Health Education" under MEDICAL CARE THAT IS COVERED: HMO BENEFITS).
3. The following items are covered under your *prescription drug* benefits:
  - a. Insulin, glucagon, and other *prescription drugs* for the treatment of diabetes.

- b. Insulin syringes, disposable pen delivery systems for insulin administration.
- c. Testing strips, lancets, and alcohol swabs.

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

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

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

## MEDICAL CARE THAT IS NOT COVERED

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

### APPLICABLE TO HMO BENEFITS

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

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

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

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

This exclusion does not apply to *medically necessary* treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity will be covered only when criteria is met as recommended by our Medical Policy.

**Surrogacy.** Any services or supplies provided in connection with a surrogate pregnancy (i.e., the bearing of a child by another woman for an infertile couple), unless the surrogate mother is an enrolled Anthem Blue Cross PLUS *member*.

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

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

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

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

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

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

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

**Outpatient Drugs and Medications.** Outpatient *prescription drugs* or medications and insulin, except as specifically stated in the "Home

Health Care" and "Prescription Drug for Abortion" provisions of MEDICAL CARE THAT IS COVERED or under YOUR PRESCRIPTION DRUG BENEFITS section of this booklet. Non-prescription, over-the-counter patent or proprietary drugs or medicines. Cosmetics, health or beauty aids.

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

#### **APPLICABLE TO PLUS BENEFITS**

**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*.

**Excess Amounts.** Any amounts in excess of *covered expense* or the PLUS Medical Benefit Maximums.

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

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

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

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

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

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

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

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

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

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

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

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

Any other routine physical examination or test which does not directly treat an actual illness, injury or condition, except as specifically stated in the "Routine Gynecological Examinations for Females" provision of MEDICAL CARE THAT IS COVERED: PLUS BENEFITS.

**Outpatient Prescription Drugs and Medications.** Outpatient *prescription drugs* or medications and insulin, except as specifically stated in the "Infusion Therapy" or "Home Infusion Therapy" and

“Prescription Drug for Abortion” provisions of MEDICAL CARE THAT IS COVERED or under YOUR PRESCRIPTION DRUG BENEFITS section of this booklet. Non-prescription, over-the-counter patent or proprietary drugs or medicines. Cosmetics, health or beauty aids.

**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.**

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

#### APPLICABLE TO HMO AND PLUS BENEFITS

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

**Experimental or Investigative.** Any *experimental* or *investigative* procedure or medication. But, if you are denied benefits because it is determined that the requested treatment is *experimental* or *investigative*, you may request an independent medical review as described in GRIEVANCE PROCEDURES.

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

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

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

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

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

**Government Treatment.** Any services 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. We will not cover payment for these services if you are not required to pay for them or they are given to you for free.

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

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

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

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

**Mental 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 us.

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

**Hearing Aids or Tests.** Hearing aids or services related to the fitting or making of a hearing aid, except as specifically provided in this *plan* for hearing examinations under your HMO benefits and hearing aid services as specifically stated in the "Hearing Aid Services" provision of MEDICAL CARE THAT IS COVERED: HMO AND PLUS BENEFITS.

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

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

**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.

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

**Sterilization Reversal.** Reversal of sterilization.

**Infertility Treatment.** Artificial insemination or in vitro fertilization procedures, and any related laboratory procedures. *Infertility* treatment, family planning, or birth control services, except as specifically stated in the "Infertility and Birth Control" provision of MEDICAL CARE THAT IS COVERED.

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

**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.

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

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

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

Any other routine physical examination or test which does not directly treat an actual illness, injury or condition, except as specifically stated in the "Prostate Cancer Screening", "Other Cancer Screening Tests", and "HIV Testing" provisions of MEDICAL CARE THAT IS COVERED: HMO AND PLUS BENEFITS.

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

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

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

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

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

**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.

## REIMBURSEMENT FOR ACTS OF THIRD PARTIES

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

1. We will automatically have a lien, to the extent of benefits provided, upon any recovery, whether by settlement, judgment or otherwise, that you receive from the third party, the third party's insurer, or the third party's guarantor. The lien will be in the amount of benefits we paid under this *plan* for the treatment of the illness, disease, injury or condition for which the third party is liable.
  - If we paid the provider other than on a capitated basis, our lien will not be more than amount we paid for those services.
  - If we paid the provider on a capitated basis, our lien will not be more than 80% of the usual and customary charges for those services in the geographic area in which they were given.

- If you hired an attorney to gain your recovery from the third party, our lien will not be for more than one-third of the money due you under any final judgment, compromise, or settlement agreement.
  - If you did not hire an attorney, our lien will not be for more than one-half of the money due you under any final judgment, compromise or settlement agreement.
  - If a final judgment includes a special finding by a judge, jury, or arbitrator that you were partially at fault, our lien will be reduced by the same comparative fault percentage by which your recovery was reduced.
  - Our lien is subject to a pro rata reduction equal to your reasonable attorney's fees and costs in line with the common fund doctrine.
2. You must advise us in writing, within 60 days of filing a claim against the third party and take necessary action, furnish such information and assistance, and execute such papers as we may require to facilitate enforcement of our rights. You must not take action which may prejudice our rights or interests under your *plan*. Failure to give us such notice or to cooperate with us, or actions that prejudice our rights or interests will be a material breach of this *plan* and will result in your being personally responsible for reimbursing us.
  3. We will be entitled to collect on our lien even if the amount you or anyone recovered for you (or your estate, parent or legal guardian) from or for the account of such third party as compensation for the injury, illness or condition is less than the actual loss you suffered.

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

## **USING YOUR HMO BENEFITS**

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

## PRIMARY CARE

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

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

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

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

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

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

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

## SECOND OPINIONS

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

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

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

- Questions about the reasonableness or necessity of recommended surgical procedures.
- Questions about the diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including but not limited to a serious chronic condition.
- The clinical indications are unclear or are complex and confusing.
- A diagnosis is in doubt because of conflicting test results.
- The first *physician* is unable to diagnose the condition.
- The treatment plan in progress is not improving your medical condition within an appropriate period of time.
- You have attempted to follow the treatment plan or you have consulted with the *specialist* regarding serious concerns about your diagnosis or plan of care.

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

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

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

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

An approval letter is sent to you and the *specialist*. The letter includes the services approved and the date of your scheduled appointment. It

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

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

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

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

## **HOSPITAL STAYS**

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

For information about *emergency* admissions, see EMERGENCY CARE. For information about admissions for the treatment of *mental or nervous disorders* or substance abuse, see UTILIZATION REVIEW PROGRAM.

## **REFERRAL CARE**

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

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

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

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

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

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

## EMERGENCY CARE

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

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

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

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

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

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

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

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

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

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

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

## URGENT CARE

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

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

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

## CARE OUTSIDE OF CALIFORNIA

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

If you are going to be outside of California for more than 90 days, you may be able to get a guest membership in a medical group in the city you are visiting. Before you leave home, call the Anthem Blue Cross HMO Customer Service number on your I.D. card and ask to speak with the Guest Membership Coordinator.

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

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

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

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

## EXTRAORDINARY CIRCUMSTANCES

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

## UTILIZATION REVIEW PROGRAM

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

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

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

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

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

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

## UTILIZATION REVIEW REQUIREMENTS

Utilization reviews are conducted for the following services:

- All inpatient *hospital stays* and *residential treatment center* admissions covered under your PLUS benefits.
- *Facility-based care* for the treatment of *mental or nervous disorders* or substance abuse covered under your HMO and PLUS benefits.
- The following services under your PLUS benefits:
  1. Organ and tissue transplants.
  2. Visits for physical therapy, physical medicine and occupational therapy beyond those described under the "Physical Therapy, Physical Medicine and Occupational Therapy" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.
  3. Home infusion therapy.
  4. Home health care.
  5. Admissions to a *skilled nursing facility*.
  6. Bariatric surgical services performed at a *Centers of Medical Excellence* facility.
  7. Specific diagnostic procedures, including but not limited to: Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scan), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), 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).
  - *Facility-based care* for the treatment of *mental or nervous disorders* or substance abuse.
  - Visits for physical therapy, physical medicine and occupational therapy beyond those described under the "Physical Therapy, Physical Medicine and Occupational Therapy" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.
  - Home infusion therapy.
  - Home health care.
  - Admissions to a *skilled nursing facility*.
  - Bariatric surgical services performed at a *Centers of Medical Excellence* facility.
  - Specific diagnostic procedures, including but not limited to: Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scan), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), and Nuclear Cardiac Imaging.
2. **Concurrent review** determines whether services are *medically necessary* and appropriate when we are notified while service is ongoing, for example, an emergency admission to the hospital.
  3. **Retrospective review** is performed to review services that have already been provided. This applies in cases when pre-service or concurrent review was not completed, or in order to evaluate and audit medical documentation subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified.

## EFFECT ON BENEFITS

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

1. The appropriate utilization reviews must be performed in accordance with this *plan*. When pre-service review is not performed as required for an inpatient *hospital* or *residential treatment center* admission, 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:
  - Organ and tissue transplants when both of the following criteria are met:
    - a. The services are *medically necessary*; and
    - b. The *physicians* on the surgical team and the facility in which the transplant is to take place are approved for the transplant requested.
  - A specified number of additional visits for physical therapy, physical medicine and occupational therapy if you need more visits than is provided under the “Physical Therapy, Physical Medicine or Occupational Therapy” provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.
  - 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.
  - Bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss if:
    - a. The services are to be performed for the treatment of morbid obesity.
    - b. The *physicians* on the surgical team and the facility in which the surgical procedure is to take place are approved for the surgical procedure requested; and
    - c. The bariatric surgical procedure will be performed at a *Centers of Medical Excellence (CME)* facility.
  - 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), 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 *Prudent Buyer Plan providers* or *participating providers* will initiate the review on your behalf. A non-*Prudent Buyer Plan provider* or *non-participating provider* may initiate the review for you, or you may call us directly. The toll-free number for pre-service review is printed on your identification card.
3. If you do not receive the reviewed service within 60 days of the certification, or if the nature of the service changes, a new pre-service review must be obtained.
4. We will determine if services are *medically necessary* and appropriate. For inpatient *hospital* and *residential treatment center* stays, we will, if appropriate, specify a specific length of *stay* for services. For *facility-based care* for the treatment of *mental or nervous disorders* and substance abuse we will, if appropriate, specify the type and level of services, as well as their duration. You, your *physician* and the provider of the service will receive a written confirmation showing this information.

## Concurrent Reviews

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

2. When *Prudent Buyer Plan providers* or *participating providers* have been informed of your need for utilization review, they will initiate the review on your behalf. You may ask a *non-Prudent Buyer Plan provider* or a *non-participating provider* to call the toll free number printed on your identification card or you may call directly.
3. When we determine that the service is *medically necessary* and appropriate, we will, depending upon the type of treatment or procedure, specify the period of time for which the service is medically appropriate. We will also determine the medically appropriate setting.
4. If we determine that the service is not *medically necessary* and appropriate, your *physician* will be notified by telephone no later than 24 hours following our decision. We will send written notice to you and your *physician* within two business days following our decision. However, care will not be discontinued until your *physician* has been notified and a plan of care that is appropriate for your needs has been agreed upon.

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

#### **Retrospective Reviews**

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

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

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

#### **THE MEDICAL NECESSITY REVIEW PROCESS**

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

1. A decision on the medical necessity of a pre-service request will be made no later than 5 business days from receipt of the information reasonably necessary to make the decision, and based on the nature of your medical condition.
2. A decision on the medical necessity of a concurrent request will be made no later than one business day from receipt of the information reasonably necessary to make the decision, and based on the nature of your medical condition. However, care will not be discontinued until your *physician* has been notified and a plan of care that is appropriate for your needs has been agreed upon.
3. A decision on the medical necessity of a retrospective review will be made and communicated in writing no later than 30 days from receipt of the information necessary to make the decision to you and your *physician*.
4. If we do not have the information we need, we will make every attempt to obtain that information from you or your *physician*. If we are unsuccessful, and a delay is anticipated, we will notify you and your *physician* of the delay and what we need to make a decision. We will also inform you of when a decision can be expected following receipt of the needed information.
5. All pre-service, concurrent and retrospective reviews for medical necessity are screened by clinically experienced, licensed personnel (called "Review Coordinators") using pre-established criteria and our medical policy. These criteria and policies are developed and approved by practicing providers not employed by us, and are evaluated at least annually and updated as standards of practice or technology change. Requests satisfying these criteria are certified as *medically necessary*. Review Coordinators are able to approve most requests.
6. A written confirmation including the specific service determined to be *medically necessary* will be sent to you and your provider no later than 2 business days after the decision, and your provider will be initially notified by telephone within 24 hours of the decision for pre-service and concurrent reviews.

7. If the request fails to satisfy these criteria or medical policy, the request is referred to a Peer Clinical Reviewer. Peer Clinical Reviewers are health professionals clinically competent to evaluate the specific clinical aspects of the request and render an opinion specific to the medical condition, procedure and/or treatment under review. Peer Clinical Reviewers are licensed in California with the same license category as the requesting provider. When the Peer Clinical Reviewer is unable to certify the service, the requesting *physician* is contacted by telephone for a discussion of the case. In many cases, services can be certified after this discussion. If the Peer Clinical Reviewer is still unable to certify the service, your provider will be given the option of having the request reviewed by a different Peer Clinical Reviewer.
8. Only the Peer Clinical Reviewer may determine that the proposed services are not *medically necessary* and appropriate. Your *physician* will be notified by telephone within 24 hours of a decision not to certify and will be informed at that time of how to request reconsideration. Written notice will be sent to you and the requesting provider within two business days of the decision. This written notice will include:
  - an explanation of the reason for the decision,
  - reference of the criteria used in the decision to modify or not certify the request,
  - the name and phone number of the Peer Clinical Reviewer making the decision to modify or not certify the request,
  - how to request reconsideration if you or your provider disagree with the decision.
9. Reviewers may be plan employees or an independent third party we choose at our sole and absolute discretion.
10. You or your *physician* may request copies of specific criteria and/or medical policy by writing to the address shown on your plan identification card. We disclose our medical necessity review procedures to health care providers through provider manuals and newsletters.

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

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

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

- Your coverage under this *plan* ends;
- The *agreement* with the *group* terminates;
- You reach a benefit maximum that applies to the services in question;
- Your benefits under the *plan* change so that the services in question are no longer covered or are covered in a different way.

## PERSONAL CASE MANAGEMENT

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

### HOW PERSONAL CASE MANAGEMENT WORKS

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

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

1. You require extensive long-term treatment;
2. We anticipate that such treatment utilizing services or supplies covered under this *plan* will result in considerable cost;

3. Our cost-benefit analysis determines that the benefits payable under this *plan* for the alternative plan of treatment can be provided at a lower overall cost than the benefits you would otherwise receive under this *plan*; and
4. You (or your legal guardian) and your *physician* agree, in a letter of agreement, with our recommended substitution of benefits and with the specific terms and conditions under which alternative benefits are to be provided.

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

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

#### **EFFECT ON BENEFITS**

1. Benefits are provided for an alternative treatment plan on a case-by-case basis only. We have absolute discretion in deciding whether or not to authorize services in lieu of benefits for any *member*, which alternatives may be offered and the terms of the offer.
2. Our authorization of services in lieu of benefits in a particular case in no way commits us to do so in another case or for another *member*.
3. The personal case management program does not prevent us from strictly applying the expressed benefits, exclusions and limitations of this *plan* at any other time or for any other *member*.

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

#### **DISAGREEMENTS WITH MEDICAL MANAGEMENT DECISIONS**

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

medical information that supports the medical necessity of the services.

2. If you, your representative, or your *physician* acting on your behalf find the reconsidered decision still unsatisfactory, a request for an appeal of a reconsidered decision may be submitted in writing to us.
3. If the appeal decision is still unsatisfactory, your remedy may be binding arbitration. (See BINDING ARBITRATION.)

### **QUALITY ASSURANCE**

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

## **YOUR PRESCRIPTION DRUG BENEFITS**

### **PRESCRIPTION DRUG COVERED EXPENSE**

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

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

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

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

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

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

## **PRESCRIPTION DRUG CO-PAYMENTS**

After the *pharmacy benefits manager* determines *prescription drug covered expense*, they will subtract your Prescription Drug Co-Payment for each *prescription*.

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

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

## **HOW TO USE YOUR PRESCRIPTION DRUG BENEFITS**

**When You Go to a Participating Pharmacy.** To identify you as a *member* covered for *prescription drug* benefits, you will be issued an identification card. You must present this card to *participating pharmacies* when you have a *prescription* filled. Provided you have properly identified yourself as a *member*, a *participating pharmacy* will only charge your Co-Payment.

For information on how to locate a *participating pharmacy* in your area, call 1-800-700-2541 (or TTY/TDD 1-800-905-9821).

**Please note that presentation of a prescription to a pharmacy or pharmacist does not constitute a claim for benefit coverage.** If you present a *prescription* to a *participating pharmacy*, and the *participating pharmacy* indicates your *prescription* cannot be filled, or requires an

additional Co-Payment, this is not considered an adverse claim decision. If you want the *prescription* filled, you will have to pay either the full cost, or the additional Co-Payment, for the *prescription drug*. If you believe you are entitled to some *plan* benefits in connection with the *prescription drug*, submit a claim for reimbursement to the *pharmacy benefits manager* at the address shown below:

**Prescription Drug Program  
Attn: Claims Department  
P.O. Box 66583  
St. Louis, MO. 63166-6583**

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

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

**Prescription Drug Program  
Attn: Claims Department  
P.O. Box 66583  
St. Louis, MO. 63166-6583**

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

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

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

**When You Order Your Prescription Through the Mail.** You can order your *prescription* through the mail service *prescription drug* program. Not all medications are available through the mail service pharmacy.

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

Your first mail service *prescription* must also include a completed Patient Profile questionnaire. The Patient Profile questionnaire can be obtained by calling the toll-free number below. You need only enclose the *prescription* or refill notice, and the appropriate payment for any subsequent mail service prescriptions, or call the toll-free number. Co-payments can be paid by check, money order or credit card.

Order forms can be obtained by contacting:

**Prescription Drug Program - Mail Service**  
**P.O. Box 66558**  
**St. Louis, MO. 63166-6558**  
**1-866-274-6825**

**When You Order Your Prescription Through Specialty Drug Program.** You can only order your *prescription* for a *specialty drug* through the specialty drug program unless you are given an exception from the specialty drug program (see PRESCRIPTION DRUG CONDITIONS OF SERVICE). Specialty Drug Program only fills *specialty drug prescriptions*. Specialty Drug Program will deliver your medication to you by mail or common carrier (you cannot pick up your medication at Anthem Blue Cross).

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

You or your *physician* may order your *specialty drug* by calling 1-877-241-3489. When you call Specialty Drug Program, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your *specialty drug* to you. (If you order your *specialty drug* by telephone, you will need to use a credit card or debit card to pay for it.) You may also submit your *specialty drug prescription* with the appropriate payment for the amount of the purchase (you can pay by check, money order, credit card or debit card), and a properly completed order form to Specialty Drug Program at the address shown below. Once you have met your deductible, if any, you will only have to pay the cost of your Co-Payment.

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

You or your *physician* may obtain a list of *specialty drugs* available through Specialty Drug Program or order forms by contacting Member Services at the number shown below or online at [www.anthem.com/ca](http://www.anthem.com/ca).

**Specialty Pharmacy Program**  
**Attn: Claims Department**  
**P.O. Box 66583**  
**St. Louis, MO. 63166-6583**

**If you don't get your *specialty drug* through the specialty drug program, you will not receive any benefits under this *plan* for them.**

### **PRESCRIPTION DRUG UTILIZATION REVIEW**

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

### **PRESCRIPTION DRUG FORMULARY**

We use a *prescription drug formulary* to help your *physician* make prescribing decisions. The presence of a *drug* on the *plan's prescription drug formulary* list does not guarantee that you will be prescribed that *drug* by your *physician*. These medications, which include both generic and *brand name drugs*, are listed in the *prescription drug formulary*. The *formulary* is updated quarterly to ensure that the list includes *drugs* that are safe and effective. Note: The *formulary drugs* may change from time to time.

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

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

In order for you to get a *drug* that requires prior authorization, your *physician* must make a written request to us for you to get it using an Outpatient Prescription Drug Prior Authorization of Benefits form. The

form can be facsimiled or mailed to us. If your *physician* needs a copy of the form, he or she may call us at 1-800-700-2541 (or TTY/TDD 1-800-905-9821) to request one. The form is also available on-line at [www.anthem.com/ca](http://www.anthem.com/ca).

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

- We will review it and decide if we will approve benefits within 72-hours. (As soon as we can, based on your medical condition, as *medically necessary*, we may take less than 72-hours to decide if we will approve benefits.) We will tell you and your *physician* what we have decided in writing - by fax to your *physician* and by mail to you.
- If more information is needed to make a decision, or we cannot make a decision for any reason, we will tell your *physician*, within 24-hours after we get the form, what information is missing and why we cannot make a decision. If, for reasons beyond our control, we cannot tell your *physician* what information is missing within 24-hours, we will tell your *physician* that there is a problem as soon as we know that we cannot respond within 24-hours. In either event, we will tell you and your *physician* that there is a problem – always in writing by facsimile and, when appropriate, by telephone to your *physician* and in writing by mail to you.
- As soon as we can, based on your medical condition, as *medically necessary*, but, not more than 48-hours after we have all the information we need to decide if we will approve benefits, we will tell you and your *physician* what we have decided in writing - by fax to the *physician* and by mail to you.

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

- Based on your medical condition, as *medically necessary*, we will review it and decide if we will approve benefits within 5-business days. We will tell you and your *physician* what we have decided in writing - by fax to your *physician*, and by mail, to you.
- If more information is needed to make a decision, we will tell your *physician* in writing within 5-business days after we get the request what information is missing and why we cannot make a decision. If, for reasons beyond our control, we cannot tell your *physician* what information is missing within 5-business days, we will tell your *physician* that there is a problem as soon as we know that we cannot respond within 5-business days. In any event, we will tell you and your *physician* that there is a problem in writing by facsimile, and

when appropriate, by telephone to your *physician*, and in writing to you by mail.

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

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

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

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

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

- Your coverage under this *plan* ends;
- The *agreement* with the *group* terminates;
- You reach a benefit maximum that applies to *prescription drugs*, if the *plan* includes such a maximum;
- Your *prescription drug* benefits under the *plan* change so that *prescription drugs* are no longer covered or are covered in a different way.

A revocation or modification of a prior authorization of benefits for *prescription drugs* applies only to unfilled portions or remaining refills of the *prescription*, if any, and not to *drugs* you have already received.

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

#### **PRESCRIPTION DRUG CONDITIONS OF SERVICE**

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

1. It must be prescribed by a licensed prescriber and be dispensed within one year of being prescribed, subject to federal and state laws.
2. It must be approved for general use by the State of California Department of Health Services or the Food and Drug Administration (FDA).
3. It must be for the direct care and treatment of your illness, injury or condition. Dietary supplements, health aids or drugs prescribed for cosmetic purposes are not included. However formulas prescribed by a *physician* for the treatment of phenylketonuria are covered.
4. It must be dispensed from a licensed retail *pharmacy*, through our mail service program or through our specialty drug program.
5. **If it is an approved *compound medication*, be dispensed by a participating *pharmacy*.** Call 1-800-700-2541 (or TTY/TDD 1-800-905-9821) to find out where to take your prescription for an approved *compound medication* to be filled. (You can also find a participating *pharmacy* at [www.anthem.com/ca](http://www.anthem.com/ca).) **Some compound medications must be approved before you can get them (See PRESCRIPTION DRUG FORMULARY: PRIOR AUTHORIZATION). You will have to pay the full cost of the *compound medications* you get from a *pharmacy* that is not a *participating pharmacy*.**
6. **If it is a *specialty drug*, be obtained by using the specialty drug program.** See the section HOW TO USE YOUR PRESCRIPTION DRUG BENEFITS: WHEN YOU ORDER YOUR PRESCRIPTION THROUGH SPECIALTY DRUG PROGRAM for how to get your *drugs* by using the specialty drug program. **You will have to pay the full cost of any *specialty drugs* you get from a retail *pharmacy* that you should have obtained from the specialty drug program. If you order a *specialty drug* through the mail service program, it will be forwarded to the**

**specialty drug program for processing and will be processed according to specialty drug program rules.**

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

- a. The first two month's supply of a *specialty drug* which is available through a participating retail *pharmacy*;
- b. *Drugs*, which due to medically necessity, must be obtained immediately; or
- c. A *member* who is unable to pay for delivery of their medication (i.e., no credit card) ; or
- d. A *member* for whom, according to the Coordination of Benefit rules, this *plan* is not the primary plan.

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

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

If you order your *specialty drug* through the specialty drug program and it does not arrive, if your *physician* decides that it is *medically necessary* for you to have the *drug* immediately, we will authorize an override of the specialty drug program requirement for 30-day supply or less, to allow you to get an emergency supply of medication from

a *participating pharmacy* near you. A Dedicated Care Coordinator from the specialty drug program will coordinate the exception and you will not be required to make an additional co-payment.

7. It must not be used while you are confined in a *hospital, skilled nursing facility, rest home, sanatorium, convalescent hospital, or similar facility*. Also, it must not be dispensed in or administered by a *hospital, skilled nursing facility, rest home, sanatorium, convalescent hospital, or similar facility*. Other *drugs* that may be prescribed by your *physician* while you are confined in a rest home, sanitarium, convalescent hospital or similar facility, may be purchased at a *pharmacy* by the member, or a friend, relative or care giver on your behalf, and are covered under this *prescription drug* benefit.
8. For a retail *pharmacy* or specialty drug program, the *prescription* must not exceed a 30-day supply.

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

9. Certain *drugs* have specific quantity supply limits based on our analysis of prescription dispensing trends and the Food and Drug Administration dosing recommendations.
10. For the mail service program, the *prescription* must not exceed a 90-day supply.
11. The *drug* will be covered under YOUR PRESCRIPTION DRUG BENEFITS only if it is not covered under another benefit of your *plan*.
12. *Drugs* for the treatment of impotence and/or sexual dysfunction are limited to six tablets/units for a 30-day period and are available at retail *pharmacies* only. Documented evidence of contributing medical condition must be submitted to us for review.

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

1. Outpatient *drugs* and medications which the law restricts to sale by *prescription*. Formulas prescribed by a *physician* for the treatment of phenylketonuria. These formulas are subject to the copayment for *brand name drugs*.

2. Insulin.
3. Syringes when dispensed for use with insulin and other self-injectable *drugs* or medications.
4. *Prescription* oral contraceptives; contraceptive diaphragms. Contraceptive diaphragms are limited to one per *year* and are subject to the copayment for *brand name drugs*.
5. Injectable *drugs* which are self-administered by the subcutaneous route (under the skin) by the patient or *family member*. *Drugs* with Food and Drug Administration (FDA) labeling for self-administration.
6. All compound *prescription drugs* which contain at least one covered *prescription* ingredient.
7. Diabetic supplies (i.e. test strips and lancets).
8. Inhaler spacers and peak flow meters for the treatment of pediatric asthma. These items are subject to the copayment for *brand name drugs*.
9. *Prescription drugs* for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.

#### **PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED**

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

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

3. *Drugs* and medications used to induce spontaneous and non-spontaneous abortions. While not covered under this *prescription drug* benefit, FDA approved medications that may only be dispensed by or under direct supervision of a *physician*, such as *drugs* and medications used to induce non-spontaneous abortions, are covered as specifically stated in the “Prescription Drug for Abortion” provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to the benefit.
4. *Drugs* and medications dispensed or administered in an outpatient setting; including, but not limited to, outpatient *hospital* facilities and *physicians'* offices. While not covered under this *prescription drug* benefit, these services are covered as specified under the “Hospital,” “Home Health Care,” “Hospice Care,” and “Home Infusion Therapy” provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.
5. Professional charges in connection with administering, injecting or dispensing of *drugs*. While not covered under this *prescription drug* benefit, these services are covered as specified under the “Professional Services” and “Home Infusion Therapy” provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.
6. *Drugs* and medications which may be obtained without a *physician's* written *prescription*, except insulin or niacin for cholesterol lowering.

7. *Drugs* and medications dispensed by or while you are confined in a *hospital, skilled nursing facility, rest home, sanatorium, convalescent hospital, or similar facility* While not covered under this *prescription drug* benefit, such *drugs* are covered as specified under the "Hospital", "Skilled Nursing Facility", and "Hospice Care", provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits. While you are confined in a rest home, sanitarium, convalescent hospital or similar facility, *drugs* and medications supplied and administered by your *physician* are covered as specified under the "Professional Services" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to the benefit. Other *drugs* that may be prescribed by your *physician* while you are confined in a rest home, sanitarium, convalescent hospital or similar facility, may be purchased at a *pharmacy* by the *member*, or a friend, relative or care giver on your behalf, and are covered under this *prescription drug* benefit.
8. Durable medical equipment, devices, appliances and supplies, even if prescribed by a *physician*, except *prescription* contraceptive diaphragms as specified under PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED. While not covered under this *prescription drug* benefit, these items are covered as specified under the "Durable Medical Equipment", "Hearing Aid Services", and "Diabetes" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.
9. Services or supplies for which you are not charged.
10. Oxygen. While not covered under this *prescription drug* benefit, oxygen is covered as specified under the "Hospital", "Skilled Nursing Facility", "Home Health Care" and "Hospice Care" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.
11. Cosmetics and health or beauty aids. However, health aids that are *medically necessary* and meet the requirements for durable medical equipment as specified under the "Durable Medical Equipment" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), are covered, subject to all terms of this *plan* that apply to that benefit.

12. *Drugs* labeled "Caution, Limited by Federal Law to Investigational Use" or Non-FDA approved investigational *drugs*. Any *drugs* or medications prescribed for *experimental* indications. If you are denied a *drug* because we determine that the *drug* is *experimental* or *investigative*, you may ask that the denial be reviewed by an external independent medical review organization. (See the section "Independent Medical Review of Denials of Experimental or Investigative Treatment" (see Table of Contents) for how to ask for a review of your *drug* denial.)
13. Any expense incurred for a *drug* or medication in excess of: *prescription drug maximum allowed amount*.
14. *Drugs* which have not been approved for general use by the State of California Department of Health Services or the Food and Drug Administration. This does not apply to *drugs* that are *medically necessary* for a covered condition.
15. Over-the-counter smoking cessation *drugs*. This does not apply to *medically necessary drugs* that you can only get with a *prescription* under state and federal law.
16. *Drugs* used primarily for cosmetic purposes (e.g., Retin-A for wrinkles). However, this will not apply to the use of this type of *drug* for *medically necessary* treatment of a medical condition other than one that is cosmetic.
17. *Drugs* used primarily for the purpose of treating infertility, unless *medically necessary* for another covered condition.
18. Anorexiant and *drugs* used for weight loss except when used to treat morbid obesity (e.g., diet pills and appetite suppressants).
19. *Drugs* obtained outside of the United States unless they are furnished in connection with *urgent care* or an *emergency*.
20. Allergy desensitization products or allergy serum. While not covered under this *prescription drug* benefit, such *drugs* are covered as specified under the "Hospital", "Skilled Nursing Facility", and "Professional Services" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.
21. Infusion *drugs*, except *drugs* that are self-administered subcutaneously. While not covered under this *prescription drug* benefit, infusion *drugs* are covered as specified under the "Professional Services" and "Home Infusion Therapy" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of

Contents), subject to all terms of this *plan* that apply to those benefits.

22. Herbal supplements, nutritional and dietary supplements. However, formulas prescribed by a *physician* for the treatment of phenylketonuria that are obtained from a *pharmacy* are covered as specified under PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED. Special food products that are not available from a *pharmacy* are covered as specified under the "Special Food Products" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to the benefit.
23. *Prescription drugs* with a non-prescription (over-the-counter) chemical and dose equivalent except insulin. This does not apply if an over-the-counter equivalent was tried and was ineffective.
24. *Compound medications* obtained from other than a *participating pharmacy*. **You will have to pay the full cost of the compound medications you get from a non-participating pharmacy.**
25. *Specialty drugs* that must be obtained from the specialty 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. If you order a specialty drug through the mail service program, it will be forwarded to the specialty drug program for processing and will be processed according to specialty drug program rules.**

## COORDINATION OF BENEFITS

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

## DEFINITIONS

The meanings of key terms used in this COORDINATION OF BENEFITS 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.

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

**Other Plan** is any of the following:

1. Group, blanket or franchise insurance coverage;
2. Group service plan contract, group practice, group individual practice and other group prepayment coverages;
3. Group coverage under labor-management trustee plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans;
4. Medicare. This does not include Medicare when by law its benefits are secondary to those of any private insurance program or other non-governmental program.

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

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

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

#### **EFFECT ON BENEFITS**

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

1. If This Plan is the Principal Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan.
2. If This Plan is not the Principal Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed Allowable Expense.
3. The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if you were covered under This Plan only.

## ORDER OF BENEFITS DETERMINATION

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

1. A plan which has no Coordination of Benefits provision provides benefits before a plan which has a Coordination of Benefits provision. This includes Medicare in all cases except when the law requires that This Plan pays before Medicare.
2. A plan which covers you as a *subscriber* pays before a plan which covers you as a dependent. But if you are a Medicare beneficiary, covered as a retired *subscriber* under this *plan*, and also covered as a dependent of an employee with current employment status under another plan, this rule will change. According to Medicare's rules, Medicare pays after a plan that covers you as a dependent (the "active" plan) but before the plan that covers you as a *subscriber* (the "retired" plan). This means the plan that covers you as a dependent will pay before the plan that covers you as a *subscriber*.

**For example:** You are covered as a retired *subscriber* under this plan and a Medicare beneficiary (Medicare would pay first, this plan would pay second). You are also covered as a dependent of an active employee under another plan provided by an employer group of 20 or more employees (then, according to Medicare's rules, Medicare would pay second). In this situation, the plan which covers you as a dependent of an active employee will pay first and the plan which covers you as a retired *subscriber* will pay last, after Medicare.

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

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

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

- ii. The plan which covers that *child* as a dependent of the stepparent (married to the parent with custody).
  - iii. The plan which covers that *child* as a dependent of the parent without custody.
  - iv. The plan which covers that *child* as a dependent of the stepparent (married to the parent without custody).
- c. Regardless of a and b above, if there is a court decree which establishes a parent's financial responsibility for that *child's* health care coverage, a plan which covers that *child* as a dependent of that parent provides benefits first.
4. The plan covering the *member* as a laid-off or retired employee or as a dependent of a laid-off or retired employee provides benefits after a plan covering the *member* as other than a laid-off or retired employee or the dependent of such a person. However, if either plan does not have a provision regarding laid-off or retired employees, provision 6 applies.
5. The plan covering the *member* under a continuation of coverage provision in accordance with state or federal law pays after a plan covering the *member* as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan do not agree under these circumstances with the order of benefit determination provisions of This Plan, this rule will not apply.
6. When the above rules do not establish the order of payment, the plan on which you have been enrolled the longest provides benefits first unless two of the plans have the same effective date. In this case, Allowable Expense is split equally between the two plans.

#### **OUR RIGHTS UNDER THIS PROVISION**

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

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

**Facility of Payment.** If payments which should have been made under This Plan have been made under any Other Plan, we have the right to

pay that Other Plan any amount we determine to be warranted to satisfy the intent of this provision. Any such amount will be considered a benefit paid under This Plan, and such payment will fully satisfy our liability under this provision.

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

## **BENEFITS FOR MEDICARE ELIGIBLE MEMBERS**

### **UNDER THE HMO BENEFITS**

**For Active Employees and Family Members Age 65 or More Who Are Eligible for Medicare.** If you are age 65 or more and a *full-time employee* or a *family member of a full-time employee*, and eligible for Part A of Medicare, you will receive the benefits of this *plan*, without regard to Medicare. But if you have elected Medicare as your primary benefit program you shall not be entitled to any benefits under this *plan*.

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

1. You are a *retired employee* age 65 or more and eligible for Part A of Medicare;
2. You are a *spouse* age 65 or more of a *retired employee* and eligible for Part A of Medicare;
3. 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
4. You are entitled to Medicare benefits as a disabled person, unless you have current employment status, as determined by Medicare rules, and are enrolled under this *plan* through a *group* of 100 or more employees (according to federal OBRA legislation);

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

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

1. Medicare must provide benefits first for any services covered both by Medicare and under this *plan*.
2. For services you receive that are covered both by Medicare and under this *plan*, that are not prepaid by us, coverage under this *plan* will apply only to Medicare deductibles, coinsurance, and other charges for covered services over and above what Medicare pays.
3. For services you received that are covered both by Medicare and under this *plan*, that are prepaid by us, we make no additional payment.
4. For any given claim, the combination of benefits provided by Medicare and the benefits provided under this *plan* will not be more than what is considered allowable expense for the covered services.

#### **UNDER THE PLUS BENEFITS**

**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.

## HOW COVERAGE BEGINS AND ENDS

### HOW COVERAGE BEGINS

#### ELIGIBLE STATUS

1. **Subscribers.** You are in an eligible status if you are (a) an active, regularly assigned, full-time staff employee who works at least 30 hours a week in the conduct of the business of the *group*, (b) an active, regularly assigned staff employee in an approved “9 to 12 month” position who works at least 30 hours a week in the conduct of the business of the *group*, (c) an active, regularly assigned, full-time faculty member employed under a regular (non-adjunct) faculty contract, serving at least a half-time appointment (.5 fte) during each academic year or (d) a *retired employee* who is between the age of 55 and 65 on the date of retirement, is retired from active full-time employment, and was covered under a *group* sponsored plan immediately prior to retirement.
2. **Family Members.** The following persons are eligible to enroll as *family members*: (a) Either the *subscriber's spouse* or *domestic partner*; and (b) A *child*.

**Exception.** Any person who does not reside or work within the Anthem Blue Cross PLUS service area, or who is not a resident of the United States, is not eligible under this *plan*.

### Definition of Family Member

1. **Spouse** is the *subscriber's* spouse under a legally valid marriage. Spouse does not include any person who is: (a) covered as a *subscriber*, or (b) in active service in the armed forces.
2. **Domestic partner** is the *subscriber's* domestic partner under a legally registered and valid domestic partnership. Domestic partner does not include any person who is: (a) covered as a *subscriber*, or (b) in active service in the armed forces.
3. **Child** is the *subscriber's*, *spouse's* or *domestic partner'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 *family member* 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* or *spouse* is legal guardian is considered eligible on the date of the court decree (the "eligibility date"). We must receive legal evidence of the decree.

**Note.** *Family member* includes a previously enrolled *spouse* or *child* of a retired employee over age 65 provided the *spouse* is under age 65.

## ELIGIBILITY DATE

1. **For Subscribers:** You become eligible for coverage on the first day of the month coinciding with or following your date of hire. (This is your "waiting" period.)
2. **For Family Members:** You become eligible for coverage on the later of: (a) the date the *subscriber* becomes eligible for coverage; or (b) the date you meet the *family member* definition.

## Exceptions to the Waiting Period

1. If, after you have completed the waiting period, you cease to be eligible due to termination of employment, and you return to an eligible status within six months after the date your employment terminated, you will become eligible on the first day of the month coinciding with or 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 *family members*, the *subscriber* must properly file an application. An application is considered properly filed, only if it is personally signed, dated, and given to the *group* within 45 days from your initial eligibility date. We must receive this application from the *group* within 90 days. If any of these steps are not followed, your coverage may be denied.

## EFFECTIVE DATE

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

1. **Timely Enrollment:** If you enroll for coverage before, on, or within 45 days\* after your initial eligibility date, then your coverage will begin as follows: (a) for *subscribers*, on your eligibility date; and (b) for *family members*, on the later of (i) the date the *subscriber's* coverage begins, or (ii) the first day of the month coinciding with or following the date the *family member* becomes eligible. If you become eligible before the *agreement* takes effect, coverage begins on the effective date of the *agreement*, provided the enrollment application is on time and in order.

\*Note. 30 days for mid-year changes.

**Exception.** For a newly married couple, the *spouse* is eligible on the date of marriage. For a new domestic partnership, the *domestic partner* is eligible on the date of the domestic partnership.

2. **Late Enrollment for Family Members.** If you file an enrollment application or membership change form for *family members* with the *group* more than 30 days after their eligibility date, they must wait until the *group's* next Open Enrollment Period to enroll.
3. **Disenrollment:** If *family members* are disenrolled from coverage under the *plan*, the family member will be eligible to reapply for coverage as set forth in the "Enrollment" provision above, during the *group's* next Open Enrollment period (see OPEN ENROLLMENT PERIOD).

NOTE: You may enroll your *family members* earlier than the *group's* next Open Enrollment Period if they 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 30 days. For the *child's* enrollment to continue beyond this 30-day period, the *subscriber* must submit a membership change form to the *group* within the 30-day period. We must then receive the form from the *group* within 90 days.

### **Special Enrollment Periods**

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

1. You have met all of the following requirements:
  - a. You were covered as an individual or dependent under either:
    - i. Another employer group health plan or health insurance coverage, including coverage under a COBRA or CalCOBRA continuation; or
    - ii. A state Medicaid plan or under a state child health insurance program (SCHIP), including the Healthy Families Program or the Access for Infants and Mothers (AIM) Program.
  - b. You certified in writing at the time you became eligible for coverage under this *plan* that you were declining coverage under this *plan* or disenrolling because you were covered under another health plan as stated above and you were given written notice that if you choose to enroll later, you may be required to wait until the *group's* next open enrollment period to do so.
  - c. Your coverage under the other health plan wherein you were covered as an individual or dependent ended as follows:

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

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

- ii. If the other health plan was a state Medicaid plan or a state child health insurance program (SCHIP), including the Healthy Families Program or the Access for Infants and Mothers (AIM) Program, coverage ended because you lost eligibility under the program. You must properly file an application with the *group* within 60 days after the date your coverage ended.
2. A court has ordered coverage be provided for a *spouse*, *domestic partner* or dependent *child* under your employee health plan and an application is filed within 30 days from the date the court order is issued.
  3. We do not have a written statement from the *group* stating that prior to declining coverage or disenrolling, you received and signed acknowledgment of a written notice specifying that if you do not enroll for coverage within 30 days after your eligibility date, or if you disenroll, and later file an enrollment application, your coverage may not begin until the first day of the month following the end of the *group's* next open enrollment period.
  4. You have a change in family status through either marriage or domestic partnership, or the birth, adoption, or placement for adoption of a *child*:
    - a. If you are enrolling following marriage or domestic partnership, you and your new *spouse* or *domestic partner* must enroll within

30 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 30 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 30 days of the date a claim or a portion of a claim is denied due to your meeting or exceeding the lifetime limit on all benefits under the other plan.
- 6. You become eligible for assistance, with respect to the cost of coverage under the employer's group *plan*, under a state Medicaid or SCHIP health plan, including any waiver or demonstration project conducted under or in relation to these plans. You must properly file an application with the *group* within 60 days after the date you are determined to be eligible for this assistance.

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

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

## **OPEN ENROLLMENT PERIOD**

The *group* has an open enrollment period once each *year*. During that time, an individual who meets the eligibility requirements as a *subscriber* under this *plan* may enroll. A *subscriber* may also enroll any eligible *family members* at that time. Persons eligible to enroll as *family members* 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 from us, as provided below:

1. If the *agreement* terminates, your coverage ends at the same time. The *agreement* may be canceled or changed without notice to you.
2. If the *group* no longer provides coverage for the class of *members* to which you belong, your coverage ends on the effective date of that change. If the *agreement* is amended to delete coverage for *family members*, a *family member's* coverage ends on the effective date of that change.
3. Coverage for *family members* ends when *subscriber's* coverage ends.
4. Coverage ends at the end of the period for which subscription charges have been paid to us on your behalf when the required subscription charges for the next period are not paid.
5. If you voluntarily cancel coverage at any time, coverage ends on the subscription charge due date coinciding with or following the date of voluntary cancellation, as provided by written notice to us.
6. If you no longer meet the requirements set forth in the "Eligible Status" provision of HOW COVERAGE BEGINS, your coverage ends as of the subscription charge due date coinciding with or following the date you cease to meet such requirements.

#### Exceptions to item 6:

- a. **Leave of Absence.** If you are a *subscriber* and the *group* pays subscription charges to us on your behalf, your coverage may continue (i) for up to 12 months during a medical or sabbatical leave of absence; or (ii) for up to one month during a personal leave of absence. Such leave of absence must be approved by the *group*.

b. **Handicapped Children:** If a *child* reaches the age limit shown in the "Eligible Status" provision of this section, the *child* will continue to qualify as a *family member* if he or she is (i) covered under this *plan*, (ii) chiefly dependent on the *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.

7. If you do not pay your co-payment to a provider within 31-days from the date that you are sent a bill by a provider to make your co-payment, if requested in writing to us by the provider, Anthem will send you a written notice to let you know that you have not paid your co-payment. If you do not pay your co-payment to the provider within 15-days from the date we sent our notice to you, we will terminate your coverage at 12:00 midnight on the fifteenth day following the date we sent the notice to you telling you of this. If your coverage is terminated, Anthem will tell the *group* not to pay any further subscription charges for you. Within 30-days, we will return the pro-rata portion of any monies paid to us by the *group* for your coverage for the unexpired period for which payment has been received together with amounts due on claims, if any, less any amounts due us. The *group* will return your portion of the money returned to them to you.

If your coverage was ended because you did not pay your co-payment, and you have now paid it, you may have your coverage reinstated by re-enrolling as follows:

- a. If you paid your co-payment and re-enroll on, or within 31-days after the date your coverage was ended, then your coverage will be reinstated to the date your coverage ended. (There will be no lapse of coverage.)
  - b. If you do not pay your co-payment within 31-days after your coverage would end due to failure to make the required co-payment, but subsequently paid your co-payment and re-enroll within 31-days after you paid your co-payment, then your coverage will start on the next subscription charge due date shown in the *agreement* under the same terms that apply to others in your classification. (There will be a lapse of coverage for the time period between when we ended your coverage and the date your employer again pays subscription charges for your coverage.)
  - c. If you did not pay your co-payment within 31-days after the date your coverage ended, and you do not re-enroll within 31-days of the date you paid your co-payment, you will be eligible to enroll again during the *group's* next Open Enrollment.
8. If there is misconduct by you or a *family member*, in one of the ways described below, termination is effective upon the later of: (1) the date shown in the written notice to you; or (2) the date the written notice was mailed to you:
- a. If you are acting in a way that threatens the safety of Anthem employees, providers, other plan members or other patients, your conduct may result in Anthem ending your coverage under the *plan* or your provider asking Anthem to end your coverage under the *plan*.
  - b. If you or a *family member* commits fraud or deception in the use of services or facilities, you or a *family member* may individually have your coverage terminated. If you, as the *subscriber*, have your coverage terminated for fraud or deception, coverage for all other *family members* will also end.
  - c. If you or a *family member* purposely gives us incorrect or incomplete material information, and we rely on such information in providing health care services to that *member*, we may end coverage to that *member*. If you, the *subscriber*, furnish incorrect or incomplete material information, you and all *family members* may have your coverage ended. No statement made by you, unless it is fraudulent and in writing, will be used in any contest to end your coverage under this *plan*. After your coverage under this plan has been in force for three years, no statement made by you will be used to end your coverage.

9. Coverage ends if you are a *retiree* who reaches age 65. However, coverage may continue for *family members* until:
  - a. The *spouse* reaches age 65, unless divorced or annulled prior to that date. In the event of the retiree's death, coverage may be continued until the attainment of age 65 or remarriage.
  - b. The child ceases to meet the definition of child and is no longer eligible under the *plan*.
  - c. The spouse and child become covered under another employer plan.

**Note:** If a marriage or domestic partnership terminates, the *subscriber* must give or send to the *group* written notice of the termination. Coverage for a former *spouse* or *domestic partners*, and their dependent *children*, if any, ends according to the "Eligible Status" provisions. If Anthem suffers a loss because of the *subscriber* failing to notify the *group* of the termination of their marriage or domestic partnership, Anthem may seek recovery from the *subscriber* for any actual loss resulting thereby. Failure to provide written notice to the *group* will not delay or prevent termination of the marriage or domestic partnership. If the *subscriber* notifies the *group* in writing to cancel coverage for a former *spouse* or *domestic partner* and the *children* of the *spouse* or *domestic partner*, if any, immediately upon termination of the *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, CALCOBRA CONTINUATION OF COVERAGE, COVERAGE FOR SURVIVING FAMILY MEMBERS, EXTENSION OF BENEFITS and HIPAA COVERAGE AND CONVERSION.

### **Medical Group Termination**

You must live or work within the *enrollment area* of your *primary care physician/medical group*. If you change your permanent residence or employment location, and your new residence or employment location is not within the *enrollment area* of your current *primary care physician/medical group*, your coverage at that *primary care physician/medical group* ends as of the date of your move. You must request a transfer to another *primary care physician/medical group*, by calling the Customer Service number shown on your ID card or by properly filing a membership change form with the *group* within 31 days of your move. In addition, if you move outside the Anthem Blue Cross PLUS service area, you will not be eligible for Anthem Blue Cross PLUS.

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

**Member-Provider Relationship.** If you refuse to follow a treatment your *primary care physician* recommends when there is no other better choice, your coverage may end with that *primary care physician* and/or *medical group*. We will help you get coverage with another *primary care physician* and/or *medical group*.

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

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

### DEFINITIONS

The meanings of key terms used in this CONTINUATION OF COVERAGE 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 *agreement* as either a *subscriber* or *family member*; 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: (a) any person who was not enrolled during the Initial Enrollment Period, including any *family members* acquired during the COBRA continuation period, with the exception of newborns and adoptees as specified above; or (b) a *domestic partner*, or a *child* of a *domestic partner*, if they are eligible under HOW COVERAGE BEGINS AND ENDS.

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

**1. For Subscribers and Family Members:**

- a. The *subscriber's* 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 Family Members.** Cancellation or a substantial reduction of retiree benefits under the *plan* due to the *group's* filing for Chapter 11 bankruptcy, provided that:

- a. The *agreement* expressly includes coverage for retirees; and
- b. Such cancellation or reduction of benefits occurs within one year before or after the *group's* filing for bankruptcy.

**3. For Family Members:**

- a. The death of the *subscriber*;
- b. The *spouse's* divorce or legal separation from the *subscriber*;
- c. The end of a *child's* status as a dependent *child*, as defined by the *agreement*; or
- d. The *subscriber's* entitlement to Medicare.

**ELIGIBILITY FOR COBRA CONTINUATION**

A *subscriber* or *family member*, **other than a *domestic partner*, and a *child of a domestic partner***, may choose to continue coverage under the *agreement* if your coverage would otherwise end due to a Qualifying Event.

**TERMS OF COBRA CONTINUATION**

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

- 1. For Qualifying Events 1, or 2, the *group* or its administrator will notify the *subscriber* of the right to continue coverage.
- 2. For Qualifying Events 3(a) or 3(d) above, a *family member* will be notified of the COBRA continuation right.

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

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

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

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

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

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

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

1. A *spouse* whose COBRA continuation began due to divorce, separation or death of the *subscriber*;
2. A *child* if neither the *subscriber* nor the *spouse* has enrolled for this COBRA continuation coverage (if more than one *child* is so enrolled, the subscription charge will be the family rate); and
3. A *child* whose COBRA continuation began due to the person no longer meeting the dependent *child* definition.

**Subsequent Qualifying Events.** Once covered under the COBRA continuation, it's possible for a second Qualifying Event to occur. If that happens, a *member*, 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 subscription charge is paid, coverage is reinstated back to the date of the original Qualifying Event, so that no break in coverage occurs.

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

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

1. The end of 18 months from the Qualifying Event, if the Qualifying Event was termination of employment or reduction in work hours;\*
2. The end of 36 months from the Qualifying Event, if the Qualifying Event was the death of the *subscriber*, divorce or legal separation, or the end of dependent *child* status;\*
3. The end of 36 months from the date the *subscriber* became entitled to Medicare, if the Qualifying Event was the *subscriber's* entitlement to Medicare. If entitlement to Medicare does not result in coverage terminating and Qualifying Event 1 occurs within 18 months after Medicare entitlement, coverage for Qualified Beneficiaries other than the *subscriber* will end 36 months from the date the *subscriber* became entitled to Medicare;
4. The date the *agreement* terminates;
5. The end of the period for which subscription charges 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  
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under that *prior plan*. Additional note: If your COBRA continuation under this *plan* began on or after January 1, 2003 and ends in accordance with item 1, you may further elect to continue coverage for medical benefits only under CalCOBRA for the balance of 36 months (COBRA and CalCOBRA combined). All COBRA eligibility must be exhausted before you are eligible to further continue coverage under CalCOBRA. Please see CALCOBRA CONTINUATION OF COVERAGE in this booklet for more information.

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

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

If continuation coverage ends due to items 2 or 7 above, a surviving spouse and *family members* are eligible for the coverage specified in this *plan* under COVERAGE FOR SURVIVING FAMILY MEMBERS.

## **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 *group* with proof of the Social Security Administration's determination of disability during the first 18 months of the COBRA continuation period and no later than 60 days after the later of the following events:

1. The date of the Social Security Administration's determination of the disability;
2. The date on which the original Qualifying Event occurs;
3. The date on which the Qualified Beneficiary loses coverage; or
4. The date on which the Qualified Beneficiary is informed of the obligation to provide the disability notice.

**Cost of Coverage.** For the 19th through 29th months that the total disability continues, the *group* must remit the cost for the extended continuation coverage to us. This cost (called the "subscription charge") 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 by the *group* each month during the period of extended continuation coverage. We must receive timely payment of the subscription charge each month from the *group* in order to maintain the extended continuation coverage in force.
3. The *group* may require that you pay the entire cost of the extended continuation coverage.

If a second Qualifying Event occurs during this extended continuation, the total COBRA continuation may continue for up to 36 months from the date of the first Qualifying Event. The subscription charge 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 *agreement* terminates;

4. The end of the period for which subscription charges 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 *group* within 30 days of a final determination by the Social Security Administration that you are no longer totally disabled.

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

## **CALCOBRA CONTINUATION OF COVERAGE**

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

1. 18 months after the qualifying event, if the qualifying event was termination of employment or reduction in work hours; or
2. 29 months after the qualifying event, if you qualified for the extension of COBRA continuation during total disability.

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

## TERMS OF CALCOBRA CONTINUATION

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

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

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

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

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

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

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

If subscription charges are not received when due, your coverage will be cancelled. We will cancel your coverage only upon sending you written notice of cancellation at least 15 days prior to cancelling your coverage. If you make payment in full within 15 days after we issue this notice of cancellation, your coverage will not be cancelled. If you do not make the required payment in full within this 15 day period, your coverage will be cancelled as of 12:00 midnight on the fifteenth day after the date on which the notice of cancellation is sent and will not be reinstated. Any payment we receive more than 15 days after we issue the notice of cancellation will be refunded to you within 20 business days.

**Change of Subscription Charge.** The amounts of the subscription charges may be changed by us as of any subscription charge due date. We will provide you with written notice at least 30 days prior to the date any subscription charge increase goes into effect.

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

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

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

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

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

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

4. The end of the period for which subscription charges are last paid (your coverage will be cancelled upon written notification, as explained under "Payment Dates", above);
5. The date you become covered under any other health plan, unless the other health plan contains an exclusion or limitation relating to a pre-existing condition that you have. In this case, this continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied;
6. The date you become entitled to Medicare; or
7. The date you become covered under a federal COBRA continuation.

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

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

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

## **SENIOR COBRA CONTINUATION FOR QUALIFYING MEMBERS**

This section does not apply to any individual who is not eligible for this continuation prior to January 1, 2005. Subject to payment of subscription charges as stated in the *agreement*, coverage under this *plan* may be continued for the *subscriber*, the *subscriber's spouse*, and the *subscriber's former spouse* (if any) under Section 1373.621 of the Health and Safety Code and Section 2800.2 of the Labor Code, in accordance with the following provisions. This continuation may be elected following the CONTINUATION OF COVERAGE (the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), or Title X of P.L. 99-272) and the CALCOBRA CONTINUATION OF COVERAGE shown above.

For the purposes of this section, "former *spouse*" means: (a) an individual who is divorced from the *subscriber*; or (b) an individual who was married to the *subscriber* at the time of the *subscriber's* death.

**Requirements.** The *subscriber* and *spouse* may continue coverage under this *plan* if:

1. The *subscriber*, or the *subscriber* on behalf of himself or herself and the *spouse*, was entitled to, and had elected to continue coverage under, COBRA or CalCOBRA, as described in the preceding sections;
2. The *subscriber* or *spouse* has not elected to continue coverage under any other available continuation;
3. The *subscriber* has worked for the employer for at least the prior five years; and
4. The *subscriber* is at least 60 years old on the date employment with the employer ended.

The former *spouse* may continue coverage under this *plan* in accordance with this section if he or she was covered as a qualified beneficiary under COBRA or CalCOBRA, as described in the preceding section.

**Notice and Election.** The employer will notify the *subscriber* or *spouse* and the former *spouse* of the right to continue coverage within 180 days prior to the date continuation of coverage under COBRA or CalCOBRA is scheduled to end.

For the *subscriber* and *spouse*, this continuation may be chosen for both, for the *subscriber* only, or for the *spouse* only. The former *spouse* may elect this continuation for himself or herself only.

To elect this continuation, you must notify us in writing within 30 days prior to the date continuation coverage under COBRA or CalCOBRA is scheduled to end. If you fail to elect this continuation when first eligible, you may not elect this continuation at a later date. You must remit the initial subscription charge to us within 45 days after you elect this continuation.

**Cost of Coverage.** You are required to pay the entire cost of this continuation coverage. You must remit this cost to us each month during the continuation period. We must receive payment of the subscription charge each month in order to continue the coverage in force. The rate for continuation coverage under this section shall be 213% of the applicable *group* rate. For the purpose of determining subscription charges payable, the *spouse* or former spouse continuing coverage alone will be considered to be a *subscriber*.

**Payment Dates.** The first payment is due along with your enrollment form within 45 days after you elect continuation coverage. We will bill you for any retroactive charges which may be due. Succeeding subscription charges are due on the first day of each following month (the Subscription Charge Due Date).

**Grace Period.** For every Subscription Charge Due Date, except the first, there is a 31-day grace period in which to pay subscription charges. If subscription charges are not received by the end of the grace period, your coverage will be canceled at the end of the period for which subscription charges are last paid.

**Change of Subscription Charge.** The amounts of the subscription charges may be changed by us as of any Subscription Charge Due Date. We will provide you with written notice at least 30 days prior to the date any subscription charge increase goes into effect.

**Accuracy of Information.** You are responsible for supplying accurate, up-to-date eligibility information. We shall rely upon the latest information received as correct without verification; but we maintain the right to verify any eligibility information you provide. We can hold you responsible for any loss or expense we incur because of your failure to do so.

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

1. The end of the period for which subscription charges are last paid;
2. The date the *agreement* terminates;
3. The date, following the election of Senior COBRA, the *subscriber, spouse, or former spouse* first becomes covered under any group health plan not maintained by the employer;
4. The date, following the election of Senior COBRA, the *subscriber, spouse, or former spouse* first becomes entitled to Medicare;
5. The date the *subscriber, spouse, or former spouse* reaches age 65;  
or
6. For the *spouse or former spouse*, five years from the date the *spouse's or former spouse's* COBRA or CalCOBRA continuation coverage ended.

If your continuation under this *plan* ends in accordance with item 6, you are eligible for medical conversion coverage. If your continuation under this *plan* ends in accordance with items 2 or 6, you may be eligible for HIPAA coverage. Please see HIPAA COVERAGE AND CONVERSION in this booklet for more information.

## COVERAGE FOR SURVIVING FAMILY MEMBERS

If the *subscriber* dies while covered under this *plan*, coverage continues for an enrolled *spouse* or *child* until one of the following occurs:

1. The surviving *spouse* remarries;
2. The surviving *spouse* reaches age 65;
3. The surviving *spouse* and *child* become covered under another employer plan;
4. Subscription charges are not paid to us on the *member's* behalf;
5. The *group* cancels coverage for the class of *subscribers* to which the *members* belong;
6. The *agreement* between the *group* and us terminates; or
7. The *child* no longer meets all of the conditions of coverage in HOW COVERAGE BEGINS AND ENDS.

**Note:** The cost of continuing coverage under this provision will be paid by the group for the first twelve months. Thereafter, the *spouse* or *child* will be responsible for payment of the subscription charges. The cost of continuing coverage may be more than the cost of coverage the *group* provides to its employees or their *family members*.

## EXTENSION OF BENEFITS

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

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

2. If you are not confined as an inpatient but wish to apply for total disability benefits, you must do so by submitting written certification by your *physician* of the total disability. We must receive this certification within 90 days of the date coverage ends under this *plan*. At least once every 90 days while benefits are extended, we must receive proof that your total disability is continuing.
3. Your extension of benefits will end when any one of the following circumstances occurs:
  - a. You are no longer totally disabled.
  - b. The maximum benefits available to you under this *plan* are paid.
  - c. You become covered under another group health plan that provides benefits without limitation for your disabling condition.
  - d. A period of up to 12 months has passed since your extension began.

## **HIPAA COVERAGE AND CONVERSION**

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

### **HIPAA Coverage**

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

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

4. You must not be eligible for Medicare, Medi-Cal, or any group medical coverage and cannot have other medical coverage.

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

### Conversion Coverage

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

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

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

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

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

## GENERAL PROVISIONS

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

**Independent Contractors.** Our relationship with providers is that of an independent contractor. *Medical groups, physicians*, and other health care professionals, *hospitals, skilled nursing facilities* and other community agencies are not our agents nor are we, or any of our employees, an employee or agent of any *hospital, medical group* or medical care provider of any type.

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

### Out-of-California Providers –

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

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

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

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

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

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

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

### **Terms of Coverage**

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

2. The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date you receive the service or supply for which the charge is made.
3. The *agreement* is subject to amendment, modification or termination according to the provisions of the *agreement* without your consent or concurrence.

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

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

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

For services provided under your Plus benefits, *physicians* and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. A participating *physician* may, after notice from us, be subject to a reduced negotiated rate in the event the participating *physician* fails to make routine referrals to *Prudent Buyer Plan providers*, except as otherwise allowed (such as for *emergency services*).

*Hospitals* and other health care facilities may be paid either a fixed fee or on a discounted fee-for-service basis.

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

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

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

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

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

**Payment to Providers.** We will pay the benefits of this *plan* directly to *contracting hospitals*, *Prudent Buyer Plan providers*, *CMEs* and medical transportation providers. If you or one of your *family members* receives services from *non-contracting hospitals* or *non-Prudent Buyer Plan providers*, payment will be made directly to the *subscriber* and you will be responsible for payment to the provider. Any assignment of benefits, even if assignment includes the providers right to receive payment, is void unless an *authorized referral* has been approved by Anthem. We will pay *non-contracting hospitals* and other providers of service directly when *emergency services* and care are provided to you or one of your *family members*. We will continue such direct payment until the emergency care results in stabilization. If you are a MediCal beneficiary and you assign benefits in writing to the State Department of Health

Services, we will pay the benefits of this *plan* to the State Department of Health Services. These payments will fulfill our obligation to you for those covered services.

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

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

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

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

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

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

**Public Policy Participation.** We have established a Public Policy Committee (that we call our Consumer Relations Committee) to advise

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

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

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

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

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

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

**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 *medical group* or *physician* that does not have an Anthem Blue Cross PLUS Provider Agreement or Prudent Buyer Plan Participating Provider Agreement in effect with us. If you are a new *member*, you may request Transition Assistance if any one of the following conditions applies:

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Anthem in consultation with you and the *non-participating provider* or *non-Prudent Buyer Plan provider* and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time you enroll with Anthem.
3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.
4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.

5. The care of a newborn *child* between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the time the *child* enrolls with Anthem.
6. Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the time you enroll with Anthem.

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

We will notify you by telephone, and the provider by telephone and fax, as to whether or not your request for Transition Assistance is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the *plan*. Financial arrangements with *non-participating providers* and *non-Prudent Buyer Plan providers* are negotiated on a case-by-case basis. We will request that the *non-participating provider* or *non-Prudent Buyer Plan provider* agree to accept reimbursement and contractual requirements that apply to *Prudent Buyer Plan providers*, including payment terms. If the *non-participating provider* or *non-Prudent Buyer Plan provider* does not agree to accept said reimbursement and contractual requirements, we are not required to continue that provider's services. If you do not meet the criteria for Transition Assistance, you are afforded due process including having a *physician* review the request.

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

You must be under the care of the *medical group* or *physician* at the time the contract terminates. The terminated *medical group* or *physician* must agree in writing to provide services to you in accordance with the terms and conditions of the agreement with Anthem prior to termination. The *medical group* or *physician* must also agree in writing to accept the terms and reimbursement rates that apply to *Prudent Buyer Plan providers*. If the *medical group* or *physician* does not agree with these

contractual terms and conditions, we are not required to continue the *medical group's* or *physician's* services beyond the contract termination date.

Anthem will provide such benefits for the completion of covered services by a terminated *medical group* or *physician* only for the following conditions:

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Anthem in consultation with you and the terminated *medical group* or *physician* and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the date the *medical group's* or *physician's* contract terminates.
3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.
4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.
5. The care of a newborn *child* between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the date the *medical group's* or *physician's* contract terminates.
6. Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the date the *medical group's* or *physician's* contract terminates.

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

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

We will notify you by telephone, and the provider by telephone and fax, as to whether or not your request for continuity of care is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the *plan*. Financial arrangements with terminated *medical groups* and *physicians* are negotiated on a case-by-case basis. We will request that the terminated *medical group* or *physician* agree to accept reimbursement and contractual requirements that apply to *Prudent Buyer Plan providers*, including payment terms. If the terminated *medical group* or *physician* does not agree to accept these reimbursement and contractual requirements, we are not required to continue that provider's services. If you disagree with our determination regarding continuity of care, you may file a grievance with us by following the procedures described in the section entitled GRIEVANCE PROCEDURES.

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

## **GRIEVANCE PROCEDURES**

### **HMO Benefits**

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

If you are dissatisfied and wish to file a grievance, you may request a "Member Issue Form" from your *medical group* or Anthem. Complete the form and send it to us, or you may call Customer Service and ask the customer service representative to complete the form for you. You may also submit a grievance to us online or print the Member Issue Form through the Anthem website at [www.anthem.com/ca](http://www.anthem.com/ca). You must include all pertinent information from your Anthem Blue Cross PLUS Identification Card and the

details and circumstances of your concern or problem. You must submit your grievance to us no later than 180 days following the date you receive a denial notice from us or your *medical group* or any other action or incident with which you are dissatisfied. Your issue will then become part of our formal grievance process and will be resolved accordingly. If your condition is acute or urgent, you have the right to request an expedited review of an appeal for service which has been denied by your *medical group*. Expedited appeals must be resolved within three days.

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

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

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

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

### **PLUS Benefits**

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

If you are not satisfied with the resolution based on your initial inquiry, you may request a copy of the Plan Grievance Form from the customer

service representative. You may complete and return the form to us, or ask the customer service representative to complete the form for you over the telephone. You may also submit a grievance to us online or print the Plan Grievance Form through the Anthem website at [www.anthem.com/ca](http://www.anthem.com/ca). You must submit your grievance to us no later than 180 days following the date you receive a denial notice from us or any other incident or action with which you are dissatisfied. Your issue will then become part of our formal grievance process and will be resolved accordingly. All grievances received by us will be acknowledged in writing, together with a description of how we propose to resolve the grievance.

#### **Resolving Your Grievance (HMO and PLUS Benefits)**

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

**Questions about your prescription drug coverage.** If you have outpatient *prescription drug* coverage and you have questions or concerns, you may call the Pharmacy Customer Service number listed on your ID card. If you are dissatisfied with the resolution of your inquiry and want to file a grievance, you may write to us at the address listed above and follow the formal grievance process.

#### **Independent Medical Review of Denials of Experimental or Investigative Treatment**

If coverage for a proposed treatment is denied because we or your *medical group* determine that the treatment is *experimental* or *investigative*, you may ask that the denial be reviewed by an external independent medical review organization contracting with the Department of Managed Health Care ("DMHC"). Your request for this review may be submitted to the DMHC. You pay no application or processing fees of any kind for this review. You have the right to provide information in support of your request for review. A decision not to participate in this review process may cause you to forfeit any statutory right to pursue legal action against us regarding the disputed health care service. You will receive an application form and an addressed envelope for you to use to request this review with any grievance disposition letter denying coverage for this reason. You may also request an application

form by calling us at the telephone number listed on your identification card or write to us at one of the following addresses:

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

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

- You have a life-threatening or seriously debilitating condition, described as follows:
  - ◆ A life-threatening condition is a condition or disease where the likelihood of death is high unless the course of the disease is interrupted or a condition or disease with a potentially fatal outcome where the end point of clinical intervention is the patient's survival.
  - ◆ A seriously debilitating condition is a disease or condition that causes major, irreversible morbidity.
- Your *medical group* or *physician* must certify that either (a) standard treatment has not been effective in improving your condition, (b) standard treatment is not medically appropriate, or (c) there is no more beneficial standard treatment covered by this *plan* than the proposed treatment.
- The proposed treatment must either be:
  - ◆ Recommended by a *participating provider* or *Prudent Buyer Plan provider* who certifies in writing that the treatment is likely to be more beneficial than standard treatments, or
  - ◆ Requested by you or by a licensed board certified or board eligible *physician* qualified to treat your condition. The treatment requested must be likely to be more beneficial for you than standard treatments based on two documents of scientific and medical evidence from the following sources:
    - a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized standards;

- b) Medical literature meeting the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database of Health Services Technology Assessment Research (HSTAR);
- c) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;
- d) Either of the following: (i) The American Hospital Formulary Service's Drug Information, or (ii) the American Dental Association Accepted Dental Therapeutics;
- e) Any of the following references, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: (i) the Elsevier Gold Standard's Clinical Pharmacology, (ii) the National Comprehensive Cancer Network Drug and Biologics Compendium, or (iii) the Thomson Micromedex DrugDex;
- f) Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and
- g) Peer reviewed abstracts accepted for presentation at major medical association meetings.

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

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

Within three business days of receiving notice from the DMHC of your request for review we will send the reviewing panel all relevant medical records and documents in our possession, as well as any additional information submitted by you or your *medical group* or *Prudent Buyer Plan provider*. Any newly developed or discovered relevant medical records identified by us or by a *participating provider* or *Prudent Buyer*

*Plan provider* after the initial documents are sent will be immediately forwarded to the reviewing panel. The external independent review organization will complete its review and render its opinion within 30 days of its receipt of request for review (or within seven days if your *medical group* determines that the proposed treatment would be significantly less effective if not provided promptly). This timeframe may be extended by up to three days for any delay in receiving necessary records.

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

### **Independent Medical Review of Grievances Involving a Disputed Health Care Service**

You may request an independent medical review ("IMR") of disputed health care services from the Department of Managed Health Care ("DMHC") if you believe that we or your *medical group* have improperly denied, modified, or delayed health care services. A "disputed health care service" is any health care service eligible for coverage and payment under your *plan* that has been denied, modified, or delayed by us or your *medical group*, in whole or in part because the service is not *medically necessary*.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. We must provide you with an IMR application form and an addressed envelope for you to use to request IMR with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against us regarding the disputed health care service.

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

1. One or more of the following conditions has been met:
  - (a) Your provider has recommended a health care service as *medically necessary*,
  - (b) You have received *urgent care* or *emergency services* that a provider determined was *medically necessary*, or

- (c) You have been seen by a *participating provider* for the diagnosis or treatment of the medical condition for which you seek independent review;
2. The disputed health care service has been denied, modified, or delayed by us or your *medical group*, based in whole or in part on a decision that the health care service is not *medically necessary*; and
  3. You have filed a grievance with us or your *medical group* and the disputed decision is upheld or the grievance remains unresolved after 30 days. If your grievance requires expedited review you need not participate in our grievance process for more than three days. The DMHC may waive the requirement that you follow our grievance process in extraordinary and compelling cases.

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

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

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

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

### **Department of Managed Health Care**

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at the **telephone number listed on your identification card** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a

grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site (<http://www.hmohelp.ca.gov>) has complaint forms, IMR applications forms and instructions online.

## **BINDING ARBITRATION**

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this *plan* or the *agreement*, 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 Anthem agree to be bound by these arbitration provisions and acknowledge that they are giving up their right to trial by jury for both medical malpractice claims and any other disputes.

California Health & Safety Code section 1363.1 requires that any arbitration agreement include the following notice based on California Code of Civil Procedure 1295(a): **It is understood that any dispute as to medical malpractice, that is, whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings and except for disputes regarding a claim for damages within the jurisdictional limits of the small claims court. Both parties to this contract, by entering into it, acknowledge that they**

**are giving up their constitutional right to have any and all disputes, including medical malpractice claims, decided in a court of law before a jury, and instead are accepting the use of arbitration.**

The *member* and Anthem agree to give up the right to participate in class arbitrations 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 Anthem and Anthem 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 initiated by the *member* making written demand on Anthem. The arbitration will be conducted by Judicial Arbitration and Mediation Services (“JAMS”), according to its applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by agreement of the *member* and Anthem, or by order of the court, if the *member* and Anthem cannot agree.

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

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

## **DEFINITIONS**

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

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

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

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

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

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

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

**Authorized referral** occurs when you, because of your medical needs, are referred to (a) a *non-Prudent Buyer Plan provider* for medical care under your PLUS benefits or (b) a *non-participating provider* for the treatment of *mental or nervous disorders* or substance abuse under your HMO and PLUS benefits, but only when:

1. There is no *Prudent Buyer Plan provider* or *participating provider* who practices in the appropriate specialty, 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-Prudent Buyer Plan provider* or *non-participating provider* by a *physician* who is a *Prudent Buyer Plan provider* or *participating provider*; and
3. The referral has been authorized by us before services are rendered.

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

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

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

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

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

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

**Compound Medication** is a mixture of *prescription drugs* and other ingredients, of which at least one of the components is commercially available as a prescription product. Compound medications do not include:

1. Duplicates of existing products and supplies that are mass-produced by a manufacturer for consumers; or
2. Products lacking a National Drug Code (NDC) number.

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

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

**Creditable coverage** is any individual or group plan that provides medical, hospital and surgical coverage, including continuation or conversion coverage, coverage under Medicare or Medicaid, TRICARE, the Federal Employees Health Benefits Program, programs of the Indian Health Service or of a tribal organization, a state health benefits risk pool, coverage through the Peace Corps, the State Children's Health Insurance Program, or a public health plan established or maintained by a state, the United States government, or a foreign country. Creditable coverage does not include accident only, credit, coverage for on-site

medical clinics, disability income, coverage only for a specified disease or condition, hospital indemnity or other fixed indemnity insurance, Medicare supplement, long-term care insurance, dental, vision, workers' compensation insurance, automobile insurance, no-fault insurance, or any medical coverage designed to supplement other private or governmental plans. Creditable coverage is used to 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.

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

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

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

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

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

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

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

**Enrollment area** is the geographical area within a 15-mile or 30-minute radius of the *medical group* selected by the *subscriber*.

**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.

**Family member** meets the *plan's* eligibility requirements for family members as outlined under HOW COVERAGE BEGINS AND ENDS.

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

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

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

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

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

**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*.

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

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

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

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

**Medically necessary** procedures, supplies, services or equipment are those that Anthem determines to be:

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

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

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

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

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

**Non-contracting hospital** is a *hospital* which does not have a Standard Hospital Contract in effect with us 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 providers** are licensed health care providers which are not *participating providers*. They do not have an Anthem Blue Cross PLUS Provider Agreement in effect with us at the time services are rendered.

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

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

9. A home infusion therapy provider.

**Other health care provider** is one of the following providers:

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

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

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

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

**Pharmacy** means a licensed retail pharmacy.

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

**Physician** means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided, or
2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license and such license is required to render that service, is providing a service for which benefits are specified in this booklet, and when benefits would be provided if the services were provided by a physician as defined in 1 above:
  - a. A dentist (D.D.S. or D.M.D.)
  - b. An optometrist (O.D.)
  - c. A dispensing optician
  - d. A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
  - e. A licensed clinical psychologist
  - f. A chiropractor (D.C.)
  - g. An acupuncturist (A.C.)

- h. A licensed clinical social worker (L.C.S.W.)
- i. A marriage and family therapist (M.F.T.)
- j. A physical therapist (P.T. or R.P.T.)\*
- k. A speech pathologist\*
- l. An audiologist\*
- m. An occupational therapist (O.T.R.)\*
- n. A respiratory care practitioner (R.C.P.)\*
- o. A *psychiatric mental health nurse*\*
- p. A nurse midwife\*\*
- q. A nurse practitioner
- r. A physician assistant
- s. A registered dietitian (R.D.)\* for the provision of diabetic medical nutrition therapy only

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

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

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

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

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

**Prescription drug maximum allowed amount** is the maximum amount we will allow for any *drug*. The amount is determined by us using prescription drug cost information provided to us by the *pharmacy benefits manager*. The amount is subject to change. You may determine

the prescription drug maximum allowed amount of a particular drug by calling 1-800-700-2541 (or TTY/TDD 1-800-905-9821).

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

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

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

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

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

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

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

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

**Prior Plan** is a plan sponsored by the *group* which was replaced by this *plan* within 60 days. A member is considered covered under the prior plan if that member: (1) was covered under the prior plan on the date that plan terminated; (2) properly enrolled for coverage within 31 days of this *plan's* Effective Date; and (3) had coverage terminate solely due to the prior plan's termination.

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

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

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

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

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

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

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

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

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

1. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community and is at risk of being removed from the home or has

already been removed from the home or the mental disorder has been present for more than six months or is likely to continue for more than one year without treatment.

2. The child is psychotic, suicidal, or potentially violent.
3. The child meets special education eligibility requirements under California law (Government Code Section 7570).

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

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

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

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

**Subscriber** is the person who, by meeting the *plan's* eligibility requirements for subscribers, is allowed to choose membership under this *plan* for himself or herself and his or her eligible *family members*. Such requirements are outlined in HOW COVERAGE BEGINS AND ENDS. A person may enroll as a subscriber under only one health plan provided by Anthem, or any of its affiliates, which is sponsored by the *group*.

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

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

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

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

**Urgent care** is the services received for a sudden, serious, or unexpected illness, injury or condition, which is not an *emergency*, but which requires immediate care for the relief of pain or diagnosis and treatment of such condition.

**We (us, our)** refers to Anthem Blue Cross.

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

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

## FOR YOUR INFORMATION

### ORGAN DONATION

Each year, organ transplantation saves thousands of lives. The success rate for transplantation is rising but there are far more potential recipients than donors. More donations are urgently needed.

Organ donation is a singular opportunity to give the gift of life. Anyone age 18 or older and of sound mind can become a donor when he or she dies. Minors can become donors with parental or guardian consent.

Organ and tissue donations may be used for transplants and medical research. Today it is possible to transplant more than 25 different organs and tissues; this can save the lives of as many as eight people and improve the lives of another 50 people. Your decision to become a donor could someday save or prolong the life of someone you know, perhaps even a close friend or family member.

If you decide to become a donor, please discuss it with your family. Let your physician know your intentions as well. You may register as a donor by obtaining a donor card from the Department of Motor Vehicles. Be sure to sign the donor card and keep it with your driver's license or identification card. In California, you may also register online at:

[www.donatelifecalifornia.org/](http://www.donatelifecalifornia.org/)

While organ donation is a deeply personal decision, please consider making this profoundly meaningful and important gift.

## **ANTHEM BLUE CROSS WEB SITE**

Information specific to your benefits and claims history are available by calling the 800 number on your identification card or on the Anthem Blue Cross web site at [www.anthem.com/ca](http://www.anthem.com/ca). To access benefit information, claims payment status, benefit maximum status, participating providers or to order an ID card, simply log on to the web site, select "Member", and click the "Register" button on your first visit to establish a User ID and Password to access the personalized and secure MemberAccess Web site. Once registered, simply click the "Login" button and enter your User ID and Password to access the MemberAccess Web site. Our privacy statement can also be viewed on our website. You may also submit a grievance online or print the Plan Grievance form through the website.

## **LANGUAGE ASSISTANCE PROGRAM**

Anthem 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](http://www.anthem.com/ca).

## SUMMARY PLAN DESCRIPTION

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA) – It is not a part of your Evidence of Coverage and Disclosure (Evidence of Coverage) Form. But, this document together with the attached Evidence of Coverage form, issued by Anthem Blue Cross, constitutes the Summary Plan Description required by ERISA.

1. **Plan Name.** The designated name of the Plan is Pepperdine University Health and Welfare Plan.

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

Pepperdine University  
24255 Pacific Coast Highway  
Malibu, California 90263  
9310) 506-4397

3. **Plan Numbers:**

The Employer's Identification Number (EIN) is 95-1644037.

The Plan Number is 501.

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

5. **Source of Plan Contributions.** The contributions necessary to finance the Plan are provided by the employer and the employee. However, any contributions necessary to cover a retiree and/or his dependents are paid entirely by the retiree. Any required employee contributions under this plan are subject to the Pre-Tax Premium Cafeteria Plan of Pepperdine University.

6. **Plan Year.** The Plan's records are maintained on a plan year basis beginning each year on September 1 and ending on the following August 31.

7. **Type of Administration/Funding.** Benefits are furnished under a health care plan purchased by the Plan Sponsor and provided by Anthem Blue Cross (Anthem) under which Anthem is financially responsible for the payment of benefits.

Anthem's address is:

Anthem Blue Cross  
21555 Oxnard Street  
Woodland Hills, California 91367

8. **Plan Administrator.** The name, address and telephone number of the Plan Administrator is:

Pepperdine University  
24255 Pacific Coast Highway  
Malibu, California 90263  
(310) 506-4397

9. **Agent for Service of Legal Process.** The name and address of the designated agent for the service of legal process for the Plan is:

Vice President and General Counsel  
Pepperdine University  
24255 Pacific Coast Highway  
Malibu, California 90263  
(310) 506-4607

Service of legal process may also be served on the Plan Administrator, Pepperdine University.

10. **Description of Benefits.** The Evidence of Coverage pages set forth the benefits, copays, deductible, payment rates, benefit maximums, limitations and exclusions, and the extent to which preventive care is provided under the Anthem Blue Cross PLUS (Point-Of-Service "POS") Plan. An explanation of these benefits may be found in the sections entitled INTRODUCTION TO ANTHEM BLUE CROSS PLUS, SUMMARY OF BENEFITS, YOUR MEDICAL BENEFITS (including the subsections HMO BENEFIT CO-PAYMENTS, PLUS BENEFITS: HOW COVERAGE EXPENSE IS DETERMINED, PLUS BENEFITS: MEDICAL DEDUCTIBLES, CO-PAYMENTS, OUT-OF-POCKET AMOUNTS AND BENEFIT MAXIMUMS, COMBINED HMO AND PLUS MEDICAL BENEFIT MAXIMUMS, CONDITIONS OF COVERAGE, MEDICAL CARE THAT IS COVERED, HMO BENEFITS, PLUS BENEFITS, HMO AND PLUS BENEFITS, MEDICAL CARE THAT IS NOT COVERED, APPLICABLE TO HMO BENEFITS, APPLICABLE TO PLUS BENEFITS, and APPLICABLE TO HMO AND PLUS BENEFITS), REIMBURSEMENT FOR ACTS OF THIRD PARTIES, USING YOUR HMO BENEFITS (including the subsections PRIMARY CARE, SECOND OPINIONS, HOSPITAL STAYS, REFERRAL CARE, EMERGENCY CARE, URGENT CARE, AWAY FROM HOME CARE, and EXTRAORDINARY CIRCUMSTANCES) UTILIZATION REVIEW PROGRAM (including the subsection THE MEDICAL NECESSITY REVIEW PROCESS), PERSONAL CASE MANAGEMENT (including the subsections DISAGREEMENTS WITH MEDICAL MANAGEMENT DECISIONS and QUALITY ASSURANCE), COORDINATION OF BENEFITS, BENEFITS FOR MEDICARE ELIGIBLE MEMBERS (including the subsections UNDER THE HMO BENEFITS and UNDER THE PLUS BENEFITS), EXTENSION OF BENEFITS, GENERAL PROVISIONS, GRIEVANCE PROCEDURES, BINDING ARBITRATION and DEFINITIONS. Information about prescription drug

benefits, copays, benefit maximums, limitations and exclusions, including what drugs are covered under the Anthem Blue Cross PLUS Plan, and how it is decided what drugs the plan will cover, is provided in the section YOUR PRESCRIPTION DRUG BENEFITS (including the subsections PRESCRIPTION DRUG COVERED EXPENSE, PRESCRIPTION DRUG CO-PAYMENTS, PRESCRIPTION DRUG UTILIZATION REVIEW, PREFERRED DRUG PROGRAM, PRESCRIPTION DRUG CONDITIONS OF SERVICE, PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED and PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED).

If your health care plan includes coverage for pregnancy and maternity care, Federal law prohibits the restriction of benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal delivery or 96 hours following a cesarean section. A health care provider also may not be required to obtain authorization for prescribing a length of stay for childbirth that does not exceed these time periods.

#### **Statement of Rights Under the Women’s Cancer Rights Act of 1998**

Did you know that your plan, as required by the Women’s Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from mastectomy (including lymphedema)? Call your Plan Administrator (see item 8 above) for more information.

#### **Coverage for a Child Due to a Qualified Medical Support Order (“QMCSO”)**

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

- 11. Eligibility for Participation.** The eligibility requirements for participation under the Anthem Blue Cross PLUS Plan are set forth in the Evidence of Coverage Form in the section entitled HOW COVERAGE BEGINS AND ENDS under the subsection HOW COVERAGE BEGINS.

12. **Summary Plan Modification Date:** Amended through September 1, 2011.

13. **Grounds for Ineligibility or Loss or Denial of Benefits.** Details describing the circumstances which may result in: (a) disqualification from the Anthem Blue Cross PLUS Plan; (b) ineligibility for benefits; or (c) denial, loss, forfeiture or suspension of benefits under the Plan are set forth and identified in the Evidence of Coverage, as outlined below:

- Reasons for ineligibility or loss of benefits may be found in the section entitled HOW COVERAGE BEGINS AND ENDS under the subsection HOW COVERAGE ENDS.
- Benefits may be denied or suspended if statements a Plan participant has made in connection with obtaining coverage were false.
- Information concerning situations under which benefits may be reduced or denied may be found in the sections entitled INTRODUCTION TO ANTHEM BLUE CROSS PLUS, SUMMARY OF BENEFITS, YOUR MEDICAL BENEFITS (including the subsections HMO BENEFIT CO-PAYMENTS, PLUS BENEFITS: HOW COVERAGE EXPENSE IS DETERMINED, PLUS BENEFITS: MEDICAL DEDUCTIBLES, CO-PAYMENTS, OUT-OF-POCKET AMOUNTS AND BENEFIT MAXIMUMS, COMBINED HMO AND PLUS MEDICAL BENEFIT MAXIMUMS, CONDITIONS OF COVERAGE, MEDICAL CARE THAT IS COVERED, HMO BENEFITS, PLUS BENEFITS, HMO AND PLUS BENEFITS, MEDICAL CARE THAT IS NOT COVERED, APPLICABLE TO HMO BENEFITS, APPLICABLE TO PLUS BENEFITS, and APPLICABLE TO HMO AND PLUS BENEFITS), REIMBURSEMENT FOR ACTS OF THIRD PARTIES, USING YOUR HMO BENEFITS (including the subsections PRIMARY CARE, SECOND OPINIONS, HOSPITAL STAYS, REFERRAL CARE, EMERGENCY CARE, URGENT CARE, AWAY FROM HOME CARE, and EXTRAORDINARY CIRCUMSTANCES) UTILIZATION REVIEW PROGRAM (including the subsection THE MEDICAL NECESSITY REVIEW PROCESS), PERSONAL CASE MANAGEMENT (including the subsections DISAGREEMENTS WITH MEDICAL MANAGEMENT DECISIONS and QUALITY ASSURANCE), COORDINATION OF BENEFITS, BENEFITS FOR MEDICARE ELIGIBLE MEMBERS (including the subsections UNDER THE HMO BENEFITS and UNDER THE PLUS BENEFITS), EXTENSION OF BENEFITS, GENERAL PROVISIONS, GRIEVANCE PROCEDURES, BINDING ARBITRATION and DEFINITIONS. Information about prescription drug benefits, copays, benefit maximums, limitations and exclusions, including what drugs are covered under the Anthem Blue Cross PLUS Plan, and how it is decided what drugs the plan will cover, is provided in the section YOUR PRESCRIPTION DRUG BENEFITS (including the subsections

PRESCRIPTION DRUG COVERED EXPENSE, PRESCRIPTION DRUG CO-PAYMENTS, PRESCRIPTION DRUG UTILIZATION REVIEW, PREFERRED DRUG PROGRAM, PRESCRIPTION DRUG CONDITIONS OF SERVICE, PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED and PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED).

14. **Claims Procedures.** The Evidence of Coverage Form contains information on reporting claims, including the time limitations on submitting a claim. Claim forms may be obtained from the Plan Administrator or Anthem. In addition to this information, ERISA applies some additional claim procedure rules. The additional rules required by ERISA are set forth below.

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

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

**Non-Urgent Care Pre-Service (when care has not yet been received).** Anthem must notify you within 15-days after they receive your request for benefits that they have it and what they have determined your benefits to be. If they need more than 15-days to determine your benefits, due to reasons beyond their control, they must notify you within that 15-day period that they need more time to

determine your benefits. But, in any case, even with an extension, they cannot take more than 30-days to determine your benefits. If you do not properly submit all the necessary information for your request for benefits to them, they must notify you, within 5-days after they get it and tell you what information is missing. You have 45-days to provide them with the information they need to process your request for benefits. The time period during which Anthem is waiting for receipt of the necessary information is not counted toward the time frame in which Anthem must make the benefit determination.

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

#### **Concurrent Care Decisions:**

- **Reduction of Benefits** – If, after approving a request for benefits in connection with your illness or injury, Anthem decides to reduce or end the benefits they have approved for you, in whole or in part:
  - They must notify you sufficiently in advance of the reduction in benefits, or the end of benefits, to allow you the opportunity to appeal their decision before the reduction in benefits or end of benefits occurs. In their notice to you, Anthem must explain their reason for reducing or ending your benefits and the plan provisions upon which the decision was made.
  - To keep the benefits you already have approved, you must successfully appeal Anthem's decision to reduce or end those benefits. You must make your appeal to them at least 24-hours prior to the occurrence of the reduction or ending of benefits. If you appeal the decision to reduce or end your benefits when there is less than 24-hours to the occurrence of the reduction or ending of benefits, your appeal may be treated as if you were appealing an urgent care denial of benefits (see the section "Urgent Care," above), depending upon the circumstances of your condition.

- If Anthem receives your appeal for benefits at least 24-hours prior to the occurrence of the reduction or ending of benefits, they must notify you of their decision regarding your appeal within 24-hours of their receipt of it. If Anthem denies your appeal of their decision to reduce or end your benefits, in whole or in part, they must explain the reason for their denial of benefits and the plan provisions upon which the decision was made. You may further appeal the denial of benefits according to the rules for appeal of an urgent care denial of benefits (see the section “Urgent Care,” above).
- **Extension of Benefits** – If, while you are undergoing a course of treatment in connection with your illness or injury, for which benefits have been approved, you would like to request an extension of benefits for additional treatments:
  - You must make a request to Anthem for the additional benefits at least 24-hours prior to the end of the initial course of treatment that had been previously approved for benefits. If you request additional benefits when there is less than 24-hours till the end of the initially prescribed course of treatment, your request will be handled as if it was a new request for benefits and not an extension and, depending on the circumstances, it may be handled as an Urgent or Non-Urgent Care Pre-service request for benefits.
  - If Anthem receives your request for additional benefits at least 24-hours prior to the end of the initial course of treatment, previously approved for benefits, they must notify you of their decision regarding your request within 24-hours of their receipt of it if your request is for urgent care benefits. If Anthem denies your request for additional benefits, in whole or in part, they must explain the reason for their denial of benefits and the plan provisions upon which the decision was made. You may appeal the adverse benefit determination according to the rules for appeal for Urgent, Pre-Service or Post-Service adverse benefit determinations, depending upon the circumstances.

**Non - Urgent Care Post-Service (reimbursement for cost of medical care).** Anthem must notify you, within 30-days after they receive your claim for benefits, that they have it and what they determine your benefits to be. If they need more than 30-days to determine your benefits, due to reasons beyond their control, they must notify you within that 30-day period that they need more time to determine your benefits. But, in any case, even with an extension, they cannot take more than 45-days to determine your benefits. If

you do not submit all the necessary information for your claim to them, they must notify you, within 30-days after they get it and tell you what information is missing. You have 45-days to provide them with the information they need to process your claim. The time period during which Anthem is waiting for receipt of the necessary information is not counted toward the time frame in which Anthem must make the benefit determination.

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

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

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

You may have representation throughout the appeal and review procedure.

For the purposes of this provision, the meanings of the terms “urgent care,” “Non-Urgent Care Pre-Service,” and “Non - Urgent Care Post-Service,” used in this provision, have the meanings set forth by ERISA for a “claim involving urgent care,” “pre-service claim,” and “post-service claim,” respectively.

15. **Amendment and Termination of the Plan.** Pepperdine University (Plan Administrator) reserves the right to change, suspend, amend or end the benefits program, and the terms on which benefits, if any, will be available to its employees. The Vice President for Finance and Administration of Pepperdine University is authorized to amend or modify, in a manner consistent with the terms of the Group Benefit Agreement, or terminate the benefits program at any time and from time to time. Any such amendment, modification or termination will be made by written amendment executed by the Vice President for Finance and Administration of the University.

PLEASE NOTE: Please do not interpret any statement in this booklet to mean that your participation in Pepperdine University's benefits program is a guarantee of continued employment or is intended to be an employment contract of any form.

### **STATEMENT OF ERISA RIGHTS**

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

#### **Receive Information About Your Plan and Benefits**

- Examine, without charge, at the Plan Administrator's office and at other locations, such as worksites, all Plan documents, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies;
- Receive a summary of the Plan's annual financial report; the Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

#### **Continue Group Health Plan Coverage**

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months

after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

### **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of your benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

### **Enforce Your Rights**

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials requested and to pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court, except that, any dispute concerning denial or partial denial of a claim must be resolved by binding arbitration as provided in the Plan booklet, unless otherwise prohibited under any applicable state or federal law. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### **Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.