

SELF-INSURED SCHOOLS OF
CALIFORNIA

October 1, 2013

Your Anthem Blue Cross HMO Plan

Combined Evidence of Coverage and Disclosure Form

**Anthem Blue Cross
21555 Oxnard Street
Woodland Hills, California 91367
Phone Number: 800-999-3643
www.anthem.com/ca**

This booklet, called the “Combined Evidence of Coverage and Disclosure Form”, gives you important information about 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. You can get a copy of the health plan contract from your employer.

Many words used in this booklet are explained in the “Important Words to Know” section. When reading through this booklet, check that section to be sure that you understand what these words mean. Each time these words are used they are *italicized*.

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Welcome to Anthem Blue Cross HMO

Thank you for choosing our health plan.

Anthem Blue Cross HMO is here to serve you. This booklet tells you all about your health care plan and its benefits.

- ◆ It tells you about what kinds of care this *plan* covers and doesn't cover.
- ◆ It tells you what you have to do, or what has to happen so you can get benefits.
- ◆ It tells you what kinds of *doctors* and other *health care providers* you can go to for care.
- ◆ It tells you about options you may have if your coverage ends.

Take some time to read it now.

- ◆ Keep this booklet handy for any questions you may have later on.

We're here to help you!!

We want to give you the help you need. If you have any questions,

- ◆ Please call us at the 800 number on your Member ID card for Anthem Blue Cross HMO Customer Service.
- ◆ Or write us at:

Anthem Blue Cross

Attn.: Anthem Blue Cross HMO

P.O. Box 4089

Woodland Hills, CA. 91365

website: www.anthem.com/ca

We can help you get the health care you need.

Getting Started

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

Choosing Your Primary Care Doctor

When you enroll you should choose a *primary care doctor*. Your *primary care doctor* will be the first *doctor* you see for all your health care needs. If you need special kinds of care, this *doctor* will refer you to other kinds of *health care providers*.

Your *primary care doctor* will be part of an Anthem Blue Cross HMO contracting *medical group*. There are two types of Anthem Blue Cross HMO *medical groups*.

- ◆ A *primary medical group (PMG)* is a group practice staffed by a team of *doctors*, nurses, and other *health care providers*.
- ◆ An *independent practice association (IPA)* is a group of *doctors* in private offices who usually have ties to the same *hospital*.

You and your family members can enroll in whatever *medical group* is best for you, that is accepting new patients.

- ◆ You must live or work within fifteen (15) miles or thirty minutes (30) of the *medical group*.
- ◆ You and your family members do not have to enroll in the same *medical group*.
- ◆ For a child, you may choose a *primary care doctor* who is a pediatrician.

We publish a directory of *Anthem Blue Cross HMO providers*.

You can get a directory from your plan administrator (usually your employer) or from us. The directory lists all *medical groups*, *IPAs*, and the *primary care doctors* and *hospitals* that are affiliated with each *medical group* or *IPA*. You may call our *Customer Service number* on your Member ID card or you may write to us and ask us to send you a directory. You may also search for an *Anthem Blue*

Cross HMO provider using the “Provider Finder” function on our website at www.anthem.com/ca. The listings include the credentials of our *primary care doctors* such as specialty designations and board certification.

If You Need Help Choosing

We can help you choose a *doctor* who will meet your needs.

- ◆ Call our *Customer Service number* on your Member ID card.
- ◆ Talk to the *Anthem Blue Cross HMO coordinator* at your *medical group*. Your *Anthem Blue Cross HMO coordinator* can also help you:
 - Understand the services and benefits you can get through Anthem Blue Cross HMO.
 - Get answers to any questions you may have about your *medical group*.

Changing Your Medical Group

You may find out later on that you need to change your *medical group*. You may move or you may have some other reason.

Here’s what you can do:

- ◆ Ask your employer for a *membership change form*. Fill out the form, sign it and turn it in to your employer.

OR

- ◆ Call our *Customer service number* on your Member ID card. We will need to know why you want to change your *medical group*.

The change will take place on the first day of the next month as long as you aren’t still getting treatment from your *doctor* or specialist within the *medical group*.

If you move to an area not served by Anthem Blue Cross HMO, we will not be able to cover your medical care. If you move, let your employer know within 30 days. That way you can enroll in a

different health care plan right away, and still get the health care you need.

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

When You Need Care

When You Need Routine Care

◆ **Call your *primary care doctor's* office.**

◆ **Make an appointment.**

When you call:

- Tell them you are an Anthem Blue Cross HMO *member*.
- Have your Member ID card handy. They may ask you for:
 - Your group number
 - Member I.D. number
 - Office visit *copay*
- Tell them the reason for your visit.

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

◆ **Please call your *doctor's office* if you cannot come for your appointment, or if you will be late.**

◆ **If you need care after normal office hours, call your *primary care doctor's* office for instructions.**

When You Need a Referral

Your *doctor* may refer you to another *doctor* or *health care provider* if you need special care. Your *primary care doctor* must OK all the care you get except for *emergency services*.

Your *doctor's medical group*, or your *primary care doctor* if they are not part of a *medical group*, has to agree that the service or care you will be getting from the other *health care provider* is *medically necessary*. Otherwise it won't be covered.

◆ You will need to make the appointment at the other *doctor's* or *health care provider's office*.

- ◆ Your *primary care doctor* will give you a referral form to take with you to your appointment. This form gives you the OK to get this care. If you don't get this form, ask for it or talk to your *Anthem Blue Cross HMO coordinator*.
- ◆ You may have to pay a *copay*. If your *primary care doctor* refers you to a non-*Anthem Blue Cross HMO provider*, and you have to pay a *copay*, any fixed dollar *copay* will be the same as if you had the same service provided by an *Anthem Blue Cross HMO provider*. But, if your *copay* is other than a fixed dollar *copay*, while your benefits levels will not change, your out-of-pocket cost may be greater if the services are provided by a non-*Anthem Blue Cross HMO provider*. You shouldn't get a bill, unless it is for a *copay*, for this service. If you do, send it to your *Anthem Blue Cross HMO coordinator* right away. The *medical group*, or *primary care doctor* if they are not part of a *medical group*, will see that the bill is paid.

Standing Referrals. If you have a condition or disease that requires continuing care from a specialist or is life-threatening, degenerative, or disabling (including HIV or AIDS), your *primary care doctor* may give you a *standing referral* to a *specialist* or *specialty care center*. The referral will be made if your *primary care doctor*, in consultation with you, and a *specialist* or *specialty care center*, if any, determine that continuing specialized care is *medically necessary* for your condition or disease.

If it is determined that you need a *standing referral* for your condition or disease, a treatment plan will be set up for you. The treatment plan:

- ◆ Will describe the specialized care you will receive;
- ◆ May limit the number of visits to the *specialist*; or
- ◆ May limit the period of time that visits may be made to the *specialist*.

If a *standing referral* is authorized, your *primary care doctor* will determine which *specialist* or *specialty care center* to send you to in the following order:

- ◆ First, an Anthem Blue Cross HMO contracting *specialist* or *specialty care center* which is associated with your *medical group*;
- ◆ Second, any Anthem Blue Cross HMO contracting *specialist* or *specialty care center*; and
- ◆ Last, any *specialist* or *specialty care center*;

that has the expertise to provide the care you need for your condition or disease.

After the referral is made, the *specialist* or *specialty care center* will be authorized to provide you health care services that are within the *specialist's* area of expertise and training in the same manner as your *primary care doctor*, subject to the terms of the treatment plan.

Remember: We only pay for the number of visits and the type of special care that your *primary care doctor* OK's. Call your *doctor* if you need more care. **If your care isn't approved ahead of time, you will have to pay for it (except for *emergency services*.)**

Ready Access

There are two ways you may get special care without getting an OK from your *medical group*. These two ways are the "Direct Access" and "Speedy Referral." programs. **Not all medical groups take part in the Ready Access program. See your Anthem Blue Cross HMO Directory for those that do.**

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

- ◆ Allergy

- ◆ Dermatology
- ◆ Ear/Nose/Throat

Ask your *Anthem Blue Cross HMO 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 *doctor* who works with your *medical group*. The *Anthem Blue Cross HMO coordinator* will give you a list of those *doctors*.

Speedy Referral. If you need special care, your *primary care doctor* may be able to refer you for it without getting an OK from your *medical group* first. The types of special care you can get through Speedy Referral depend on your *medical group*.

Obstetrical and Gynecological Care

Obstetrical and gynecological services may be received directly, without obtaining referral from your *primary care doctor*, from an obstetrician and 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 *doctor* specializing in obstetrical or gynecological care may refer you to another *doctor* 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 *doctor* specializing in obstetrical or gynecological care are the same conditions for a referral from your *participating care doctor*. See **When You Need a Referral**.
- ◆ Ask your *Anthem Blue Cross HMO coordinator* for the list of OB-GYN health care providers you must choose from.

Care for Mental or Nervous Disorders or Substance Abuse and Pervasive Developmental Disorder or Autism

You may get care for the treatment of *mental or nervous disorders* or substance abuse and pervasive developmental disorder or autism without getting an OK from your *medical group*. In order for this care to be covered, you must go to an *Anthem Blue Cross HMO provider*. Some services require that we review and OK care in advance. Please see “Mental or Nervous Disorders/Substance Abuse” in the section called “Your Benefits At Anthem Blue Cross HMO” and the section “Benefits for Pervasive Developmental Disorder or Autism” for complete information.

You can get an Anthem Blue Cross Behavioral Health Network directory listing these providers from your plan administrator (usually your employer) or from us as follows:

- ◆ You can call our *Customer Service number* shown on your Member ID card or you may write to us and ask us to send you a directory. Ask for the Behavioral Health Network directory.
- ◆ You can also search for an *Anthem Blue Cross HMO provider* using the “Provider Finder” function on our website at www.anthem.com/ca. Be sure to select the "Behavioral Health Professionals" option on the next screen following your selection of plan category.

In addition, if you are a new *member* and you enrolled in this *plan* because the employer changed health plans, and you are getting care for an acute, serious, or chronic *mental or nervous disorder* or for substance abuse from a *doctor* or other *health care provider* who is not part of the Anthem Blue Cross HMO network, you may be able to continue your course of treatment with that *doctor* or *health care provider* for a reasonable period of time before transferring to an *Anthem Blue Cross HMO provider*. To ask for this continued care or to get a copy of our written policy for this continued care, please call our *Customer Service number* shown on your Member ID card.

When You Want a Second Opinion

You may receive a second opinion about care you receive from:

- ◆ Your *primary care doctor*, or
- ◆ A *specialist* to whom you were referred by your *primary care doctor*.

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

- ◆ Questions about whether recommended surgical procedures are reasonable or necessary.
- ◆ 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 not clear or are complex and confusing.
- ◆ A diagnosis is in doubt because of test results that do not agree.
- ◆ The first *doctor or health care provider* 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 tried to follow the treatment plan or you have talked with the *doctor or health care provider* about serious concerns you have about your diagnosis or plan of care.

To ask for a second opinion about care you received from your *primary care doctor* if your *primary care doctor* is part of a *medical group*, call your *primary care doctor* or your *Anthem Blue Cross HMO coordinator* at your *medical group*. The second opinion will be provided by a qualified *doctor or health care provider* of your choice who is part of your *medical group*.

To ask for a second opinion about care you received from:

- ◆ Your *primary care doctor* if he or she is an independently contracting *primary care doctor* (not part of a *medical group*),
or
- ◆ Any *specialist*,

please call the Customer Service number shown on your ID card. The Customer Service Representative will verify your Anthem Blue Cross HMO membership, get preliminary information, and give your request to an RN Case Manager. The second opinion will be provided by a qualified *doctor* or *health care provider* of your choice who is part of the Anthem Blue Cross network. Please note that if your *primary care doctor* is part of a *medical group*, the *doctor* or *health care provider* who provides the second opinion may not necessarily be part of your *medical group*.

For any second opinion, if there is no appropriately qualified *doctor* or *health care provider* in the Anthem Blue Cross network, we will authorize a second opinion by another appropriately qualified *doctor* or *health care provider*, taking into account your ability to travel.

For all second opinions, a decision will be made promptly after your request and any necessary information are received. Decisions on urgent requests are made within a time frame appropriate to your medical condition but no later than 72 hours after you make your request. For non-urgent requests, a decision will be made within two business days after any necessary information is received.

When approved, your *primary care doctor* or Case Manager helps you with selecting a *doctor* or *health care provider* who will provide the second opinion 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. You must pay only your usual *copay* for the second opinion.

An approval letter is sent to you and the *doctor* or *health care provider* who will provide the second opinion. The letter includes

the services approved and the date of your scheduled appointment. It also includes a telephone number to call if you have questions or need additional help. Approval is for the second opinion consultation only. It does not include any other services such as lab, x-ray, or additional treatment. You and your *primary care doctor* or *specialist* will get a copy of the second opinion report, which includes any recommended diagnostic testing or procedures. When you get the report, you and your *primary care doctor* or *specialist* should work together to determine your treatment options and develop a treatment plan. Your *medical group* (or your *primary care doctor*, if he or she is an independently contracting *primary care doctor*) must authorize all follow-up care.

You may appeal a disapproval decision by following our complaint process. Procedures for filing a complaint are described later in this booklet (see “How to Make a Complaint”) and in your denial letter.

If you have questions or need more information about this program, please contact your *Anthem Blue Cross HMO coordinator* at your *medical group* or call the *Customer Service number* shown on your Member ID card.

When You Need a Hospital Stay

There may be a time when your *primary care doctor* says you need to go to the *hospital*. If it is not an *emergency*, the *medical group* will look into whether or not it is *medically necessary*. If the *medical group* OK’s your *hospital stay*, you will need to go to a *hospital* that works with your *medical group*.

When There is an Emergency

If you need *emergency services*, get the medical care you need right away. In some areas, there is a 9-1-1 emergency response system that you may call for *emergency services* (this system is to be used only when there is an *emergency* that requires an emergency response).

Once you are stabilized, your *primary care doctor* must OK any care you need after that.

- ◆ Ask the *hospital* or emergency room *doctor* to call your *primary care doctor*.
- ◆ Your *primary care doctor* will OK any other *medically necessary* care or will take over your care.

You may need to pay a *copay* for emergency room services. A *copay* is a set amount you must pay for services. We cover the rest.

If You Are In-Area. You are in-area if you are 15-miles or 30-minutes or less from your *medical group* (or 15-miles or 30-minutes or less from your *medical group's hospital*, if your *medical group* is an *independent practice association*).

If you need *emergency services*, get the medical care you need right away. If you want, you may also call your *primary care doctor* and follow his or her instructions.

Your *primary care doctor* or *medical group* may:

- ◆ Ask you to come into their office;
- ◆ Give you the name of a *hospital* or emergency room and tell you to go there;
- ◆ Order an ambulance for you;
- ◆ Give you the name of another doctor or medical group and tell you to go there; or
- ◆ Tell you to call the 9-1-1 emergency response system.

If You're Out of Area. You can still get *emergency services* if you are more than 15-miles or 30-minutes away from your *primary care doctor* or *medical group*.

If you need *emergency services*, get the medical care you need right away (follow the instructions above for When There is an Emergency). In some areas, there is a 9-1-1 emergency response system that you may call for *emergency services* (this system is to be used only when there is an *emergency* that requires an

emergency response). You must call us within 48 hours if you are admitted to a *hospital*.

Remember:

- ◆ We won't cover services that don't fit what we mean by *emergency services*.
- ◆ Your *primary care doctor* must OK care you get once you are stabilized, unless Anthem Blue Cross HMO OKs it.
- ◆ Once your *medical group* or Anthem Blue Cross HMO give an OK for *emergency services*, they cannot withdraw it.

You Need Urgent Care

If You Are In-Area. You are in-area if you are 15-miles or 30-minutes or less from your *medical group* (or 15-miles or 30-minutes or less from your *medical group's hospital*, if your *medical group* is an *independent practice association*).

If you are in area, call your *primary care doctor* or *medical group*. Follow their instructions.

Your *primary care doctor* or *medical group* may:

- ◆ Ask you to come into their office;
- ◆ Give you the name of a *hospital* or emergency room and tell you to go there;
- ◆ Order an ambulance for you;
- ◆ Give you the name of another doctor or medical group and tell you to go there; or
- ◆ Tell you to call the 9-1-1 emergency response system.

If You're Out of Area. You can get *urgent care* if you are more than 15-miles or 30-minutes away from your *primary care doctor* or *medical group*.

For *urgent care*, if care can't wait until you get back to make an appointment with your *primary care doctor*, get the medical care you need right away. You must call us within 48 hours if you are admitted to a *hospital*.

If you need a *hospital stay* or long-term care, we'll check on your progress. When you are able to be moved, we'll help you return to your *primary care doctor's* or *medical group's* area.

Remember:

- ◆ We won't cover services that don't fit what we mean by *urgent care*.
- ◆ Your *primary care doctor* must OK care you get once you are stabilized, unless Anthem Blue Cross HMO OKs it.

Triage and 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 doctor*. 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 *doctor* or 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.

Telehealth

This *plan* provides benefits for covered services that are appropriately provided through telehealth, subject to the terms and conditions of the *plan* including the requirement that all care must be provided or authorized by your *medical group* or *primary care doctor*, except as specifically stated in this booklet. In-person contact between a *health care provider* and the patient is not required for these services, and the type of setting where these services are provided is not limited. "Telehealth" is the means of providing health care services using information and

communication technologies in the consultation, diagnosis, treatment, education, and management of the patient's health care when the patient is located at a distance from the *health care provider*. Telehealth does not include consultations between the patient and the *health care provider*, or between *health care providers*, by telephone, facsimile machine, or electronic mail.

Getting Care When You Are Outside of California

If you or your family members will be away from home 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 Member ID card.
- ◆ Ask for the Guest Membership Coordinator.
- ◆ We will send you forms to fill out.
- ◆ If there is a *medical group* taking part in the national network in the city you will be visiting, you'll be a guest member while you're away from home.
- ◆ The benefits you will get may not be the same as the benefits you would get at home.

Even without a *guest membership*, you can get *medically necessary* care (*urgent care*, *emergency services*, or follow-up care) when you are away from home.

- ◆ **If you are traveling outside California**, and need health care because of a non-emergency illness or injury, call the BlueCard Access 800 number, 1-800-810-BLUE (2583).
- ◆ **The BlueCard Access Call Center will tell you if there are doctors or hospitals in the area** that can give you care. They will give you the names and phone numbers of nearby *doctors* and *hospitals* that you go to or call for an appointment.
- ◆ **If it's an emergency, get medical care right away.** You or a member of your family must call us within 48 hours after first getting care.

- ◆ **The provider may bill you for these services.** Send these bills to us. We will make sure the services were *emergency services* or *urgent care*. You may need to pay a *copay*.

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

Care Outside the United States-BlueCard Worldwide

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

- ◆ Before you leave home, call the *Customer Service number* listed on your Member ID card for coverage details. **You have coverage for services and supplies furnished only in connection with *urgent care* or an *emergency* when travelling outside the United States.**
- ◆ Always carry your current Member ID card.
- ◆ In an *emergency* or if you need *urgent care*, seek medical treatment immediately.
- ◆ **The BlueCard Worldwide Service Center is available 24 hours a day, seven days a week toll-free at (800) 810-BLUE (2583) or by calling collect at (804) 673-1177.** An assistance coordinator, along with a medical professional, will arrange a *doctor* appointment or hospitalization, if needed.
- ◆ If you are admitted to a *hospital*, you must call us within 48 hours at the *Customer Service number* listed on your Member ID card. This number is different than the phone numbers listed above for BlueCard Worldwide.

Call the BlueCard Worldwide Service Center in these non-emergent situations:

- ◆ **You need to find a *doctor* or *hospital* or need medical assistance services.** An assistance coordinator, along with a medical professional, will arrange a *doctor* appointment or hospitalization, if needed.
- ◆ **You need to be hospitalized or need inpatient care.** After calling the Service Center, you must also call us at the *Customer Service number* listed on your Member ID card for pre-service review to determine whether the services are covered. Please note that this number is different than the phone numbers listed above for BlueCard Worldwide.

Payment Information.

- ◆ **Participating BlueCard Worldwide hospitals.** When you make arrangements for hospitalization through BlueCard Worldwide, you should not need to pay upfront for inpatient care at participating BlueCard Worldwide *hospitals* except for the out-of-pocket costs (noncovered services, deductible, copays and coinsurance) you normally pay. The *hospital* will submit your claim on your behalf.
- ◆ **Doctors and/or non-participating hospitals.** You will need to pay upfront for outpatient services, care received from a *doctor*, and inpatient care not arranged through the BlueCard Worldwide Service Center. Then you can complete a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim Filing.

- ◆ **The hospital will file your claim** if the BlueCard Worldwide Service Center arranged your hospitalization. You will need to pay the hospital for the out-of-pocket costs you normally pay.
- ◆ **You must file the claim** for outpatient and *doctor* care, or inpatient care not arranged through the BlueCard Worldwide Service Center. You will need to pay the health care provider

and subsequently send an international claim form with the original bills to Anthem.

Claim Forms.

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

www.bcbs.com/bluecardworldwide.

The address for submitting claims is on the form.

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 doctor*, 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.

If You and Your Doctor Don't Agree

If you think you need a certain kind of care, but your *doctor* or *medical group* isn't recommending it, you have a right to the following:

- ◆ **Ask for a written notice** of being denied the care you felt you needed. You should get this notice within 48 hours.
- ◆ **Your *doctor* should give you a written reason** and another choice of care within 48 hours.
- ◆ **You can make a formal appeal** to the *medical group* and to Anthem. See "How to Make a Complaint" on a later page.

We Want You to Have Good Health

Ask about our many programs to:

- ◆ Educate you about living a healthy life.
- ◆ Get a health screening.
- ◆ Learn about your health problem.

For more information, please call us at our *Customer service number* shown on your Member ID card.

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 *doctor* on the internet if your *doctor* is a participant in RelayHealth. To see if your *doctor* is enrolled in the program, use the “Find Your Doctor” function on the website, www.relayhealth.com. Through this private, secure internet program, you can consult your *doctor*, request prescription refills, schedule appointments, and get lab results. You will only be required to pay a *copay* for consultations. This *copay* will be **\$10** and must be paid by credit card. You will not be required to pay a *copay* when you request prescription refills, schedule appointments and get lab results.

Your Benefits at Anthem Blue Cross HMO

It's important to remember:

- ◆ The benefits of this *plan* are given only for those services that the *medical group* finds are *medically necessary*.
- ◆ Just because a *doctor* orders a service, it doesn't mean that:
 - The service is *medically necessary*; or
 - This *plan* covers it.
- ◆ If you have any questions about what services are covered, read this booklet, or give us a call at the number on your Member ID card.
- ◆ All benefits are subject to coordination with benefits available under certain other plans.
- ◆ We have the right to be repaid by a third party for medical care we cover if your injury, disease or other health problem is their fault or responsibility.

What are Copays?

A *copay* is a set amount you pay for each medical service. You need to pay a *copay* for some services given under this *plan*, but many other supplies and services do not need a *copay*. Usually, you must pay the *copay* at the time you get the services. The *copays* you need to pay for services are shown in the next section.

If you do not pay your *copay* within 31 days from the date it's due, we have the right to cancel your coverage under the *plan*. To find out how your coverage is cancelled if you do not pay your *copay*, see "How Your Coverage Ends", in the section "What You Should Know about Your Coverage", (see Table of Contents).

Here are the Copay Limits

If you pay more than the *Copay Limits* shown below in one calendar year (January through December), you won't need to pay any more *copays* for the rest of the year.

Per Number of Members	Copay Limits
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- One *Member*.....\$1,500
- Family\$3,000*

*But, not more than \$1,500 for any one *Member* in a Family.

The following *copay* won't apply to the *Copay Limits*:

- ◆ For *infertility*, any *copay* for diagnosis and testing for finding out about it.

What We Cover

We list benefits for the services and supplies in this section. Any *copays* you must pay are shown next to the service or supply. We list things **we do NOT cover in the next section.**

Remember:
Your *primary care doctor* and your *medical group* must give or OK all your care.

Doctor Care (or services of a Health Professional)	Copay
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- ◆ Office visits for a covered illness, injury or health problem.....\$5
- ◆ Home visits, when approved by your *medical group*, at the *doctor's* discretion\$5

- ◆ Injectable or infused medications*
given by the *doctor* in the office**20%**
with a maximum
copay of **\$150**

*This does not include immunizations prescribed by
your *primary care doctor* nor allergy serums.

- ◆ Surgery in *hospital, surgery center or medical group*
and surgical assistants **No charge**
- ◆ Anesthesia services **No charge**
- ◆ *Doctor visits during a hospital stay* **No charge**
- ◆ Visit to a *specialist* **\$5**
- ◆ *Medically necessary acupuncture*
OK'd by your *primary care doctor* **\$5**

Preventive Care Services	Copay
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Preventive care services include outpatient services, supplies and office visits. Screenings and other services are covered as *preventive care services* when you have no current symptoms or prior history of a medical condition associated with that screening or service.

- ◆ Full physical exams and periodic check-ups
ordered by your *primary care doctor* including
well-woman visits **No charge**
- ◆ Vision or hearing screenings* **No charge**
- ◆ Immunizations prescribed by your
primary care doctor **No charge**
- ◆ Health education programs given by your
primary care doctor or the medical group **No charge**

◆ Health screenings as prescribed by your doctor or health care provider..... **No charge**

- Health screenings include: mammograms, Pap tests and any cervical cancer screening tests including human papillomavirus (HPV), prostate cancer screenings, and other medically accepted cancer screening tests, screenings for high blood pressure, type 2 diabetes mellitus, cholesterol, and obesity.**

◆ Counseling and intervention services as part of a full physical exam or periodic check-up for the purpose of education or counseling on potential health concerns, including sexually transmitted infections, human immunodeficiency virus (HIV), contraception, and smoking cessation counseling. **No charge**

◆ HIV testing, regardless of whether testing is related to a primary diagnosis..... **No charge**

◆ Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following: **No charge**

- Women’s contraceptives, sterilization procedures, and counseling. This includes *generic* and *single source brand name drugs* as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUD)s, and implants are also covered.
- Breast feeding support, supplies, and counseling ordered by your *primary care doctor* or *medical group*. One breast pump will be covered per calendar year under this benefit.
- Gestational diabetes screening.

* Vision screening includes a vision check by your *primary care doctor* to see if it is *medically necessary* for you to have a complete vision exam by a vision *specialist*. If OK'd by your *primary care doctor*, this may include an exam with diagnosis, a treatment program and refractions. Hearing screenings include tests to diagnose and correct hearing.

** This list is not exhaustive. Preventive tests and screenings with a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF), or those supported by the Health Resources and Services Administration (HRSA) will be covered at no charge.

You may call Customer Service using the number on your ID card for additional information about these services. (Or view the federal government's web sites, <http://www.healthcare.gov/center/regulations/prevention.html>; <http://www.ahrq.gov/clinic/uspstfix.htm>; or <http://www.cdc.gov/vaccines/recs/acip/>.)

Diabetes	Copay
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- ◆ Equipment and supplies used for the treatment of diabetes (see below).....**See “Medical Equipment”**
 - Blood glucose monitors, including monitors designed to help the visually impaired, and blood glucose testing strips.
 - Insulin pumps
 - Pen delivery systems for insulin administration (non-disposable).
 - Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin.
- ◆ Podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes-related complications **See “Prosthetic Devices”**

- ◆ Diabetes education program services supervised by a *doctor* which include:.....\$5
 - Teaching you and your family members about the disease process and how to take care of it; and
 - Training, education, and nutrition therapy to enable you to use the equipment, supplies, and medicines needed to manage the disease.
- ◆ Medical supplies **No charge**
 - Insulin syringes, disposable pen delivery systems for insulin administration. Charges for insulin and other prescriptive medications are not covered.
 - Testing strips, lancets, and alcohol swabs.

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

General Medical Care (In a Non-Hospital-Based Facility)	Copay
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- ◆ Hemodialysis treatment, including treatment at home if OK'd by the *medical group*\$5
- ◆ Medical social services **No charge**
- ◆ Chemotherapy\$5
- ◆ Radiation therapy\$5
- ◆ Infusion therapy\$5
- ◆ Allergy tests and care.....\$5
- ◆ X-ray and laboratory tests:
 - *Advanced imaging procedures*.....\$100
per test

- Genetic testing (not including *medically necessary* genetic testing of the fetus or newborn) **No charge**
- All other x-ray and laboratory tests **No charge**
- ◆ Smoking cessation programs for nicotine dependency. Smoking cessation *drugs* that may be purchased over-the-counter without a *prescription* are not covered. We cover *medically necessary* drugs for nicotine dependency that require a *prescription*. This does not include those services required under the “Preventive Care Services” benefit. See “Getting Prescription Drugs.” **No charge**

Pregnancy or Maternity Care	Copay
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Medical services for an enrolled *member* are provided for pregnancy and maternity care, including the following services: Prenatal and postnatal care, ambulatory care services (including ultrasounds, fetal non-stress tests, *doctor* office visits, and other *medically necessary* maternity services performed outside of a *hospital*), involuntary complications of pregnancy, diagnosis of genetic disorders in cases of high-risk pregnancy, and inpatient *hospital* care including labor and delivery.

- ◆ Office visit.....**\$5**
- ◆ *Doctor’s* services for normal delivery or cesarean section **No charge**
- ◆ *Hospital* services (after you satisfy your deductible, and pay any *copay* that applies, benefits are provided for the following services):
 - Inpatient services **No charge**
 - Outpatient covered services..... **No charge**
- ◆ Elective abortions including Mifepristone

taken in the *doctor's* office.....\$150

◆ Genetic testing, when *medically necessary*..... **No charge**

◆ *Hospital* services for routine nursery care of your newborn child if the newborn child's natural mother is an enrolled *member*..... **No charge**

Routine nursery care of a newborn child includes screening of a newborn for genetic diseases, congenital conditions, and other health conditions provided through a program established by law or regulation.

◆ Certain services are covered under the “Preventive Care Services” benefit. Please see that provision for further details

Note: For inpatient *hospital* services related to childbirth, we will provide at least 48 hours after a normal delivery or 96 hours after a cesarean section, unless the mother and her *doctor* decide on an earlier discharge. Please see the section called “For Your Information” for a statement of your rights under federal law regarding these services.

Infertility and Birth Control	Copay
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◆ Diagnosis and testing for *infertility*.....**50%***

◆ Sterilization for females **No Charge**

Sterilizations for females will be covered under the “Preventive Care Services benefit. Please see that provision for further details.

◆ Sterilization for males**\$50**

◆ Family planning services**\$5**

◆ Shots and implants for birth control** **No charge**

◆ Intrauterine contraceptive devices (IUDs) and diaphragms, dispensed by a *doctor*** **No charge**

◆ *Doctor's services to prescribe, fit and insert an IUD or diaphragm*** **No Charge**

***Note:** The **50% copay** made for *infertility* services will not be applied to the “*Copay Limits*.”

****Certain contraceptives and related services are covered under the “Preventive Care Services” benefit. Please see that provision for further details.**

Mastectomy	Copay
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◆ Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema **See copays that apply**

◆ Reconstructive surgery of both breasts performed to restore symmetry following a mastectomy **See copays that apply**

Reconstructive Surgery	Copay
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◆ Reconstructive surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function, reducing symptoms or creating a normal appearance, including *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 **See copays that apply**

Rehabilitative Care	Copay
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You may have **up to a 60 day period of care** after an illness or injury. The 60 day period of care starts with the first visit for rehabilitative care. The 60 day limit does not limit the number of

visits or treatments you get within the 60 day period. If you need more than the 60 day period of care, your *primary care doctor* must get the OK from your *medical group* or Anthem. It must be shown that more care is *medically necessary*. Your *medical group* or Anthem will OK the extra visits or treatments. While there is no limit on the length of the covered period of care or the number of covered visits for *medically necessary* rehabilitative care, your *medical group* or Anthem must OK the longer time period and extra visits in advance.

Rehabilitative care as described above is also provided for a *member* who is being treated for a *severe mental disorder* or for pervasive developmental disorder or autism. This care is provided even though the *member* may not have suffered an illness or injury. If more than a 60-day period of care is needed, Anthem must OK the longer time period and additional visits in advance.

- ◆ Visits for rehabilitation, such as physical therapy, chiropractic services, occupational therapy or speech therapy\$5

Inpatient Hospital Services	Copay
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- ◆ A *hospital* room with two or more beds, or a private room only if *medically necessary*, ordered by your *primary care doctor* and OK'd by your *medical group* **No charge**

Inpatient hospital services and supplies include the following:

- Operating room and special treatment room;
- Special care units;
- Nursing care;
- *Drugs* and medicines, and supplies you get during your *stay*. This includes oxygen;

- Laboratory, cardiology, pathology and radiology services;
- Physical therapy, occupational therapy, speech therapy, radiation therapy, chemotherapy and hemodialysis; and
- Blood transfusions. This includes the cost of blood, blood products or blood processing.

Outpatient (In a Hospital or Surgery Center)	Copay
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◆ Emergency room use, supplies, other services, *drugs* and medicines. This includes oxygen**\$100***

*You don't have to pay the **\$100** if you are admitted as an inpatient.

◆ Care given when surgery is done. This includes operating room use, supplies, *drugs* and medicines, oxygen, and other services..... **No charge**

◆ X-ray and laboratory tests:

- *Advanced imaging procedures*.....**\$100**
per test

- All other x-ray and laboratory tests **No charge**

◆ Other outpatient *hospital* services and supplies, including physical therapy, occupational therapy, or speech therapy.***\$5**

However, for the following outpatient services, your copay will be:

- Chemotherapy**\$5**
- Radiation therapy**\$5**
- Hemodialysis treatment**\$5**

- Infusion therapy\$5

*These rehabilitative services are limited to a 60 day period of care after an illness or injury. If you need more than the 60 day period of care, your *primary care doctor* must get the OK from your *medical group* or Anthem. (See “Rehabilitative Care” above.)

Urgent Care	Copay
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If you are more than 15-miles or 30-minutes away from your *primary care doctor* or *medical group* and require *urgent care*, get it right away. *Urgent care* is not an *emergency*. It is care that is needed right away to relieve pain, find out what is wrong, or treat the health problem. You must call us within 48 hours if you are admitted to a *hospital*.

- ◆ *Doctor’s* office visit or urgent care facility use, supplies, other services, *drugs* and medicines.
This includes oxygen\$5*

*You don’t have to pay the \$5 if you are admitted as an inpatient to a *hospital*.

- ◆ Care given when surgery is done. This includes operating room use, supplies, *drugs* and medicines, oxygen, and other services. **No charge**

Skilled Nursing Facility Services	Copay
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You can get these kinds of care in a *skilled nursing facility* for **up to 100 days in a calendar year**.

- ◆ Services and supplies provided by a *skilled nursing facility* **No charge**
 - A room with two or more beds;
 - Special treatment rooms;
 - Regular nursing services;

- Laboratory tests;
- Physical therapy, occupational therapy, speech therapy, or respiratory therapy;
- *Drugs* and medicines given during your *stay*. This includes oxygen;
- Blood transfusions; and
- Needed medical supplies and appliances.

Home Health Care	Copay
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We will cover home health care furnished by a *home health agency* (HHA) for **up to 100 visits in a calendar year**.

- ◆ Care from a registered nurse or licensed vocational nurse who works under a registered nurse or a *doctor*\$5
- ◆ Physical therapy, occupational therapy, speech therapy, or respiratory therapy\$5
- ◆ Visits with a medical social service worker.....\$5
- ◆ Care from a health aide who works under a registered nurse with the HHA (one visit equals four hours or less).....\$5
- ◆ *Medically necessary* supplies from the HHA..... **No charge**

Hospice Care	Copay
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We will cover *hospice* care if you have an illness that may lead to death. Your *primary care doctor* will work with the *hospice* and help develop your care plan. The *hospice* must send a written care plan to your *medical group* every 30 days.

- ◆ Interdisciplinary team care to develop and maintain a plan of care **No charge**

- ◆ Short-term inpatient *hospital* care in periods of crisis or as respite care. Respite care is provided on an occasional basis for up to five consecutive days per admission **No charge**
- ◆ Physical therapy, occupational therapy, speech therapy and respiratory therapy **No charge**
- ◆ Social services and counseling services **No charge**
- ◆ Skilled nursing services given by or under the supervision of a registered nurse **No charge**
- ◆ Certified home health aide services and homemaker services given under the supervision of a registered nurse **No charge**
- ◆ Diet and nutrition advice; nutrition help such as intravenous feeding or hyperalimentation **No charge**
- ◆ Volunteer services given by trained *hospice* volunteers directed by a *hospice* staff member **No charge**
- ◆ *Drugs* and medicines prescribed by a *doctor* **No charge**
- ◆ Medical supplies, oxygen and respiratory therapy supplies **No charge**
- ◆ Care which controls pain and relieves symptoms **No charge**
- ◆ Bereavement services, including assessing the needs of the bereaved family and developing a care plan to meet those needs, both before and after death. Bereavement services are available to covered members of the immediate family (spouse, children, step-children, parents, brothers and sisters) for up to one year after the employee's or covered family *member's* death **No charge**

Dental Care	Copay
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◆ Inpatient *hospital* services..... **No charge**

Inpatient *hospital* services are limited to 3 days when the *stay* is:

- Needed for dental care because of other medical problems you may have.
- Ordered by a *doctor* (M.D.) or a dentist (D.D.S. or D.M.D.)
- Approved by the *medical group*.

◆ General anesthesia and facility services when dental care must be provided in an outpatient *hospital* or *surgery center* **No charge**

These services are covered when:

- You are less than seven years old;
- You are developmentally disabled; or
- Your health is compromised and general anesthesia is *medically necessary*.

Note: No benefits are provided for the dental procedure itself or for the professional services of a dentist to do the dental procedure.

◆ Emergency care for accidental injury to natural teeth..... **No charge**

- The care is not covered if you hurt your teeth while chewing or biting.
- Anthem Blue Cross HMO does not cover any other kind of dental care.

◆ *Medically necessary* dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures..... **No charge**

“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 number* on your Member ID card. To fully understand your coverage under this *plan*, please carefully review this Evidence of Coverage document.

Diabetic Supplies	Copay
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- ◆ Diabetic supplies (test strips, lancets, alcohol swabs, and syringes for insulin – insulin itself is not covered)..... **No charge**

Special Food Products	Copay
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- ◆ Special food products and formulas that are part of a diet prescribed by a *doctor* for the treatment of phenylketonuria (PKU)..... **No charge**

These items are covered as medical supplies.

Medical Equipment	Copay
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- ◆ Medical equipment and supplies..... **20%**

You can get long-lasting medical equipment (called durable medical equipment) and supplies that are rented or bought for you if they are:

- Ordered by your *primary care doctor*.

- Used only for the health problem.
- Used only by the person who needs the equipment or supplies.
- Made only for medical use.

Equipment and supplies are **not** covered if they are:

- Only for your comfort or hygiene.
- For exercise.
- Only for making the room or home comfortable, such as air conditioning or air filters.

Pediatric Asthma Equipment and Supplies	Copay
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- ◆ Nebulizers, including face masks and tubing..... **No charge**
 - ◆ Inhaler spacers and peak flow meters **No charge**
- These items are not subject to any limits or maximums that apply to coverage for Medical Equipment.
- ◆ Pediatric asthma education program services to help you use the items listed above..... **\$5**

Organ and Tissue Transplants	Copay
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Services and supplies are given if:

- You are receiving the organ or tissue, or
 - You are the organ or tissue donor, if the person who is receiving it is a *member* of Anthem Blue Cross HMO. If you are not a *member*, the benefits are lowered by any amounts paid by your own health plan.
- ◆ Services given with an organ or tissue transplant..... **See copays that apply**

Cancer Clinical Trials	Copay
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Routine patient care costs, as defined below, for phase I, phase II, phase III and phase IV cancer clinical trials **See copays that apply**

All of the following conditions must be met:

- ◆ The treatment you get in a clinical trial must either:
 - Involve a *drug* that is exempt under federal regulations from a new drug application, or
 - Be ok'd 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.
- ◆ You must have cancer to be able to participate in these clinical trials.
- ◆ Participation in these clinical trials must be recommended by your *primary care doctor* after deciding it will help you. If the clinical trial is not provided by or through your *medical group*, your *primary care doctor* will refer you to the *doctor or health care provider* who provides the clinical trial. Please see "When You Need a Referral" in the section called "When You Need Care" for information about referrals. You will only have to pay your normal copays for the services you get.
- ◆ 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 are the costs associated with the services provided, including drugs, items, devices and services which would otherwise be covered under the *plan*, including health care services which are:

- ◆ Typically provided absent a clinical trial.

- ◆ Required solely to provide the investigational drug, item, device or service.
- ◆ Clinically appropriate monitoring of the investigational item or service.
- ◆ Prevention of complications arising from the provision of the investigational drug, item, device, or service.
- ◆ Reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or care of the complications.

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

- ◆ *Drugs* or devices not approved by the federal Food and Drug Administration that are part of the clinical trial.
- ◆ Services other than health care services, such as travel, housing, companion expenses and other nonclinical expenses that you may need because of the treatment you get for the purposes of the clinical trial.
- ◆ Any item or service provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient.
- ◆ Health care services that, except for the fact they are provided in a clinical trial, are otherwise specifically excluded from the *plan*.
- ◆ Health care services usually provided by the research sponsors free of charge to *members* enrolled in the trial.

Note: You will pay for costs of services that are not covered.

If you do not agree with the coverage or medical necessity of possible clinical trial services, please read the “Independent Medical Review of Complaints Involving a Disputed Health Care Service” (see Table of Contents).

Ambulance	Copay
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You can get these services from a licensed ambulance in an *emergency* or when ordered by your *primary care doctor*. (We will provide benefits for these services if you receive them as a result of a 9-1-1 emergency response system call for help if you think you have an *emergency*.) Air ambulance is also covered, but, only if ground ambulance service can't provide the service needed. Air ambulance service, if needed, is provided only to the nearest *hospital* that can give you the care you need.

- ◆ Base charge and mileage **\$100**
per trip
- ◆ Disposable supplies **No charge**
- ◆ Monitoring, EKG's or ECG's,
cardiac defibrillation, CPR, oxygen,
and IV solutions **No charge**

IN SOME AREAS, THERE IS A 9-1-1 EMERGENCY RESPONSE SYSTEM. THIS SYSTEM IS TO BE USED ONLY WHEN THERE IS AN *EMERGENCY*.

PLEASE USE THE 9-1-1 SYSTEM FOR MEDICAL EMERGENCIES ONLY.

Prosthetic Devices	Copay
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You can get devices to take the place of missing parts of your body.

- ◆ Surgical implants **No charge**
- ◆ Artificial limbs or eyes **No charge**
- ◆ The first pair of contact lenses or eye glasses
when needed after a covered and
medically necessary eye surgery **No charge**
- ◆ Breast prostheses following a mastectomy **No charge**

- ◆ *Prosthetic devices* to restore a method of speaking when required as a result of a laryngectomy..... **No charge**
- ◆ Therapeutic shoes and inserts designed to treat foot complications due to diabetes..... **No charge**
- ◆ Orthopedic footwear used as an integral part of a brace; shoe inserts that are custom molded to the patient..... **No charge**
- ◆ Colostomy supplies **No charge**
- ◆ Supplies needed to take care of these devices..... **No charge**

Mental or Nervous Disorders/ Substance Abuse	Copay
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You can get services for the *medically necessary* treatment of *mental or nervous disorders* or substance abuse or to prevent the deterioration of chronic conditions. These services do not include programs to stop smoking, or to help with nicotine or tobacco abuse.

- ◆ Inpatient *facility-based care* for the treatment of *mental or nervous disorders* or substance abuse..... **No charge**
- ◆ Outpatient *facility-based care* for the treatment of *mental or nervous disorders* or substance abuse..... **No charge**

Before you get services for *facility-based care* for the treatment of *mental or nervous disorders* or substance abuse, you must get our approval first. Read “Medical Management Programs” to find out how to get approvals.

- ◆ Inpatient *doctor visits* during a *stay* for the treatment of *mental or nervous disorders* or substance abuse..... **No charge**

- ◆ Office visits to a *doctor* for outpatient psychotherapy or psychological testing for the treatment of *mental or nervous disorders* or substance abuse.....\$5
- ◆ Behavioral health treatment for pervasive developmental disorder or autism.\$5

See the section “Benefits for Pervasive Developmental Disorder or Autism” for a description of the services that are covered. You must get our approval first for all behavioral health treatment services for the treatment of pervasive developmental disorder or autism in order for these services to be covered by this *plan*. Read “Medical Management Programs” to find out how to get approvals. No benefits are payable for these services if our approval is not obtained.

Benefits for Pervasive Developmental Disorder or Autism

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

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

You must obtain our approval in advance for all behavioral health treatment services for the treatment of Pervasive Developmental Disorder or autism in order for these services to be covered by this *plan* (see “Medical Management Programs” for details). No benefits are payable for these services if our approval is not obtained. You must receive services from an *Anthem Blue Cross HMO provider* in order for these services to be covered, unless you obtain an *authorized referral* to a non-*Anthem Blue Cross HMO provider* (see “Medical Management Programs” for details).

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

Definitions

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

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

Intensive Behavioral Intervention means any form of Applied Behavioral Analysis that is comprehensive, designed to address all domains of functioning, and provided in multiple settings for no more than 40 hours per week, across all settings, depending on the individual's needs and progress. Interventions can be delivered in a one-to-one ratio or small group format, as appropriate.

Qualified Autism Service Provider is either of the following:

- A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for Pervasive Developmental Disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified; or
- A person licensed as a physician and surgeon (M.D. or D.O.), physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to state law, who designs, supervises, or provides treatment for Pervasive Developmental Disorder or autism, provided the services are within the experience and competence of the licensee.

Our network of *Anthem Blue Cross HMO providers* is limited to licensed Qualified Autism Service Providers who contract with us and who may supervise and employ Qualified Autism Service Professionals or Qualified Autism Service Paraprofessionals who provide and administer Behavioral Health Treatment.

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

- Provides behavioral health treatment,
- Is employed and supervised by a Qualified Autism Service Provider,
- Provides treatment according to a treatment plan developed and approved by the Qualified Autism Service Provider,
- Is a behavioral service provider approved as a vendor by a California regional center to provide services as an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program as defined in state regulation, and
- Has training and experience in providing services for Pervasive Developmental Disorder or autism pursuant to applicable state law.

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

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

- Has adequate education, training, and experience, as certified by a Qualified Autism Service Provider.

Behavioral Health Treatment Services Covered

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

- The treatment must be prescribed by a licensed physician and surgeon (an M.D. or D.O.) or developed by a licensed clinical psychologist,
- The treatment must be provided under a treatment plan prescribed by a Qualified Autism Service Provider and administered by one of the following: (a) Qualified Autism Service Provider, (b) Qualified Autism Service Professional supervised and employed by the Qualified Autism Service Provider, or (c) Qualified Autism Service Paraprofessional supervised and employed by a Qualified Autism Service provider, and
- The treatment plan must have measurable goals over a specific timeline and be developed and approved by the Qualified Autism Service Provider for the specific patient being treated. The treatment plan must be reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate, and must be consistent with applicable state law that imposes requirements on the provision of Applied Behavioral Analysis services and Intensive Behavioral Intervention services to certain persons pursuant to which the Qualified Autism Service Provider does all of the following:
 - ◆ Describes the patient's behavioral health impairments to be treated,

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

Medical Management Programs

Medical Management Programs apply to the following services:

- ◆ *Facility-based care* for the treatment of *mental or nervous disorders* and substance abuse,
- ◆ Behavioral health treatment for pervasive developmental disorder or autism, as specified in the section “Benefits for Pervasive Developmental Disorder or Autism”, and
- ◆ *Authorized referrals* to non-Anthem Blue Cross HMO providers for the treatment of *mental or nervous disorders* and substance abuse and for behavioral health treatment for pervasive developmental disorder or autism.

The Medical Management Programs are set up to work together with you and your *doctor* to be sure that you get appropriate medical care and avoid costs you weren’t expecting.

You don’t have to get a referral from your *primary care doctor* when you go to an *Anthem Blue Cross HMO provider* for professional services, such as counseling, for the treatment of *mental or nervous disorders* or substance abuse, or for behavioral health treatment for pervasive developmental disorder or autism. You can get a directory of *Anthem Blue Cross HMO providers* who specialize in the treatment of *mental or nervous disorders* or substance abuse by calling the *Customer Service number* on your Member ID card.

Your *primary care doctor* must provide or coordinate all other care and your *medical group* must OK it.

The Medical Management Programs consist of the Utilization Review Program and the Authorization Program. These apply as follows:

- ◆ The Utilization Review Program applies to *facility-based care* for the treatment of *mental or nervous disorders* or substance abuse and to behavioral health treatment for pervasive developmental disorder or autism.

- ◆ The Authorization Program applies to referrals to non-*Anthem Blue Cross HMO providers* for the treatment of *mental or nervous disorders* or substance abuse and for behavioral health treatment for pervasive developmental disorder or autism.

We will pay benefits only if you are covered at the time you get services, and our payment will follow the terms and requirements of this *plan*.

Utilization Review Program

The utilization review program looks at whether care is *medically necessary* and appropriate, and the setting in which care is provided. We will let you and your *doctor* know if we have determined that services can be safely provided in an outpatient setting, or if we recommend an inpatient *stay*. We certify and monitor services so that you know when it is no longer *medically necessary* and appropriate to continue those services.

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

Certain services require pre-service review of benefits in order for benefits to be provided.

- ◆ *Anthem Blue Cross HMO providers* will initiate the review on your behalf.
- ◆ You may ask a non-*Anthem Blue Cross HMO provider* to call the toll free number on your Member ID card to initiate the review for you. Remember that services provided by a non-*Anthem Blue Cross HMO provider* are covered only if they are emergency services, urgent care, or services for which you received an *authorized referral*.

In both cases, it is your responsibility to initiate the process and ask your *doctor* to request pre-service review. You may

also call us directly. Pre-service review criteria are based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. We may determine that a service that was initially prescribed or requested is not *medically necessary* if you have not previously tried alternative treatments that are more cost effective.

You need to make sure that your *doctor* contacts us before scheduling you for any service that requires utilization review. If you get any such service without following the directions under “How to Get Utilization Reviews,” no benefits will be provided for that service.

Utilization review has three parts:

- ◆ **Pre-service review.** We look at non-emergency *facility-based care* for the treatment of *mental or nervous disorders* and substance abuse and decide if the proposed *facility-based care* is *medically necessary* and appropriate. We also review all behavioral health treatment for pervasive developmental disorder or autism as specified in the section “Benefits for Pervasive Developmental Disorder or Autism”.
- ◆ **Care coordination review.** We look at and decide whether scheduled, non-emergency inpatient *hospital* stays and *residential treatment center* admissions are *medically necessary* and appropriate when pre-service review is not required or we are notified while service is being provided, such as with an *emergency* admission to a *hospital*.
- ◆ **Retrospective review.** We look at services that have already been provided:
 - When a pre-authorization, pre-service or care coordination review was not completed; or
 - To examine and audit medical information after services were provided.

Retrospective review may also be done for services that continued longer than originally certified.

Effect on Benefits

- ◆ When you don't get the required pre-service review before you get *facility-based care* for the treatment of *mental or nervous disorders* or substance abuse, or for behavioral health treatment for pervasive developmental disorder or autism, we **will not provide benefits** for those services.
- ◆ *Facility-based care* for the treatment of *mental or nervous disorders* or substance abuse and behavioral health treatment for pervasive developmental disorder or autism will be provided only when the type and level of care requested is *medically necessary* and appropriate for your condition. If you go ahead with any services that have been determined to be not *medically necessary* and appropriate at any stage of the utilization review process, we **will not provide benefits** for those services.
- ◆ When services are not reviewed before or during the time you receive the services, we will review those services when we receive the bill for benefit payment. If that review determines that part or all of the services were not *medically necessary* and appropriate, we **will not provide benefits** for those services.

How to Get Utilization Reviews

Remember, you must make sure that the review has been done.

Pre-Service Reviews

No benefits will be provided if you do not get pre-service review before receiving scheduled services, as follows:

- ◆ You must tell your *doctor* that this *plan* requires pre-service review. *Doctors* who are *Anthem Blue Cross HMO providers* will ask for the review for you. The toll-free number for pre-service review is on your Member ID card.
- ◆ For all scheduled services that require utilization review, you or your *doctor* must ask for the pre-service review at least three working days before you are to get services.

- ◆ We will certify services that are *medically necessary* and appropriate. For *facility-based care* for the treatment of *mental or nervous disorders* or substance abuse we will, if appropriate, certify the type and level of services, as well as a specific length of *stay*. You, your *doctor* and the provider of the service will get a written notice showing this information.
- ◆ If you do not get the certified service within 90 days of the certification, or if the type of the service changes, you must get a new pre-service review.

Care Coordination Reviews

- ◆ If pre-service review was not done, you, your *doctor* or the provider of the service must contact us for care coordination review. If you have an *emergency* admission or procedure, you need to let us know within one working day of the admission or procedure, unless your condition prevented you from telling us or a member of your family was not available to tell us for you within that time period.
- ◆ When you tell *Anthem Blue Cross HMO providers* that you must have utilization review, they will call us for you. You may ask a non-*Anthem Blue Cross HMO provider* to call the toll free number on your Member ID card or you may call directly.
- ◆ When we decide that the service is *medically necessary* and appropriate, we will, depending upon the type of treatment or procedure, certify the service for a period of time that is medically appropriate. We will also decide on the medically appropriate setting.
- ◆ If we decide that the service is not *medically necessary* and appropriate, we will tell your *doctor* by telephone no later than 24 hours after the decision. We will send written notice to you and your *doctor* within two business days after our decision. But care will not be stopped until your *doctor* has been notified and a plan of care that meets your needs has been agreed upon.

Retrospective Reviews

- ◆ We will do a retrospective review:
 - If we were not told of the service you received, and were not able to do the appropriate review before your discharge from the *hospital* or *residential treatment center*.
 - If pre-service or care coordination review was done, but services continued longer than originally certified.
 - For the evaluation and audit of medical documentation after you got the services, whether or not pre-service or care coordination review was performed.
- ◆ If such services are determined to not have been *medically necessary* and appropriate, we will deny certification.

Authorization Program

The authorization program provides prior approval for medical care or service by a non-*Anthem Blue Cross HMO provider*. The service you receive must be a covered benefit of this *plan*.

You must get approval before you get any non-emergency or non-urgent service from a non-*Anthem Blue Cross HMO provider* for the following services:

- ◆ **Treatment of *mental or nervous disorders* or substance abuse, and**
- ◆ **Behavioral health treatment for pervasive developmental disorder or autism.**

The toll-free number to call for prior approval is on your Member ID card.

If you get any such service, and do not follow the procedures set forth in this section, no benefits will be provided for that service.

Authorized Referrals. In order for the benefits of this *plan* to be provided, you must get approval **before** you get services from non-*Anthem Blue Cross HMO providers*. When you get proper approvals, these services are called *authorized referral* services.

Effect on Benefits. If you receive *authorized referral* services from a non-*Anthem Blue Cross HMO provider*, the *Anthem Blue Cross HMO provider* copay will apply. When you do not get a referral, **no benefits are provided** for services received from a non-*Anthem Blue Cross HMO provider*.

How to Get an Authorized Referral. You or your *doctor* must call the toll-free telephone number on your Member ID card **before** scheduling an admission to, or before you get the services of, a non-*Anthem Blue Cross HMO provider*.

When an Authorized Referral Will be Provided. Referrals to non-*Anthem Blue Cross HMO providers* will be approved only when all of the following conditions are met:

- ◆ There is no *Anthem Blue Cross HMO provider* who practices the specialty you need, provides the required services or has the necessary facilities within 50-miles of your home; AND
- ◆ You are referred to the non-*Anthem Blue Cross HMO provider* by a *doctor* who is an *Anthem Blue Cross HMO provider*; AND
- ◆ The services are authorized as *medically necessary* before you get the services.

Disagreements with Medical Management Program Decisions

- ◆ If you or your *doctor* don't agree with a Medical Management Program decision, or question how it was reached, either of you may ask for a review of the decision. To request a review, call the number or write to the address included on your written notice of determination. If you send a written request it must include medical information to support that services are *medically necessary*.

- ◆ If you, your representative, or your *doctor* acting for you, are still not satisfied with the reviewed decision, a written appeal may be sent to us.
- ◆ If you are not satisfied with the appeal decision, you may use *binding arbitration*. Please read “How to Make a Complaint.”

Exceptions to the Medical Management Program

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

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

You may determine whether a health care provider participates in certain programs by checking our online provider directory on our website at www.anthemcom/ca or by calling us at the customer service telephone number listed on your ID card.

Revoking or Modifying an Authorization

An authorization for services or care that was approved through either the Utilization Review Program or the Authorization Program 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.

What We Do Not Cover

It's important for you to know that we are not able to cover all the care you may want. Some services and supplies are not covered and some have limited benefits.

Remember:

In most cases, you cannot get any care that has not been OK'd by your *primary care doctor*, your *medical group*, or Anthem.

Kinds of Services You Cannot Get with this Plan

- ◆ **Care Not Approved.** Care you got from a health care provider without the OK of your *primary care doctor* or a *doctor* specializing in OB-GYN in your *medical group*, except for *emergency services* or *urgent care*.
- ◆ **Care Not Covered.** Services you got before you were on the *plan*, or after your coverage ended.
- ◆ **Care Not Listed.** Services not listed as being covered by this *plan*.
- ◆ **Care Not Needed.** Any services or supplies that are not *medically necessary*.
- ◆ **Crime or Nuclear Energy.** Any health problem caused: (1) while you were committing or trying 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) by nuclear energy, when the government can pay for treatment.
- ◆ **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 ask that the denial be reviewed by an external independent medical review organization. (See the section "Review of Denials of

Experimental or Investigative Treatment” for how to ask for a review of your benefit denial.)

- ◆ **Government Treatment.** Any services actually given to you by a local, state or federal government agency, or by a public school system or school district, except when this *plan*'s benefits, must be provided by law. We will not cover payment for these services if you are not required to pay for them or they are given to you for free. You are not required to seek any such services prior to receiving *medically necessary* health care services that are covered by this *plan*.
- ◆ **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 *doctor*, except as specifically provided or arranged by us. This exclusion does not apply to the *medically necessary* treatment of pervasive developmental disorder or autism, to the extent stated in the section “Benefits for Pervasive Developmental Disorder or Autism”.
- ◆ **Services Given by Providers Who Are Not With Anthem Blue Cross HMO.** We will not cover these services unless your *primary care doctor* refers you, except for *emergencies* or *urgent care*.
- ◆ **Services Not Needing Payment.** Services you are not required to pay for or are given to you at no charge, except services you got at a charitable research *hospital* (not with the government). This *hospital* must:
 - Be known throughout the world as devoted to medical research.
 - Have at least 10% of its yearly budget spent on research not directly related to patient care.
 - Have 1/3 of its income from donations or grants (not gifts or payments for patient care).

- Accept patients who are not able to pay.
- Serve patients with conditions directly related to the *hospital's* research (at least 2/3 of their patients).

Work-Related. Care for health problems that are work-related if such health problems are or can be covered by workers' compensation, an employer's liability law, or a similar law. We will provide care for a work-related health problem, but, we have the right to be paid back for that care. See "Other Things You Should Know: Getting Repaid by a Third Party" on a later page.

Other Services Not Covered

- ◆ **Acupressure.** Acupressure, or massage to help pain, treat illness or promote health by putting pressure to one or more areas of the body.
- ◆ **Air Conditioners.** Air purifiers, air conditioners, or humidifiers.
- ◆ **Birth Control Devices.** Any devices needed for birth control which can be obtained without a doctor's prescription such as condoms.
- ◆ **Blood.** Benefits are not provided for the collection, processing and storage of self-donated blood unless it is specifically collected for a planned and covered surgical procedure.
- ◆ **Braces or Other Appliances or Services** for straightening the teeth (orthodontic services) except as specifically stated in "Reconstructive Surgery" and "Dental Care" under the section What We Cover.
- ◆ **Clinical Trials.** Services and supplies in connection with clinical trials, unless specifically stated in "Cancer Clinical Trials" under the section, What We Cover.
- ◆ **Commercial Weight Loss Programs.** Weight loss programs, whether or not they are pursued under medical or *doctor* 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 for treatment of anorexia nervosa or bulimia nervosa.

- ◆ **Consultations** given using telephones, facsimile machines, or electronic mail.
- ◆ **Cosmetic Surgery.** Surgery or other services done only to make you:
 - Look beautiful:
 - To improve your appearance; or
 - To change or reshape normal parts or tissues of the body.

This does not apply to reconstructive surgery you might need to:

- Give you back the use of a body part.
- Have for breast reconstruction after a mastectomy.
- Correct or repair a deformity caused by birth defects, abnormal development, injury or illness in order to improve function, symptomatology or create a normal appearance.

Cosmetic surgery does not become reconstructive because of psychological or psychiatric reasons.

- ◆ **Custodial Care or Rest Cures.** Room and board charges for a *hospital stay* mostly for a change of scene or to make you feel good. Services given by a rest home, a home for the aged, or any place like that.
- ◆ **Dental Services or Supplies.** For dental treatment, regardless of origin or cause, except as specified below. “Dental treatment” includes but is not limited to preventative care and fluoride treatments; dental x rays, supplies, appliances, dental implants and all associated expenses; diagnosis and treatment

related to the teeth, jawbones or gums, including but not limited to:

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

This exclusion does not apply to the following:

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

- ◆ **Eye Exercises or Services and Supplies for Correcting Vision.** Optometry services, eye exercises, and orthoptics, except for eye exams to find out if your vision needs to be corrected. Eyeglasses or contact lenses are not covered. Contact lens fitting is not covered.
- ◆ **Eye Surgery for Refractive Defects.** Any eye surgery just for correcting vision (like nearsightedness and/or astigmatism). Contact lenses and eyeglasses needed after this surgery.
- ◆ **Food or Dietary Supplements.** Nutritional and/or dietary supplements and counseling, except as provided in this *plan* or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.
- ◆ **Health Club Membership.** 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 *doctor*. This exclusion also applies to health spas.
- ◆ **Hearing Aids.** Hearing aids or services for fitting or making a hearing aid.

- ◆ **Immunizations.** Immunizations needed to travel outside the USA.
- ◆ **Infertility Treatment.** Any *infertility* treatment including artificial insemination or in vitro fertilization, and sperm banks.
- ◆ **Lifestyle Programs.** Programs to help you change how you live, like fitness clubs, or dieting programs. This does not apply to cardiac rehabilitation programs approved by your *medical group*.
- ◆ **Educational or Academic Services.** This plan does not cover:
 - Educational or academic counseling, remediation, or other services that are designed to increase academic knowledge or skills.
 - Educational or academic counseling, remediation, or other services that are designed to increase socialization, adaptive, or communication skills.
 - Academic or educational testing.
 - Teaching skills for employment or vocational purposes.
 - Teaching art, dance, horseback riding, music, play, swimming, or any similar activities.
 - Teaching manners and etiquette or any other social skills.
 - Teaching and support services to develop planning and organizational skills such as daily activity planning and project or task planning.

This exclusion does not apply to the *medically necessary* treatment of pervasive developmental disorder or autism, to the extent stated in the section “Benefits for Pervasive Developmental Disorder or Autism”.

- ◆ **Orthopedic Shoes.** Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat

foot complications due to diabetes, as specifically stated in “Prosthetic Devices” under the section What We Cover.

- ◆ **Outpatient Drugs.** Outpatient *prescription drugs* or medications including insulin except *drugs* for abortion or contraception when taken in the *doctor’s* office. (Also see Preventive Care Services for what is covered)
- ◆ **Personal Care and Supplies.** Services for your personal care, such as: help in walking, bathing, dressing, feeding, or preparing food. Any supplies for comfort, hygiene or beauty purposes.
- ◆ **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.
- ◆ **Routine Exams.** Routine physical or psychological exams or tests asked for by a job or other group, such as a school, camp, or sports program.
- ◆ **Scalp hair prostheses.** Scalp hair prostheses, including wigs or any form of hair replacement.
- ◆ **Sex Change.** Sex change surgery or treatments.
- ◆ **Sexual Problems.** Treatment of any sexual problems unless due to a medical problem, physical defect, or disease.
- ◆ **Sterilization Reversal.** Surgery done to reverse a sterilization.
- ◆ **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).
- ◆ **Varicose Vein Treatment.** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.

What You Should Know about Your Coverage

Participation Requirements

A. Full-Time Employees

All eligible full-time employees, as defined by SISC, or employees who receive 100% of the amount contributed towards the cost of a full-time employee must enroll under this *plan* or another plan sponsored by SISC III.

B. Less Than Full-Time Employees

Employees who work less than 90% of the fulltime equivalent for the appropriate job classification or receive less than 90% of the amount that is contributed towards an eight-hour full-time employee may decline coverage. Except as stated under “When You Can Enroll without Waiting”, employees who decline coverage when first eligible or at any subsequent Open Enrollment Period may not re-enroll under the *plan* until the next Open Enrollment Period.

Less than full-time employees or employees who receive less than the amount contributed toward the cost of a full-time employee who declined coverage and subsequently become full-time employees or begin to receive 100% of the amount contributed toward the cost of a full-time employee must enroll immediately. Such employees cannot wait until the next Open Enrollment Period to enroll. Coverage will become effective on the first day of the month following the date they become full-time employees or begin to receive 100% of the amount contributed toward the cost of a full-time employee.

C. Non-Eligible Employees

Employees who do not receive contributions towards the cost of the *plan* based on a pro-rata share of the number of hours worked or employees who work less than half-time are not eligible to enroll under the *plan*.

How Coverage Begins

You can enroll in Anthem Blue Cross HMO if:

- ◆ You are a classified non-temporary *employee* who works the minimum number of hours required by SISC III and the *participating employer*.
- ◆ You are a certificated *employee* under contract and who works a minimum of 50% of a certificated job.
- ◆ You are a *retired employee* who retired from active employment and was covered under a *plan* sponsored by SISC III immediately prior to retirement.

You can enroll the following family members in Anthem Blue Cross HMO:

- ◆ Your spouse, if you are legally married.
- ◆ Your domestic partner if you are in a legally registered and valid domestic partnership.
- ◆ Your natural children, step children, legally adopted children, or children for whom you, your spouse or domestic partner have been appointed legal guardians by a court of law, who are:
 - Under 26 years old, or
 - 26 years old or more if they are not capable of getting a self-sustaining job due to a physical or mental condition, and
 - They are unmarried.
 - They must depend chiefly on you for support and maintenance. A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.
 - A *doctor* certifies in writing that the child is incapable of getting a self-sustaining job due to a physical or mental condition. We must receive the certification, at no expense to us, within 60-days of the date you receive

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.

- They were covered under the *prior plan*, or have six or more months of other *creditable coverage*.

You can keep the child covered under the *plan* until they are no longer chiefly dependent on you for support and maintenance due to a continuing physical or mental condition.

You can't enroll as a spouse or domestic partner if you are now on active duty in the armed services.

You can enroll both as an employee and a spouse or domestic partner. If you and your spouse, or domestic partner, as the case may be, are both covered as employees under this *plan*, your children may be covered as family members of both. However, the total amount of benefits we will pay will not be more than the amount covered.

You and your family members must live or work in the Anthem Blue Cross HMO service area. You and your family members must live in the United States to be covered under this *plan*.

When Are You Covered?

You are eligible to enroll with this health plan on the first day of the month coinciding with or following the date you meet the enrollment requirements of your employer and SISC III guidelines. The time you have to wait, if any, before you are able to enroll is your "waiting period." The date you finish your waiting period is your "eligibility date." If you were covered under the *prior plan*, the time that applied to your waiting period under the *prior plan* will be applied to your waiting period under this *plan*.

Your family members are eligible to be covered:

- ◆ For all existing family members, on the date you are covered;
or

- ◆ For a new spouse and step child, if any, the first day of the month after the date your spouse and step child, if any, become a family member(s) due to marriage;
- ◆ For a new domestic partner and his or her child, if any, the first day of the month after the date your domestic partner and his or her child, if any, become a family member(s) due to the start of a domestic partnership;
- ◆ For an over age child, the first day of the month after the date your child again becomes a family member;
- ◆ The date a child becomes your family member due to birth or adoption; or
- ◆ For a child for whom you, your spouse or domestic partner is a legal guardian, the first day of the month after the date of the court decree.

To enroll, you must give your employer a signed Enrollment Form within 31 days after the day you are eligible. We must get this form from your employer within 90 days. If not, you may not be covered.

You must enroll before, on, or within 31 days after the date you were eligible. Your coverage will start on your eligibility date.

Your employer must pay the subscription charges every month in order for you to be covered. Your employer may ask you to pay all or part of these charges. Talk to your employer about how much you must pay.

For you to get benefits we must have an *agreement* with your employer and you must be covered at the time you got the service. The benefits you get will be the benefits in effect at the time the services are provided. Your employer's health plan *agreement* with us may change from time to time, or end, without your consent.

If You Want to Enroll a New Child

Here's how new children are enrolled if you are already covered:

- ◆ Any child born to you will be enrolled from the moment of birth for 31 days; and
- ◆ Any child being adopted by you will be covered for 31 days from the date:
 - You have financial responsibility for the child OR
 - You have the right to control the child's health care.

You will need to give us legal papers or other proof for either one.

For the child's enrollment to continue beyond this 31-day period, you must submit a *membership change form* to the *group* within this 31-day period. You will need to pay subscription charges, if any, for them from the date their coverage began.

When You Can Enroll Without Waiting

You may enroll without waiting for your employer's next *open enrollment* period if any of the following are true:

- ◆ **You meet all of the following requirements:**
 - You were covered as an individual or dependent under either:
 - ⇒ Another employer group health plan or health insurance coverage, including coverage under a COBRA or CalCOBRA continuation; or
 - ⇒ 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.
 - 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.

- Your employer stopped contributing toward the coverage;
- Your coverage under the other health plan wherein you were covered as an individual or dependent ended as follows:

⇒ 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 a signed Enrollment Form 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, no longer living or working in the Anthem Blue Cross HMO service area (whether or not by your choice), and any loss of eligibility for coverage after a period of time that is measured by reference to any of the foregoing.

⇒ 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 a signed Enrollment Form with the *group* within 60 days after the date your coverage ended.

- ◆ A court has ordered that your spouse, domestic partner or child be covered under your employee health plan, and you give your employer a signed Enrollment Form within 31 days from the date the court order was issued.
- ◆ We don't have a written statement from your employer stating that before you chose not to enroll or not be enrolled you were given and signed a notice that told you:
 - If you choose not to enroll for coverage within 31 days after you become eligible; or
 - If you choose to cancel your coverage; and
 - Later choose to enroll;

Your coverage may not begin until the first day of the month following the end of your employer's *open enrollment*.

- ◆ You were less than a full-time employee or an employee who received less than the amount contributed toward the cost of a full-time employee who declined coverage. You must file an application with your employer to enroll within a time period ending 31 days after: (a) the date of an increase in the number of hours worked; or (b) the date of an increase in amount contributed by your employer.

Coverage will become effective on the first day of the month following the date of the event.

- ◆ You were a less than full-time employee or an employee who received less than the amount contributed toward the cost of a full-time employee who declined coverage because you were covered elsewhere. You must file an application with your employer to enroll within a time period ending 31 days after the date you lost coverage. You must have signed a declination of coverage form when first eligible or during the Open Enrollment Period stating you declined coverage because you were covered elsewhere and evidence of loss of coverage must

be submitted to your employer with the application for enrollment.

Coverage will become effective on the first day of the month following the date you lost coverage.

- ◆ You have a change in family status through either marriage or domestic partnership, or the birth, adoption or placement for adoption of a child:
 - If you enroll following marriage or domestic partnership, you and your new spouse or domestic partner must enroll within 31 days of the date of marriage or domestic partnership. Your new spouse or domestic partner's children may also enroll, but your other children may not enroll unless they qualify under another one of these conditions listed above.
 - If you enroll following the birth, adoption or placement for adoption of a child, your spouse (if you are already married) or domestic partner may also enroll at that time. Other children may not enroll at that time unless they qualify under another one of these conditions listed above. Application must be made within 31 days of the birth or date of adoption or placement for adoption.
- ◆ All of the following conditions are met:
 - You finished the waiting period under the *plan*, but, ceased to be eligible due to the end of your employment;
 - You again become eligible to enroll within 6 months of the date your employment ended; and
 - You enroll within 31 days of your return to work.

- ◆ You met or went beyond a lifetime limit on all benefits of another health plan. Your application must be made within 31 days of the date a claim or a portion of a claim is denied because you met or went beyond a lifetime limit on all benefits of another health plan.
- ◆ 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 a signed Enrollment Form with the *group* within 60 days after the date you are determined to be eligible for this assistance.

The effective date of coverage for enrollments during a special enrollment period as described above will be on the first day of the month following the date you file the signed Enrollment Form, except as specified below:

- ◆ If a court has ordered that coverage be provided for a dependent child, coverage will become effective for that child on the earlier of:
 - The first day of the month following the date you file the signed Enrollment Form; or
 - 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.
- ◆ For enrollments following the birth, adoption, or placement for adoption of a child, coverage will be effective as of the date of birth, adoption, or placement for adoption.

Open Enrollment

If you are eligible to be covered, *Open Enrollment* is a time you can enroll yourself or your family members. Your employer has this time once a year. Talk to your employer about when Open Enrollment takes place.

You or your family members will be covered on the first day of the month following the end of the *Open enrollment* period. If you had another plan, it would end when this one starts.

When We Cannot Cancel Your Coverage

We cannot cancel your coverage while:

- ◆ This *plan* is in effect;
- ◆ You're eligible;
- ◆ Your subscription charges are paid;
- ◆ You live or work within a *medical group's* service area;
- ◆ You follow your *primary care doctor's* advice and treatment and you work with the *medical group*; and
- ◆ You pay all *copays* within 31 days after you get a bill.

The benefits of this *plan* are only for *medically necessary* services as decided by your *medical group* or Anthem.

We are not responsible for any costs you have to pay over the *plan's* benefits.

Only *members* may get benefits under this *plan*. You cannot transfer the right to benefits to another person.

How Your Coverage Ends

We are not required to send you a notice that coverage is ending if you decide, or your employer decides, to end coverage. Coverage may end:

- ◆ **If our *agreement with your employer* ends.** Coverage ends on the date the *agreement* is terminated or cancelled. If we decide to end the coverage provided to you by your employer for any of the reasons shown in the *agreement*, we will give written notice of termination, cancellation or non-renewal to your employer. Your employer will send or give you a copy of the termination, cancellation or non-renewal notice at least seven days prior to the date coverage ends.

- ◆ **If the subscription charges are not paid.** If your employer fails to pay the subscription charges as they become due, we may terminate the *agreement* as of the last day of the Grace Period described below. Nevertheless, we will terminate the *agreement* only upon first giving the employer a written Notice of Cancellation that is delivered to them at least 30-days prior to that cancellation (or any longer period of time required by applicable federal law, rule, or regulation).
- ◆ The Notice of Cancellation shall state that the *agreement* shall not be terminated if the employer makes appropriate payment in full within 30-days after we issue the Notice of Cancellation (or any longer period of time required by applicable federal law, rule, or regulation). The Notice of Cancellation shall also inform the employer that, if the *agreement* is terminated for non-payment and the employer wishes to apply for reinstatement, the employer shall be required to submit a new application for coverage, and that Anthem either may decline to permit reinstatement in its sole discretion or may permit reinstatement upon terms and conditions as it shall determine appropriate in its sole discretion, as set forth in the *agreement*. Per the *agreement*, your employer will mail a copy of our notice to them to you. If you have any questions about your coverage ending, and how it will affect you, please call the customer service phone number on your I.D. card.

Grace Period. For every Subscription Charge Due Date except the first, there is a 30-day grace period in which to pay subscription charges. The grace period begins after the last day of paid coverage. The *agreement* remains in force during the grace period, and coverage is maintained during the grace period. The employer is liable for payment of subscription charges covering any period of time that the *agreement* remains in force, including any grace period. If your employer fails to pay us the subscription charges due during the grace period, we will not end your coverage until the end of the grace period. You will not be required by us to pay the subscription charges for your employer nor will you be required to pay more than your copay for any services received during the grace period.

If subscription charges due are not paid by the end of the grace period, the *agreement* will be canceled as described above.

- ◆ **If the *agreement* is changed at your employer's request to stop covering the class of employees to which you belong.** We will no longer cover you or your family members on the date of that change.
- ◆ **If the *agreement* is changed at your employer's request to stop covering family members.** We will no longer cover your family members on the date of that change.
- ◆ **If you are no longer covered.** Your family members will no longer be covered.
- ◆ **If you do not pay your copay.** If you do not pay your *copay* to a provider within 31-days from the date that you are sent a bill by a provider to make your *copay* 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 *copay*. If you do not pay your *copay* 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 notice to you telling you of this. If your coverage is terminated, Anthem will tell your employer 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 your employer 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. Your employer will return your portion of the money returned to them to you.

If your coverage was ended because you didn't pay your *copay*, and you have now paid it, you may have your coverage reinstated by re-enrolling as follows:

- If you paid your *copay* 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.)

- If you do not pay your *copay* within 31-days after your coverage would end due to failure to make the required *copay*, but subsequently paid your *copay* and re-enroll within 31-days after you paid your *copay*, 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.)
 - If you did not pay your *copay* within 31-days after the date your coverage ended, and you do not re-enroll within 31-days of the date you paid your *copay*, you will be eligible to enroll again during your employer's next *Open Enrollment*.
- ◆ **If you decide to cancel at any time.** Your coverage ends on the next subscription charge due date after we receive written notice from your employer that you have ended your coverage. You must give your employer written notice to end your coverage.
- ◆ **If you or a family member are no longer eligible.** Your coverage ends on the next subscription charge due date following the date you are no longer eligible for coverage, except in these cases:
- **Leave of Absence.** If your employer pays the subscription charges to us, you may be covered for up to:
 - ⇒ six months while you take a short-term leave of absence if your employer allows it;
 - ⇒ twelve months while you take a sabbatical year's leave of absence if your employer allows it; or
 - ⇒ an unlimited period for a leave of absence due to illness if your employer allows it and annually certifies it.

- **Handicapped Children.** If your child has a physical or mental condition that prevents him or her from getting a self-sustaining job and reaches the upper age limit in this *plan* for a child (26 years), your child can still qualify if he or she is:

⇒ Covered under this *plan*.

⇒ Still chiefly dependent on you, your spouse or your domestic partner for support and maintenance.

⇒ Not able to get a job to self-support himself or herself because of the physical or mental condition.

A *doctor* must certify in writing that your child is incapable of self-sustaining employment due to a physical or mental condition.

We will notify you that your child's coverage will end when your child reaches the *plan's* upper age limit at least 90 days prior to the date the child reaches that age. You must send proof of the child's physical or mental condition within 60 days of the date you receive our request. If we do not complete our determination of your child's continuing eligibility by the date your child reaches the plan's upper age limit, your child will remain covered pending our determination.

After two years have passed since you gave us the first certification, you may need to send us proof that your child is still chiefly dependent on you, your spouse or your domestic partner for support and maintenance and that a physical or mental condition still exists, but we will not ask for this proof more than once a year.

We will cover your child until he or she no longer has a physical or mental condition that prevents him or her from getting a job or he or she is no longer dependent on you, your spouse or your domestic partner for support and maintenance.

A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

◆ **Fraud or misrepresentation by you or a family member.**

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:

- **Fraud or deception in the use of services or facilities.**
You or a family member may individually have your coverage terminated if any of you commits fraud or deception in the use of services or facilities. If you, as the employee, have your coverage terminated for such fraud or deception, coverage for all other family members will also end.
- **Intentional misrepresentation of material fact under the terms of the *agreement*.** 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 employee, 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 24 months, no statement made by you will be used to end your coverage.

Note: If your marriage or domestic partnership ends, you must give or send to your employer written notice that it has ended. Coverage for former spouses and domestic partners, and their dependent children, if any, ends according to the “What You Should Know about Your Coverage” provisions. If Anthem has a loss, because you fail to tell your employer your marriage or domestic partnership ended, Anthem may recover any actual loss from you. If you fail to give your employer notice in writing that your marriage or domestic partnership ended, it will not delay or

prevent the end of your marriage or domestic partnership. If you notify your employer in writing to cancel coverage for a former spouse or domestic partner, and the children of the former spouse or domestic partner, if any, right away at the end of your 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 Keeping Anthem Blue Cross HMO After Your Coverage Status Changes, Continuation of Disabled District Employees, Coverage for Surviving Spouses of Certificated Employees, Extension, and HIPAA Coverage and Conversion.

A Medical Group Can End its Services to You

- ◆ **If you move away from the area it serves.** You will need to ask to transfer to another *medical group*. If you move outside the Anthem Blue Cross HMO service area, you won't be eligible for Anthem Blue Cross HMO.
 - Call the *Customer service number* on your Member ID card, or ask your employer for a *membership change form*.
 - The change in your *medical group* will happen on the first day of the month after we get your request.
- ◆ **If you refuse to follow a treatment** your *doctor* recommends when there is no other better choice, your coverage may end with that *doctor* and/or *medical group*. We will help you get coverage with another *doctor* and/or *medical group*.
- ◆ **If your conduct threatens others.** If you act in a way that threatens the safety of Anthem employees, providers, other plan members, or other patients, or repeatedly behave in a manner that substantially impairs Anthem's ability to furnish or arrange services for you or other *members* or substantially impairs a provider's ability to provide services to other patients, your *medical group* may ask us to move you to another *medical group*. You will have the opportunity to respond to any allegations that any such behavior has occurred.

If You Believe Your Coverage Has Been Cancelled Unfairly

If you believe your coverage has been or will be improperly cancelled, you may file a complaint with us according to the procedures described in the section called “How to Make a Complaint”. You should file your complaint as soon as possible after you receive notice that your coverage will end. You may also ask for a review of the matter by the Director of the Department of Managed Health Care. If your coverage is still in effect when you file a complaint, we will continue to provide coverage to you under the terms of this *plan* until a final determination of your request for review has been made, including any review by the Director of the Department of Managed Health Care (this does not apply if your coverage is cancelled because the subscription charges have not been paid). If your coverage is maintained in force pending the outcome of the review, subscription charges must still be paid to us on your behalf.

Keeping Anthem Blue Cross HMO After Your Coverage Status Changes

If your employer employs 20 or more people, you may be able to keep on being covered even after you no longer work for that employer. This is called *COBRA*. Ask your employer for more information.

You or Your Family Members May Choose *COBRA*

You can go on being covered by Anthem:

- ◆ When your job ends, for any reason other than gross misconduct.
- ◆ When your work hours are reduced.
- ◆ When, as a retiree, your benefits are canceled or reduced because your former employer filed for Chapter 11 bankruptcy.

Your family members, other than a domestic partner, or the child of a domestic partner, can go on being covered by Anthem even.

- ◆ If you were to die.
- ◆ If you are divorced or legally separated.
- ◆ If your child is no longer qualifies as a dependent. For example, your child reaches the upper age limit of the *plan*.
- ◆ If you become entitled to Medicare.

***COBRA* does not apply to a domestic partner, or the child of a domestic partner, under this *plan*.**

Your employer will let you or your family members know that you have a right to keep your health plan under *COBRA*. If you marry or have a new child during this time, your new spouse or child can be enrolled as a family member. But only a child born to or placed for adoption with you will have the same rights as someone who was covered under the *plan* just before *COBRA* was elected.

Your employer will notify you or your family members if you can continue your coverage under *COBRA* when:

- You lose your job or your work hours are reduced.
- Your benefits as a retiree are canceled or reduced because your former employer filed for Chapter 11 bankruptcy.
- You die or become entitled to Medicare. Your employer will notify your family members.

You must inform your employer if your family members want *COBRA* coverage within 60 days from the date:

- You get a divorce or legal separation.
- Your child is no longer a dependent.

If You Want to Keep Your Health Plan

- ◆ Tell your employer within 60 days of the date you get your notice of your right to keep your health plan.
- ◆ You can have coverage for all the *members* of the family, or only some of them.
- ◆ If you don't choose *COBRA* during those 60 days, you cannot have it later.
- ◆ Your employer must send your payment and the *COBRA* forms to keep you covered within 45 days after you choose to keep it.

You may have to pay the whole cost. You should know that you may have to pay the whole cost of staying on the health plan.

- ◆ You must send your payment to the employer every month.
- ◆ Your employer must send it to Anthem. This will keep your coverage going.

The subscription charge that applies to the employee will also apply to:

- ◆ A spouse, because of divorce, separation or death.

- ◆ A child, even if you or your spouse do not choose *COBRA* (if more than one child enrolls, subscription charges for the number enrolling will apply).

How Long You Can Be Covered

You can go on being covered until the first of the following events takes place:

- ◆ The end of eighteen months (18) if you lost your job or your hours were lowered. (Note: If your *COBRA* began on or after January 1, 2003 and ends after 18 months, you can keep your medical coverage only under CalCOBRA for up to another 18 months, making a total of 36 months under *COBRA* and CalCOBRA combined. You must completely use up your eligibility under *COBRA* first. Your CalCOBRA rights are explained later in this section.)
- ◆ The date our *agreement* with your employer ends.
- ◆ The date you stop paying the monthly charges.
- ◆ The date you first become covered under another group health plan unless there is a pre-existing condition limitation that applies to you or your family member.
- ◆ The date you first become entitled to Medicare.

Your family members can go on being covered until the first of the following events takes place:

- ◆ Eighteen months (18) if you lost your job, or your hours were lowered. However, this does not apply if coverage did not end when you became entitled to Medicare before you lost your job or your work hours were lowered. *COBRA* coverage ends 36 months from the date you became entitled to Medicare if entitlement occurred within the 18 months before the date your job ended or your work hours were lowered. (Note: If your *COBRA* began on or after January 1, 2003 and ends after 18 months, or some longer period if you became entitled to Medicare before you lost your job or your work hours were lowered but sooner than 36 months, you can keep your medical

coverage only under CalCOBRA for the balance of 36 months under *COBRA* and CalCOBRA combined. You must completely use up your eligibility under *COBRA* first. Your CalCOBRA rights are explained later in this section.)

- ◆ Thirty-six months (36) if there was a death, divorce, or legal separation.
- ◆ Thirty-six months (36) if the child is no longer dependent.
- ◆ Thirty-six months (36) from your entitlement to Medicare.
- ◆ The date our *agreement* with your employer ends.
- ◆ The date they first become eligible under another group health plan unless there is a pre-existing condition limitation that applies to them.
- ◆ They stop paying monthly charges.
- ◆ They first become entitled to Medicare.

Your family members may be able to get extended *COBRA* coverage if they experience another event described above. If a second event occurs, your family members may extend *COBRA* up to 36 months from the date of the first event if:

- Your family members were originally covered under the first event; and
- Your family members were covered under the *plan* when the second event occurred.

This period may not go beyond 36 months from the date of the first event.

Retirement and COBRA

If you are a retiree and your benefits are canceled or reduced because your former employer filed for Chapter 11 bankruptcy, you may be covered for the remainder of your life. Your covered family members may continue coverage for 36 months after your death. Coverage ends when:

- Our *agreement* with your former employer ends.
- You or your family member stops paying the monthly charges.
- You or your family member first becomes covered under another group health plan that does not have a pre-existing condition limitation that applies to you or your family member.

If You or a Family Member is Disabled

If you or a family member is determined by Social Security to be disabled, your whole family may be able to be covered for up to 29 months. This is an additional 11 months following the 18 months of *COBRA* coverage due to your job loss or reduction of work hours. You may be covered for the additional 11 months if you or a family member is determined to be disabled by Social Security before the job loss or reduction of work hours or during the first 60 days of *COBRA* continuation.

You must show your employer proof that the Social Security Administration (SSA) found that you or your family member was disabled. You must show your employer this proof during the first 18 months of your *COBRA* continuation and no later than 60 days after the later of the following:

- ◆ The date of the Social Security Administration's finding of the disability.
- ◆ The date the original qualifying event happened.
- ◆ The date you lost coverage.
- ◆ The date you are told you must show your employer the disability notice.

For the 19th through 29th months that the disability goes on, the employer must send the monthly charges.

- ◆ This will be **150%** of the applicable rate for the length of time the disabled person is covered, depending on how many family members are being covered.

- ◆ If the disabled person is not covered during this additional 11 months, the charge will stay at **102%** of the applicable rate.
- ◆ The employer must send the charges to us every month.
- ◆ You may have to pay the whole cost.

This coverage will last until the first of the following events takes place:

- ◆ The end of the month following a period of 30 days after the SSA finds that the family member is no longer disabled.
- ◆ The end of 29 months. (Note: If your *COBRA* began on or after January 1, 2003 and ends after 29 months, you can keep your medical coverage only under CalCOBRA for up to another seven (7) months, making a total of 36 months under *COBRA* and CalCOBRA combined. You must completely use up your eligibility under *COBRA* first. Your CalCOBRA rights are explained later in this section.)
- ◆ You stop paying the monthly charges.
- ◆ The *agreement* with your employer ends.
- ◆ You get another health plan that will cover the disability.
- ◆ The disabled person becomes entitled to Medicare.

You must let your employer know within 30 days that the SSA found that you or your family member is no longer disabled.

If a second event occurs during this additional 11 months, *COBRA* may extend for up to 36 months from the date of the first event. The charge will be **150%** of the applicable rate for the 19th through 36th months if the disabled person is covered. This charge will be **102%** of the applicable rate for any periods of time the disabled person is not covered after the 18th month.

What About After COBRA?

After *COBRA* ends, you may be able to keep your coverage through another program called “CalCOBRA”, which is explained in the next section.

CalCOBRA

If your coverage under federal *COBRA* started on or after January 1, 2003, you can keep on being covered under CalCOBRA if your federal *COBRA* ended:

- ◆ 18 months after your qualifying event, if your job ended or your work hours were reduced; or
- ◆ 29 months after your qualifying event if you qualified for the additional 11 months of federal *COBRA* because of a disability.

You must completely use up your eligibility under federal *COBRA* before you can get coverage under CalCOBRA. You are not eligible for CalCOBRA if:

- ◆ You have Medicare;
- ◆ You have or get coverage under another group plan unless that plan has a pre-existing condition limitation that applies to you; or
- ◆ You are eligible for or covered under federal *COBRA*.

Coverage under CalCOBRA is for medical benefits only.

You will be told about your rights. Within 180 days before your federal *COBRA* ends, we will tell you that you have a right to keep your coverage under CalCOBRA. If you want to keep your coverage, you must tell us in writing within 60 days before the date your federal *COBRA* ends or when you are told of your right to keep your coverage under CalCOBRA, whichever is later. If you don't tell us in writing during this time period you will not be able to keep your coverage.

You can add family members to your CalCOBRA coverage. For dependents acquired while you are covered under CalCOBRA, coverage begins according to the enrollment provisions of this *plan*.

You may have to pay the whole cost of your CalCOBRA coverage. This cost will be:

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

We must receive your payment every month to keep your coverage going. You must send your payment to us, along with your enrollment form, within 45 days after you tell us you want to keep your coverage. You must send us the payment by first class mail or some other reliable means. Your payment must be enough to pay the amount required and the entire amount due. If we don't get the correct payment within this 45 day period, you won't be able to get coverage under CalCOBRA. After you make the first payment, all other payments are due on the first day of each following month.

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

We may change the amount of your payment as of any payment due date. If we do, we will tell you in writing at least 60 days before the increase takes effect.

You must give us current information. We will rely on the eligibility information you give us as correct without checking on it, but we maintain the right to check any information you give us.

Coverage through a *prior plan*. If you were covered through CalCOBRA under the *prior plan*, you can keep your coverage under this plan for the rest of the continuation period. But your coverage will end if you don't follow the enrollment rules and make the payments within 30 days of being told your CalCOBRA coverage under the *prior plan* will end.

When CalCOBRA starts. When you tell us in writing that you want to keep your coverage through CalCOBRA and pay the first payment, we will reinstate your coverage back to the date federal *COBRA* ended. If you enroll a family member while you are covered through CalCOBRA, the family member's coverage begins according to the enrollment provisions of this *plan*.

When CalCOBRA ends. Your coverage under CalCOBRA will end when the first of the following events takes place:

- ◆ The end of 36 months after the date of your qualifying event under federal *COBRA**
- ◆ The date our *agreement* with your employer ends.
- ◆ The date your employer stops providing coverage to the class of *members* you belong to.
- ◆ The date you stop paying the monthly charges. Your coverage will be cancelled after written notification, as explained above.
- ◆ The date you become covered under another group health plan unless there is a pre-existing condition limitation that applies to you or a family member. In this case, CalCOBRA will end at the end of the period the pre-existing condition limitation applies.

- ◆ The date you become entitled to Medicare.
- ◆ The date you become covered under federal *COBRA*.

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

* If your coverage under CalCOBRA started under a *prior plan*, the 36 month period will be dated from the time of your qualifying event under that *prior plan*.

When your coverage under CalCOBRA ends, you may be able to apply for HIPAA coverage or a conversion plan. You will get more information about these options no more than 180 days before CalCOBRA ends.

Note. 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.

Besides the ways listed above for keeping Anthem Blue Cross HMO, your spouse and family members may keep on being covered by it even after *COBRA* ends. If your *COBRA* coverage ends for either of the following reasons, and you are the surviving spouse of an employee, you may be eligible to enroll yourself and your child(ren) for coverage under the Coverage for Surviving Family Members provision described later.

- ◆ The end of the thirty-six months (36) of *COBRA* coverage if *COBRA* coverage was due to the death of the employee, divorce, or legal separation from the employee.
- ◆ The end of *COBRA* coverage due to first becoming entitled to Medicare.

Coverage For Disabled District Employees.

You may keep you coverage if you become disabled as a result of a violent act directed at you while working at your job as a district employee.

Eligibility. You must be:

- ◆ a member of the State Teachers' Retirement System; or
- ◆ a classified school employee member of the Public Employees' Retirement System; and
- ◆ covered under this *plan* at the time of the violent act causing the disability.

You may have to pay the whole cost. You should know that you may have to pay the whole cost of staying on the health plan.

- ◆ You must send your payment to your employer every month.
- ◆ Your employer must send it to Anthem. This will keep your coverage going. We will accept subscription charges only from your employer. Payment made by you directly to us will not continue coverage.

When Continuation Coverage Begins. Coverage begins on the date you became disabled, but, so, there is no break in coverage, you must:

- ◆ elect to continue coverage within sixty (60) days following when your coverage terminated; and
- ◆ pay the subscription charge.

For family members acquired and properly enrolled during the continuation, coverage begins according to the enrollment provisions of this *plan*.

How Long You Can Be Covered

You can go on being covered until the first of the following events takes place:

- ◆ The date this *plan* terminates;
- ◆ The end of the period for which monthly subscription charges are last paid; or
- ◆ The date the maximum benefits of this *plan* are paid.

For your family members, this coverage ends according to the rules in the section How Your Coverage Ends.

Coverage for Surviving Spouses of Certificated Employees

If the employee dies while covered under this *plan* as a certificated employee or a certificated *retired employee*, coverage continues for an enrolled spouse until one of the following occurs:

1. The spouse becomes covered under another group health plan, or
2. The spouse's coverage ends as described under WHAT YOU SHOULD KNOW ABOUT YOUR COVERAGE: HOW YOUR COVERAGE ENDS.

Exception: If the employee dies while covered under this *plan* as a classified employee or a classified *retired employee*, the enrolled spouse may be eligible to continue coverage under this benefit. Please consult your *participating employer* for details regarding their *agreement*.

Extension

If our *agreement with your employer ends*. Your coverage can be canceled or changed without us telling you.

But, if you or a family member is *totally disabled* and getting the care of a *doctor*, your benefits for treating the totally disabling condition will go on, if:

- ◆ The disabled person is staying in a *hospital* or *skilled nursing facility* as long as the *stay* is *medically necessary*. You will get your benefits until you are no longer staying in the *hospital*.
- ◆ If you are not now in a *hospital* or nursing facility, you may still be able to get total disability benefits. Your *doctor* must send us a written statement of your disability. It must be sent within 90 days and every 90 days after that.

If you get coverage under another health *plan* that provides benefits, without limitation, for your disability, this extension of benefits is not available.

Your benefits will end when:

- ◆ You are no longer disabled.
- ◆ Your *plan* has paid the most it can.
- ◆ You get another health plan which will cover your disability.
- ◆ Twelve (12) months have passed.

HIPAA Coverage and Conversion

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

◆ **HIPAA Coverage**

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

- You must have at least 18 months of continuous health coverage, most recently under a health plan sponsored by an employer, and have had coverage within the last 63 days.
- Your most recent coverage did not end because of non-payment of the monthly charges or fraud.

- If continuation of coverage under the employer *plan* was available under COBRA, CalCOBRA, or a similar state program, you must have elected and exhausted that coverage.
- 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 offering 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 send an application to us and make the first subscription charge payment within 63 days of the date your coverage ends. You do not have to provide proof of good health to us to get a conversion plan.

You cannot convert your *plan* if:

- Your employer got another group plan within 15 days.
- You didn't pay your subscription charges when they were due.
- You are eligible or you already have another health plan.
- You are able to get Medicare.
- You weren't covered for medical benefits under the *plan* for 90 days just before your coverage ended.

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

Important: The reason for a conversion is to give you a health plan after your group health plan ends. The benefits may not be the same, and the rates will not be the same.

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

How to Make a Complaint

While Anthem Blue Cross HMO helps you get the care you need, we don't actually give the care.

We contract with *medical groups, doctors, and other health care providers*. They are not employees of Anthem. The *hospitals, nursing facilities and other health agencies* are independent contractors.

However, we want to help you get the care and service you need. Here's how:

- ◆ **Talk to your Anthem Blue Cross HMO coordinator.** If you have questions about your services, call your *Anthem Blue Cross HMO coordinator*. He or she may be able to help you right away. You may also call the *Customer Service number* on your member ID card.
- ◆ **Filing a Complaint.** If you are still unhappy and wish to file a complaint, you should fill out a "Member Issue Form." You can get this form from your *Anthem Blue Cross HMO coordinator* or from us. Complete the form and mail it to us or you may call us at the *Customer Service number* on your member ID card and ask one of our customer service representatives to fill out the Member Issue Form for you. You may also file a complaint with us online or print the Member Issue Form through the Anthem Blue Cross website at www.anthem.com/ca.
- ◆ **If you believe your coverage has been cancelled unfairly.** If you believe your coverage has been or will be improperly cancelled, you may also file a complaint with us.

In filing a complaint, you must:

- Include the following information from your Member ID Card:
 - Your group number.
 - Your member identification number.

- Explain what happened or what you would like help with.

You must file your complaint with us no later than 180 days after the date you get a denial notice from us or your *medical group* or any other incident or action you are not satisfied with.

When you mail in the Member Issue form or file your complaint online, you are starting the formal complaint process. If you have an acute or urgent condition, you have the right to ask for an expedited review of an appeal for service that has been denied by your *medical group*. Expedited appeals must be resolved within three days.

◆ **Get help from Anthem.** You may ask for a review from Anthem.

- Just call us at the *Customer Service number* shown on your Member ID card.
- Or write to us at the following address:

Anthem Blue Cross

Grievance and Appeal Management

P.O. Box 4310

Woodland Hills, CA 91367

- Tell us all about your complaint.
- Send this along with any bills or records.

Within 30 days after we get and look at the facts of your complaint, we will send you a letter to tell you how we have solved the problem. If your case is urgent and involves an imminent threat to your health, such as severe pain or the loss of life or limb or major bodily function, we'll expedite the review and resolve your complaint within three days.

- ◆ **We will meet with you.** For issues dealing with whether a service is *medically necessary* or appropriate, you may:
 - appear in person before the committee meeting to review your appeal;
 - send someone else to represent you before the committee; or
 - have a telephone conference call with the committee.
- ◆ **You have the right to review all documents that are part of your complaint file and to give evidence and testimony as part of the complaint process.**
- ◆ **If you don't like what the committee decides or it does not decide what to do within 30 days (or within three days for urgent cases).** You may complain directly to the Department of Managed Health Care (see later page). If your case is urgent and involves an imminent threat to your health as described above, you do not have to go through this complaint process or wait 30 days to complain to the Department of Managed Health Care (DMHC). You may do so right away. You may also, at any time, use *binding arbitration* to resolve your dispute. (See "Arbitration" on a later page.)
- ◆ **If your complaint is about the cancellation of your coverage,** you may also complain to the DMHC right away if the DMHC agrees that your complaint requires immediate review. If your coverage is still in effect when you file your complaint, we will continue to provide coverage to you under the terms of the *plan* until a final determination of your request for review has been made, including any review by the Director of the Department of Managed Health Care (this does not apply if your coverage is cancelled because the subscription charges have not been paid). If your coverage is maintained in force pending the outcome of the review, subscription charges must still be paid to us on your behalf. If your coverage has already ended when you file the complaint, your coverage will not be maintained. If the Director of the Department of Managed Health Care determines that your

coverage should not have been cancelled, we will reinstate your coverage back to the date it was cancelled. Subscription charges must be paid current to us on your behalf from the date coverage is reinstated.

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 which has a contract with the California Department of Managed Health Care ("DMHC"). Your request for this review may be sent 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 give up any statutory right to pursue legal action against us regarding the disputed health care service. We will send you an application form and an addressed envelope for you to use to ask for this review with any grievance disposition letter denying coverage for this reason. You may also request an application form by calling us at the telephone number listed on your identification card or write to us at Anthem Blue Cross 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. The condition meets either or both of the following descriptions:
 - A life threatening condition or a disease is one where the likelihood of death is high unless the course of the disease is interrupted. A life threatening condition or disease can also be one with a potentially fatal outcome where the end point of clinical intervention is the patient's survival.
 - A seriously debilitating condition or disease is one that causes major irreversible morbidity.

- ◆ Your *medical group* 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 an *Anthem Blue Cross HMO 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 *doctor* 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:
 - Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized standards;
 - Medical literature meeting the criteria of the National Institute 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);
 - Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;
 - Either of the following: (i) The American Hospital Formulary Service's Drug Information, or (ii) the American Dental Association Accepted Dental Therapeutics;
 - 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;

- 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
- 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 ask for this review within six months of the date you receive a denial notice from us in response to your grievance, or from the end of the 30 day or three day grievance period, whichever applies. This application deadline may be extended by the 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 *doctor*. Any newly developed or discovered relevant medical records that we or an *Anthem Blue Cross HMO provider* identifies 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 *doctor* 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 complaint process (see “How to Make a Complaint”).

Independent Medical Review of Complaints Involving a Disputed Health Care Service

You may ask for an independent medical review (“IMR”) of disputed health care services from the Department of Managed Health Care (“DMHC”) if you think that we or your *medical group* have wrongly denied, changed, 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, changed, 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 you may have. 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 give you an IMR application form and an addressed envelope for you to use to ask for IMR with any complaint disposition letter that denies, changes, or delays health care services. A decision not to participate in the IMR process may cause you to lose any lawful right to pursue legal action against us about the disputed health care service.

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

1. One or more of the following conditions have been met:
 - (a) Your provider has recommended a health care service as *medically necessary*, or

- (b) You have had *urgent care* or *emergency services* that a provider determined was *medically necessary*, or
 - (c) You have been seen by an *Anthem Blue Cross HMO provider* for the diagnosis or treatment of the medical condition for which you want independent review;
2. The disputed health care service has been denied, changed, 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 complaint with us or your *medical group* and the disputed decision is upheld or the complaint is not resolved after 30 days. If your complaint requires expedited review you need not participate in our complaint process for more than three days. The DMHC may waive the requirement that you follow our complaint process in extraordinary and compelling cases.

You must apply for IMR within six months of the date you receive a denial notice from us in response to your complaint or from the end of the 30 day or three day complaint 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 get 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 getting 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 ask for an application form, please call us at the *Customer Service number* on your Member 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.

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 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 Blue Cross 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.

Other Things You Should Know

Using a Claim Form to Get Benefits

Here's what you or your health care provider must do:

- ◆ Fill out the claim form.
- ◆ List and describe clearly the services you got and how much they cost.
- ◆ Send the form to Anthem within 90 days of the date you got the service.

If you are not able to send the claim in within 90 days, you may have up to 12 more months. We will not pay for your benefits if you or the health care provider do not send the claims within that time. You must use claim forms; we won't accept canceled checks or receipts.

Getting Repaid by a Third Party

Sometimes someone else may have to pay for your medical care if an injury, disease, or other health problem is their fault or their responsibility. Whatever we cover will depend on the following:

- ◆ Your *medical group* and Anthem will automatically have a legal claim (lien) to get back the costs we covered, if you get a settlement or judgment from the other person or their insurer or guarantor. We should get back what we spent on your medical care.
 - 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.
- ◆ You must write to your *medical group* and Anthem about your claim within 60 days of filing a claim against the third party.
 - You will need to sign papers and give us the help we need to get back our costs.
 - If you don't do this, you will have to pay us back out of your own money.
 - ◆ We will have the right to get our money back, even if what you, or someone acting for you, got back is less than the actual loss you suffered.

Coordination of Benefits

If you're covered by this group health plan, and one or more other medical or dental plans, total benefits may be limited as shown below. These provisions apply separately each calendar year to each person and are based mainly on California law.

Definitions

When used in this section, the following words and phrases have the meanings explained here.

Allowed Expense is any needed, 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, except when by law Medicare's benefits are secondary to those of any private insurance program or another non-governmental program.

Each contract or arrangement for coverage listed above will be considered a separate plan. The rules of these provisions will apply only when the other plan has coordination of benefits provisions.

Primary Plan is the plan which will have its benefits figured first.

This Plan is the part of this *plan* that 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 primary plan, then we will figure out its benefits first without taking into account any other plan.
2. If This Plan isn't the primary plan, then we may reduce its benefits so that the benefits of all the plans aren't more than the allowed expense.
3. The benefits of This Plan will never be more than the benefits we would have paid if you were covered only under this *plan*.

If This Plan isn't the primary plan, you may be billed by a health care provider. If you receive a bill, you should submit it to your *medical group*.

Order of Benefits Determination

The following rules determine the order in which benefits will be paid:

1. A plan with no coordination provision will pay its benefits first. This always includes Medicare except when by law This Plan must pay before Medicare.
2. A plan which covers you through your employer pays before a plan which covers you as a family member. But if you have Medicare and are also a dependent of an active employee under another employer plan, this rule might change. If Medicare's rules say that Medicare pays after the plan that covers you as a dependent but before your employer's plan, then the plan that covers you as a dependent pays before a plan which covers you through your employer. This might happen if you are covered under This Plan as a retiree.
3. For a dependent child covered under plans of two parents, the plan of the parent whose birthday falls earlier in the calendar year pays before the plan of the parent whose birthday falls later in the year. But if one plan doesn't have a birthday rule provision, that plan's provisions will determine the order of benefits.

Exception to rule 3: If a dependent child's parents are divorced or separated, the following rules will be used instead of rule 3:

- a. The plan of the parent who has custody, will pay first, unless he or she has remarried.
 - b. If the parent with custody has remarried, then the order is 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. However, if there is a court decree which holds one parent responsible for that child's health care coverage, the plan which covers that child as a dependent of the responsible parent pays first.
4. The plan covering you as a laid-off or retired employee or as such employee's dependent pays after another plan covering you. But if either plan doesn't have a rule about laid-off or retired employees, rule 6 applies.
 5. A plan covering you under a state or federal continuation of coverage pays after another plan. However, if the other plan doesn't have this rule, this rule won't apply.
 6. When the rules above don't apply, the plan that has covered you longer pays first unless two of the plans have the same effective date. In this case, allowed expense is split evenly between the two plans.

Our Rights Under This Provision

Responsibility For Timely Notice. We aren't responsible for coordination of benefits unless we get information from the asking party.

Reasonable Cash Value. If you get benefits from another plan in the form of services, the value of services in cash will be considered allowed expense and a benefit paid.

Facility of Payment. If another plan pays benefits that this plan should have paid, we will pay the other plan an amount determined by us. This will be considered a benefit paid under this *plan*, and will fully satisfy what we are responsible for.

Right of Recovery. If we pay benefits that are more than we should have paid under this provision, the *medical group* and we may recover the extra amounts from one or more of the following:

- ◆ The persons to or for whom payments were made;
- ◆ Insurance companies or service plans; or
- ◆ Other organizations.

If You Qualify for Medicare

Active Employees and Family Members Age 65 or Over Who Are Eligible for Medicare

If you are:

- ◆ Age 65 or over; AND
- ◆ An Employee who is not retired; OR
- ◆ A Dependent of the Employee above who is not retired; AND
- ◆ Eligible for Part A of Medicare; AND
- ◆ Eligible and enrolled under this *plan*;

you will get the benefits of this *plan* without taking into account Medicare unless you've chosen Medicare as your primary plan. If

you've chosen Medicare as your primary health plan, you won't be able to get any benefits under this *plan*.

Other Members Who are Eligible for Medicare

If you are:

- ◆ A *retired employee* age 65 or more and eligible for Part A of Medicare; OR
- ◆ The spouse of a *retired employee* and are age 65 or more; OR
- ◆ Getting treatment for end-stage renal disease after the first 30 months you are entitled to end-stage renal disease benefits under Medicare; OR
- ◆ Entitled to Medicare benefits as a disabled person, unless you have a current employment status (as determined by Medicare's rules) and are enrolled in this *plan* through a group of 100 or more employees;

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:

- ◆ Medicare must provide benefits first for any services covered both by Medicare and under this *plan*.
- ◆ 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.

- ◆ For services you received that are covered both by Medicare and under this *plan*, that are prepaid by us, we make no additional payment.
- ◆ 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 allowed expense for the covered services.

If you have questions about how your benefits will be coordinated with Medicare, please call our *Customer Service number* on your Member ID card.

Other Things You Should Know

Transition Assistance for New Members: Transition Assistance is a process that allows for completion of covered services for new *members* receiving services from a *doctor* who is not an *Anthem Blue Cross HMO provider*. If you are a new *member*, you may request Transition Assistance if any one of the following conditions applies:

- ◆ 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.
- ◆ 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 *doctor* who is not an *Anthem Blue Cross HMO provider* and consistent with good professional practice. Completion of

covered services shall not exceed twelve (12) months from the time you enroll with Anthem.

- ◆ 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.
- ◆ 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.
- ◆ 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.
- ◆ 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.

Call us at the *customer service number* listed on your ID card to ask for transition assistance or to get 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 doctors who are not *Anthem Blue Cross HMO providers* are negotiated on a case-by-case basis. We will ask that the *doctor* agree to accept reimbursement and contractual requirements that apply to *Anthem Blue Cross HMO providers*, including payment terms, who are not capitated. If the *doctor* does not agree to accept said reimbursement and contractual requirements, we are not required to continue that *doctor's*

services. If you do not meet the criteria for Transition Assistance, you are afforded due process including having your request reviewed.

Continuity of Care after Termination of *Medical Group*:

Subject to the terms and conditions set forth below, Anthem will provide benefits at the *Anthem Blue Cross HMO provider* level for covered services (subject to applicable copayments, coinsurance, deductibles and other terms) received from a *medical group* at the time the *medical group's* contract with us terminates (unless the *medical group'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* at the time the *medical group's* contract terminates. The terminated *medical group* 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 terminated *medical group* must also agree in writing to accept the terms and reimbursement rates that apply to *Anthem Blue Cross HMO providers* who are not capitated. If the terminated *medical group* does not agree with these contractual terms and conditions, we are not required to continue the terminated *medical group's* services beyond the contract termination date.

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

- ◆ 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.
- ◆ 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* and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the date the *medical group's* contract terminates.

- ◆ 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.
- ◆ 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.
- ◆ 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* contract terminates.
- ◆ 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* contract terminates.

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

Please call us at the *Customer Service number* listed on your ID card to ask for continuity of care or to get 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 *medical group* 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* are negotiated on a case-by-case basis. We will ask that the terminated *medical group* agree to accept reimbursement and contractual requirements that apply to *Anthem Blue Cross HMO providers*, including payment terms, who are not capitated. If the terminated *medical group* does not agree to accept the same reimbursement and contractual requirements, we are not required to continue that *medical group's* services. If you disagree with our determination regarding continuity of care, you may file a complaint with us by following the procedures described in the section called "How to Make a Complaint".

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

Transition Assistance and Continuity of 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.

How we pay your providers. Your *medical group* is paid a set amount for each *member* per month. Your *medical group* may also get added money for some kinds of special care or for overall efficiency, and for managing services and referrals. *Hospitals* and

other health care facilities are paid a set amount for the kind of service they give you or an amount based on a negotiated discount from their standard rates. If you want more information, please call us at the telephone number listed on your Member ID Card, or you may call your *medical group*.

You do not have to pay any *Anthem Blue Cross HMO provider* for what we owe them, even if we don't pay them. But you may have to pay a non-*Anthem Blue Cross HMO provider* any amounts not paid to them by us.

Information About the BlueCard® Program. We have a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates (“Licensees”) referred to generally as “Inter-Plan Programs”. Whenever you obtain healthcare services outside of our service area, the claims for these services may be processed through one of these Inter-Plan Programs.

Typically, when accessing care outside of our service area and the service area of our corporate parent, you will obtain care from healthcare providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, you may obtain care from non-participating healthcare providers.

Our payment practices in both instances are described below.

We cover only limited healthcare services received outside of our corporate parent's service area. As used in this provision, “Out-of-Area Covered Healthcare Services” consist of *urgent care*, *emergency services*, or follow-up care obtained outside the geographic area our corporate parent serves (see “Getting Care When You Are Outside of California” in the section “When You Need Care”). Any other services will not be covered when processed through any Inter-Plan Programs arrangements. These “other services” must be provided or authorized by your *primary care doctor*.

Under the BlueCard® Program, when you obtain Out-of-Area Covered Healthcare Services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations. However the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

The BlueCard® Program enables you to obtain Out-of-Area Covered Healthcare Services, as defined above, from a healthcare provider participating with a Host Blue, where available. The participating healthcare provider will automatically file a claim for the Out-of-Area Covered Healthcare Services provided to you, so there are no claim forms for you to fill out. You will be responsible for any *copay* amount, as stated in this *plan*.

If you need *emergency services*, get the medical care you need right away (see “When There is an Emergency” in the section “When You Need Care”). In some areas, there is a 9-1-1 emergency response system that you may call for *emergency services* (this system is to be used only when there is an *emergency* that requires an emergency response).

Whenever you access covered healthcare services outside our and, if applicable, our corporate parent’s service area and the claim is processed through the BlueCard® Program, the amount you pay for covered healthcare services, if not a flat dollar copayment, is calculated based on the lower of:

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

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

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

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

When you can't get care. If there is an epidemic or public disaster and you can't get care for covered services, we'll refund the unearned part of the subscription charge paid for you. We must receive a request for the refund in writing and along with proof of the need for care within 31 days. This payment meets our duty under this *plan*.

Right of Recovery. Whenever payment has been made in error, or the reasonable cash value of benefits provided under this *plan* exceeds the maximum amount for which we are liable, we and your *medical group* will have the right to recover such payment or excess amount from you or, if applicable, the provider, in accordance with applicable laws and regulations. In the event we recover a payment made in error from the provider, except in cases of fraud or misrepresentation on the part of the provider, we will only recover such payment from the provider within 365 days of the date we made the payment on a claim submitted by the provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

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

We have oversight responsibility for compliance with provider and vendor and subcontractor contracts. We may enter into a

settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a provider, vendor, or subcontractor resulting from these audits if the return of the overpayment is not feasible.

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

Who takes care of your COBRA or ERISA coverage. Anthem is not the *plan* administrator of your *COBRA* or ERISA coverage. Your employer, or someone your employer hires, most often takes care of administering your employer's health plan. The employer must let you know about any changes, give you notices, or let you know about the details of the health plan.

Workers' Compensation. Our health plan *agreement* with your employer doesn't change your coverage by the Workers' Compensation program. It doesn't take the place of Workers' Compensation.

Renewing our *agreement* with your employer. We can renew our *agreement* at certain times. We may change the subscription charges, or other terms of the *plan* from time to time without your consent.

Terms of Coverage

- ◆ In order for you to be entitled to benefits, both the *agreement* and your coverage under it must be in effect on the date the expense giving rise to a claim for benefits is incurred.
- ◆ Your benefits will depend on what is covered on the date you get the service or supply for which the charge is made.
- ◆ The *agreement* can be amended, modified or terminated without your consent.

Consumer Relations Committee. We have a special committee made up of people who are covered by our plan, health care providers taking part in Anthem Blue Cross HMO, and a member of our Board of Directors. This committee reviews information about finances and any complaints of *members* among other things. It advises the Board of Directors about how to make sure *members* are served well and with respect.

Confidential Information. We will make every effort and take care to keep your medical data secret. We may use data about services provided to you and others for statistical study and research. If the data is released to a third party, it will not identify you. Medical data about you can only be given to others if you agree to it in writing or if required by law. A consent to release medical data must be signed, dated and describe the kind of data and to who it may be disclosed. You may access your own medical records.

We may release your medical data to:

- ◆ professional peer review organizations; and
- ◆ your employer.

This will only be done to report claims experience to them or for them to audit our operation. We will only give them data that is needed to do 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 New Technology. Anthem reviews and evaluates new technology. It does this using criteria set by its medical directors. The criteria it uses helps it decide if:

- ◆ the new technology is still investigational; or
- ◆ has medical necessity.

A committee called Medical Policy and Technology Assessment Committee (MPTAC) gives Anthem guidance. They also validate

Anthem's medical policy. MPTAC is made up of about 20 doctors. They come from various medical specialties and geographic areas. They include Anthem's medical directors, doctors in academic medicine and doctors who practice managed care medicine. Anthem's conclusions, based on MPTAC guidance, are incorporated into Anthem's medical policy used to:

- ◆ form decision protocols for particular diseases and injuries; or
- ◆ treatments for particular disease or injuries; and
- ◆ determine what is *medically necessary*.

Conformity with Laws. Any provision of the *agreement* 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.

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*. Call the *customer service number* listed on your *member ID card* to request a certificate of creditable coverage.

Important Words to Know

The meanings of key terms used in this booklet are shown below.

Advanced imaging procedures are imaging procedures, including, but not limited to, Magnetic Resonance Imaging (MRI), Computerized Tomography (CT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography, and nuclear cardiac imaging.

For a complete list of *advanced imaging procedures* or if you need more information, please contact your *medical group*.

Agreement is the Group Benefit Agreement between Anthem and the *group* (your employer). In it, we agree to what benefits will be given to you.

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

Anthem Blue Cross HMO coordinator is the person at your *medical group* who can help you with understanding your benefits and getting the care you need.

Anthem Blue Cross HMO providers are licensed health care providers who have an agreement with Anthem to provide services to you.

Authorized referral occurs when you, because of your medical needs, are referred to a non-*Anthem Blue Cross HMO provider* for the treatment of *mental or nervous disorders* or substance abuse, but only when:

1. There is no *Anthem Blue Cross HMO provider* who practices in the appropriate specialty, provides the required services, or has the necessary facilities within a 30-mile radius of your home or within the county in which your home is located, whichever is less;

2. You are referred in writing to the non-*Anthem Blue Cross HMO provider* by a *doctor* who is an *Anthem Blue Cross HMO provider*, and
3. We have authorized the referral before you receive services.

Binding Arbitration is a process used to resolve complaints. It is used instead of going to a court of law. In binding arbitration, you and Anthem agree to meet with an arbitrator and go by the decision of the arbitrator.

COBRA is a special law that gives you a chance to keep your health plan even if you lose your job, have a reduction in hours or a change in dependents status. You will usually have to pay the monthly charges to keep the *plan* under COBRA.

Copay is the amount you pay to get a *medically necessary* service with an *Anthem Blue Cross HMO provider*. Anthem pays the provider the rest.

Copay Limit is the most you will have to pay in one calendar year in *copays*.

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, or 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.
- ◆ 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 coverage.
- ◆ Credit insurance.
- ◆ Coverage for on-site medical clinics.
- ◆ Disability income insurance.
- ◆ Coverage only for a specified disease or condition.
- ◆ Hospital indemnity or other fixed indemnity insurance.
- ◆ Medicare supplement coverage.
- ◆ Long-term care insurance.
- ◆ Dental coverage.
- ◆ Vision coverage.
- ◆ Workers' compensation insurance
- ◆ Automobile insurance, including no-fault automobile insurance.
- ◆ 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 for 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 for 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 giving medicine which you usually do yourself, or any other care for which the services of a health care provider are not needed.

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

Customer Service number is the 800-number you can call at Anthem to answer your questions about Anthem Blue Cross HMO. You will find the number on your Member ID card.

Doctor means a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is given.

Drug means a prescribed drug approved by the State of California or the federal government for use by the public. Under this *plan*, insulin is thought of as a *prescription drug*.

Emergency is a sudden, serious, and unexpected illness, injury, or health problem (including sudden and unexpected severe pain), or a *psychiatric emergency medical condition*. This includes any illness, injury or health problem you reasonably believe could endanger your health if you don't get medical care right away. We or your *medical group* will make the final decision about whether services were given for an emergency.

Emergency services are services given because of a medical or psychiatric *emergency*.

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

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

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

Guest membership is a special way you can get care when you go out of town for more than 90 days. If you know ahead of time, you can apply for a guest membership in a *medical group* in the city you are going to visit. Call the Anthem Blue Cross HMO *Customer service number* on your Member ID card and ask for the Guest Membership Coordinator.

Health care provider means the kinds of providers, other than M.D.s or D.O.s, that take care of your health and are covered under this *plan*. The provider must:

- ◆ Have a license to practice where the care is given.
- ◆ Provide a service covered by that license.
- ◆ Give you a service that is paid for under this *plan*.

Home health agencies are licensed providers who give you skilled nursing and other services in your home. Medicare must approve them as home health providers and/or be recognized by the Joint Commission on the Accreditation of Healthcare Organizations.

Hospice is an agency or organization that gives a specialized form of interdisciplinary care that controls pain and relieves symptoms and helps with the physical, emotional, social, and spiritual discomforts of a terminally ill person, as well as giving support to the primary caregiver and the patient's family. A hospice must be currently licensed as a hospice according to Health and Safety Code section 1747 or a licensed *home health agency* with federal Medicare certification according to Health and Safety Code sections 1726 and 1747.1. You may ask for a list of *hospices*.

Hospital is a place which provides diagnosis, treatment and care supervised by *doctors*. It must be licensed as a general acute care hospital.

The term hospital will also include *psychiatric health facilities* (only for acute care of a *mental or nervous disorder* or substance abuse) and *residential treatment centers*.

Independent practice association (IPA) is a *medical group* made up of a group of *doctors* who practice in private offices. The IPA has an agreement with Anthem to provide health care.

Infertility means: (1) you have a health problem your *doctor* sees as the reason you are unable to have a baby; or (2) you are unable to get pregnant or to carry a pregnancy to a live birth after a year or more of having sex without birth control.

Investigative 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 *doctors* with an agreement with Anthem to provide health care.

Medically necessary procedures, services, supplies or equipment are those that your *medical group* or Anthem decides are:

- ◆ Appropriate and necessary for the diagnosis or treatment of the medical condition.
- ◆ Provided for the diagnosis or direct care and treatment of the medical condition.
- ◆ Within standards of good medical practice within the organized medical community.
- ◆ Not primarily for your convenience, or for the convenience of your *doctor* or another provider.
- ◆ Not more costly than an alternative service or sequence of services that is medically appropriate and is likely to produce equivalent therapeutic or diagnostic results in regard to the

diagnosis or treatment of the patient's illness, injury, or condition.

- ◆ 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:
 - 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
 - Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
 - 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 person who gets the health plan from his or her employer or an enrolled family member. An employee may enroll in only one health plan provided by Anthem, or any of its affiliates, which is sponsored by the *group*.

Membership Change Form is a form you need to make changes in your health plan. You may need a new *medical group*, or to add a new family member. Ask your employer for the form if you need it.

Mental or nervous disorders are health problems that affect:

- ◆ Your thinking and your ability to figure things out.
- ◆ The way you see or hear things.

- ◆ The way you feel.
- ◆ The way you act.

A mental or nervous disorder is seen mainly as symptoms or signs that are distortions of normal thinking, seeing, feeling, or acting. This is true no matter what the cause of the disorder may be.

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.

Open Enrollment is a period of time each year that you can change your *plan* options. You can also add or drop eligible family members if you need to. Talk to your employer about when Open Enrollment takes place.

Participating Employer is an employer that has a *participation agreement* in effect with SISC as of the employee’s effective date.

Plan is the set of benefits talked about in this booklet. From time to time, there may be some changes in what is covered depending on the *agreement* we have with your employer. If changes are made to the plan, you will get a new booklet or a copy of an amendment showing the changes that were made.

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, and are to become effective in accordance with those laws, including but not limited to, the Patient Protection and Affordable Care Act (PPACA). Sources for determining which services are recommended include the following:

- ◆ Services with an “A” or “B” rating from the United States Preventive Services Task Force (USPSTF);

- ◆ Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- ◆ 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
- ◆ Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.

Please call Customer Service using the number 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 doctor is a *doctor* who is a member of the *medical group* you have chosen to give you health care. *Primary care doctors* include general and family practitioners, internists and pediatricians. Certain *specialists* as we may approve may also be designated *primary care doctors*.

Prior plan is a plan sponsored by your employer which was replaced by this *plan* within 60 days of when it ended. You are considered covered under the prior plan if you:

- ◆ Were covered under the prior plan on the date that plan ended;
- ◆ Properly enrolled for coverage within 31 days of this *plan's* effective date; and
- ◆ Had coverage terminate solely due to the prior plan's ending.

Prosthetic devices take the place of a body part that does not work or is missing. These include orthotic devices, rigid or semi-supportive devices which may support the motion of a weak or diseased part of the body.

Psychiatric emergency medical condition is a *mental or nervous disorder* that manifests itself by acute symptoms of sufficient severity that the patient is either:

- ◆ An immediate danger to himself or herself or to others, or
- ◆ Immediately unable to provide for or utilize food, shelter, or clothing due to the *mental or nervous disorder*.

Psychiatric health facility is a 24-hour facility, that is:

- ◆ Licensed by the California Department of Health Services.
- ◆ Qualified to provide short-term inpatient treatment.
- ◆ Accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHCO).
- ◆ Staffed by a professional staff which includes a *doctor* as medical director.

Residential treatment center is an inpatient treatment facility where the *member* resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation of *mental or nervous disorders* 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 employee of the group employer who meets the group employer's rules for retirement. A retired employee may enroll in only one health plan provided by Anthem, or any of its affiliates, which is sponsored by the *group*.

Severe mental disorders include the following psychiatric diagnoses listed 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).

Single source brand name drugs are drugs with no generic substitute.

Skilled nursing facility is a place that gives 24-hour skilled nursing services. It must be licensed and be seen as a skilled nursing facility under Medicare.

Stay is when you are admitted as an inpatient to a *hospital* or nursing facility. It starts when you are admitted to a facility and ends when you are discharged from that facility.

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

Specialty care center means a center that is accredited or designated by an agency of the State of California or the federal government or by a voluntary national health organization having

special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

Standing referral means a referral by a *primary care doctor* to a *specialist* for more than one visit to the *specialist*, as indicated in the treatment plan, if any, without the *primary care doctor* having to provide a specific referral for each visit.

Surgery center is a facility (not a *hospital* or *doctor's* office) that does surgery when you do not have to stay overnight. The center must be licensed and meet the standards of JCAHCO.

Totally disabled means because of illness or injury, you cannot work for income at any job that you are trained for and you are unemployed. If you are retired, it means you cannot do all the activities usual for a person of your age. For a family member it means he or she cannot do all the activities usual for persons of that age.

Urgent care means the services you get for a sudden, serious, or unexpected illness, injury or condition to keep your health from getting worse. It is not an *emergency*. Care is needed right away to relieve pain, find out what is wrong, or treat the health problem.

For Your Information

Your Rights and Responsibilities as an Anthem Blue Cross Member

As an Anthem Blue Cross *member* you have certain rights and responsibilities to help make sure that you get the most from your plan and access to the best care possible. That includes certain things about your care, how your personal information is shared and how you work with us and your doctors. It's kind of like a "Bill of Rights". It helps you know what you can expect from your overall health care experience and become a smarter health care consumer.

You have the right to:

- Speak freely and privately with your doctors and other health professionals about all health care options and treatment needed for your condition, no matter what the cost or whether it's covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect, dignity, and the right to privacy.
- Privacy, when it comes to your personal health information, as long as it follows state and Federal laws, and our privacy rules.
- Get information about our company and services, and our network of doctors and other health care providers.
- Get more information about your rights and responsibilities and give us your thoughts and ideas about them.
- Give us your thoughts and ideas about any of the rules of your health care plan and in the way your plan works.
- Make a complaint or file an appeal about:
 - Your health care plan
 - Any care you get
 - Any covered service or benefit ruling that your health care plan makes

- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future; and the right to have your doctor tell you how that may affect your health now and in the future
- Participate in matters that deal with the company policies and operations.
- Get all of the most up-to-date information about the cause of your illness, your treatment and what may result from that illness or treatment from a doctor or other health care professional. When it seems that you will not be able to understand certain information, that information will be given to someone else that you choose.
- Get help at any time, by contacting your local insurance department.

You have the responsibility to:

- Choose any primary care physician (doctor), also called a PCP, who is in our network if your health care plan says that you have to have a PCP.
- Treat all doctors, health care professionals and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers and call their office if you have a delay or need to cancel.
- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- To the extent possible, understand your health problems and work with your doctors or other health care professionals to make a treatment plan that you all agree on.
- Follow the care plan that you have agreed on with your doctors or health care professionals.
- Tell your doctors or other health care professionals if you don't understand any care you're getting or what they want you to do as part of your care plan.
- Follow all health care plan rules and policies.

- Let our Customer Service department know if you have any changes to your name, address or family members covered under your plan.
- Give us, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health care plans and insurance benefits you have in addition to your coverage with us.

For details about your coverage and benefits, please read your Evidence of Coverage.

ORGAN DONATION

Each year, organ transplantation saves thousands of lives. The success rate for transplantation is rising but there are far more potential recipients than donors. More donations are urgently needed.

Organ donation is a singular opportunity to give the gift of life. Anyone age 18 or older and of sound mind can become a donor when he or she dies. Minors can become donors with parental or guardian consent.

Organ and tissue donations may be used for transplants and medical research. Today it is possible to transplant more than 25 different organs and tissues; this can save the lives of as many as eight people and improve the lives of another 50 people. Your decision to become a donor could someday save or prolong the life of someone you know, perhaps even a close friend or family member.

If you decide to become a donor, please discuss it with your family. Let your physician know your intentions as well. You may register as a donor by obtaining a donor card from the Department of Motor Vehicles. Be sure to sign the donor card and keep it with your driver's license or identification card. In California, you may also register online at:

www.donatelifecalifornia.org/

While organ donation is a deeply personal decision, please consider making this profoundly meaningful and important gift.

ANTHEM BLUE CROSS WEB SITE

Information specific to your benefits and claims history are available by calling the 800 number on your identification card or on the Anthem Blue Cross web site at www.anthem.com/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.

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

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

STATEMENT OF RIGHTS UNDER THE NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However the plan or issuer may pay for a shorter stay if the attending *doctor* (e.g., your *doctor*, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a *doctor* or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

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

This *plan*, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications

resulting from a mastectomy (including lymphedema). If you have any questions about this coverage, please contact your *medical group* or call us at the customer service telephone number listed on your ID card.



***Your Anthem Blue Cross HMO
Plan Amendment***

Anthem Blue Cross (“Anthem”) agrees to modify your Combined Evidence of Coverage and Disclosure (Evidence of Coverage) Form by this amendment. All other provisions of the Evidence of Coverage Form which are not inconsistent with this amendment remain in effect. Officers of Anthem have approved this amendment.

The following **Hearing Aid Services** benefit is added to the section called “Your Benefits at Anthem Blue Cross HMO – What We Cover”:

Hearing Aid Services	Copay
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- ◆ Covered hearing aids
(one per ear every 3 years).....**50%**

The following hearing aid services are covered when ordered by or purchased as a result of a written recommendation from:

- an otolaryngologist; or
- a state-certified audiologist.

Services include:

- Audiological evaluations to:
 - measure the extent of hearing loss; and
 - determine the most appropriate make and model of hearing aid.

These evaluations will be covered under the *plan* benefits for office visits to *doctors*.

- Hearing aids (monaural or binaural) including:
 - ear mold(s), the hearing aid instrument; and
 - batteries, cords and other ancillary equipment.
- Visits for fitting, counseling, adjustments and repairs for a one year period after receiving the covered hearing aid.

No benefits will be provided for the following:

- Charges for a hearing aid which exceeds specifications prescribed for the correction of hearing loss;
- Surgically implanted hearing devices (i.e., cochlear implants, audient bone conduction devices). *Medically necessary* surgically implanted hearing devices may be covered under your *plan's* benefits for *prosthetic devices* (see “Prosthetic Devices”).
- Charges for a hearing aid which is not determined to be *medically necessary*, or for more than one hearing aid per ear every 3 years.

The **Hearing Aid** exclusion, under the section called “Your Benefits at Anthem Blue Cross HMO – What We Do Not Cover”, is deleted and no longer in effect.

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