LLNS – Core Value Plan

Benefit Program Summary

January 1, 2016

CORE Value Plan
Employees and Retirees
Living In California without Medicare

IMPORTANT

This is a summary of highlights of the above-named Benefit Program, a component of the LLNS Health and Welfare Benefit Plan for Employees, ERISA Plan 501 and the LLNS Health and Welfare Benefit Plan for Retirees, ERISA Plan 502 (each a "Plan"). Receipt of this document and/or your participation in a Plan and any benefit programs under a Plan do not guarantee your employment or any rights or benefits under a Plan. LLNS reserves the right to amend or terminate each Plan or any benefit program(s) under a Plan at any time. Each Plan and the benefit programs referred to in this summary are governed by a Federal law (known as ERISA), which provides rights and protections to Plan participants and beneficiaries.

For more information on LLNS benefit programs, see the LLNS Health and Welfare Benefit Plan for Employees Summary Plan Description or the LLNS Health and Welfare Benefit Plan for Retirees Summary Plan Description, as applicable, available from the LLNL Benefits Office at 925-422-9955. SPDs are also available electronically at https:\\benefits.llnl.gov (for employees) or at www.llnsretireebenefits.com (for retirees).

Dear Member*:*

This Benefit Program Summary provides a complete explanation of your benefits, limitations and other *benefit program* provisions which apply to you.

Subscribers and covered family members ("*members*") are referred to in this booklet as "you" and "your". "We", "us" and "our" refers to the *benefit program*.

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

Please read this Benefit Program Summary carefully so that you understand all the benefits your *benefit program* offers. Keep this Benefit Program Summary handy in case you have any questions about your coverage.

In addition to the information contained in this Benefit Program Summary, the LLNS Health and Welfare Benefit Plan for Employees Summary Plan Description or the LLNS Health and Welfare Benefit Plan for Retirees Summary Plan Description, as applicable, contains important information about your LLNS welfare benefits. This *benefit program* is a part of the LLNS Summary Plan Description ("SPD"). The LLNS SPD applicable to you depends on whether you are an employee or a retiree and is referred to in this Benefit Program Summary as "your LLNS SPD."

For additional information:

For Employees:

LLNL Benefits Office

Mailing Address
P.O. Box 808, L-640
Livermore, CA 94551

Street Address
7000 East Ave., L-640
Livermore, CA 94550

Telephone: 925-422-9955
Fax: 925-422-8287

Web address https:\\benefits.llnl.gov

For Retirees:

Customer Care Center
844-750-5567 (866-994-LLNS)

Web address www.llnsretireebenefits.com

Claims Administrator's Web address:

www.anthem.com/ca/llns

Note: Anthem Blue Cross Life and Health Insurance Company provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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

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LLNS BENEFIT PROGRAM SUMMARY

JANUARY 1, 2016

We encourage you to review your Benefit Program Summary carefully. You should also carefully read your LLNS SPD.

ELIGIBILITY

If the *benefit program* is a High Deductible Health Plan *benefit program*, employees are only eligible to enroll in the *benefit program* if they meet the benefit program's geographic service area criteria.

Subscribers

Information about employee or retiree eligibility can be found in your LLNS Health and Welfare plan SPD.

Eligible Dependents (Family Members)

Information about dependent eligibility can be found in your LLNS Health and Welfare plan SPD.

More Information

For information on who qualifies and how to enroll:

For Employees:
LLNL Benefit Office
925-422-9955
https:\\benefits.llnl.gov

For Retirees:
Customer Care Center
844-750-5567
www.llnsretireebenefits.com

Claims Administrator's Web Address:

www.anthem.com/ca/llns

MEDICARE PRIVATE CONTRACTING PROVISION AND PROVIDERS WHO DO NOT ACCEPT MEDICARE

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

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

If you choose to enter into such a "private contract" arrangement as described above with one or more physicians or practitioners, or if you choose to obtain services from a provider who does not participate in Medicare, under the law you have in effect "opted out" of Medicare for the services provided by these physicians or other practitioners. In either case, no benefits will be paid by this Benefit Program for services rendered by these physicians or practitioners with whom you have so contracted, even if you submit a claim. You will be fully liable for the payment of the services rendered. Therefore, it is important that you confirm that your provider takes Medicare prior to obtaining services for which you wish the Benefit Program to pay.

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

TERMINATION OF COVERAGE

Information on how coverage terminates can be found in your LLNS Health and Welfare plan SPD.

Continuation of Coverage During Leave of Absence, Layoff or Retirement

Contact the LLNS Benefits Office for information about continuing your coverage in the event of an authorized leave of absence, a layoff or upon retirement.

Optional Continuation of Coverage

If your coverage or that of a Family Member ends, you and/or your Family Member may be entitled to elect continued coverage under the terms of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended and if that continued coverage ends, specified individuals may be eligible for further continuation under California law.

The Health Plan Administrator (we are not the administrator) will notify either you or a Family Member of the right to continue coverage under COBRA. However, if the event that qualifies a Family Member for this continuation is due to divorce or termination of domestic partnership, or because a child no longer qualifies as a dependent, you must inform the Health Plan Administrator within 60 days of the qualifying event in order to continue coverage. The Health Plan Administrator, in turn, will promptly give you official notice of the continuation right.

If you choose to continue coverage, you must notify us within 60 days of the date you receive notice of your COBRA continuation right from your Health Plan Administrator. The COBRA continuation coverage may be chosen for all Members within a family, or only for selected Members.

You must remit the initial subscription charge to us within 45 days after you elect COBRA continuation coverage.

Other Coverage Options Besides COBRA Continuation Coverage. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a *spouse's* plan). Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

PLAN ADMINISTRATION

Please refer to your LLNS Health and Welfare Plan SPD for Employees for more information.

Administration of the benefit program

The Benefits and Investment Committee is the benefit program *administrator* for the *benefit program* described in this Benefit Program Summary. If you have a question, you may direct it to:

Lawrence Livermore National Security, LLC
Benefits and Investment Committee

Mailing address:
P.O. Box 808, L-640
Livermore, CA 94551

Street Address:
7000 East Ave., L-640
Livermore, CA 94550

Claims under the *benefit program* are processed by Anthem Blue Cross Life and Health Insurance Company at the following address and phone number:

Anthem Blue Cross Life and Health Insurance Company
P.O. Box 60007
Los Angeles, CA 90060-007

Anthem Blue Cross Life and Health's Customer Service number is 1-866-641-1689

Group Case Number. The Group Case Number for this *benefit program* is: 175203

TYPES OF PROVIDERS

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

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

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

If you need details about a provider's license or training, or help choosing a *physician* who is right for you, call the customer service number on the back of your ID card.

How to Access Primary and Specialty Care Services

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

To make an appointment call your *physician's* office:

- Tell them you are a Prudent Buyer Plan *member*.
- Have your Member ID card handy. They may ask you for your group number, member I.D. number, or office visit copay.
- Tell them the reason for your visit.

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

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

Participating Providers Outside of California

If you are outside of the California service areas, please call the toll-free BlueCard Provider Access number on your ID card to find a *participating provider* in the area you are in. A directory of PPO Providers for outside of California is available upon request.

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

The *claims administrator* has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. *Members* seeking services from *non-participating providers* could be balance billed by the *non-participating provider* for those services that are determined to be not payable as a result of these review processes and meets the criteria set forth in any applicable state regulations adopted pursuant to state law. A claim may also be determined to be not payable due to a provider's failure to submit medical records with the claims that are under review in these processes.

Physicians. "Physician" means more than an M.D. Certain other practitioners are included in this term as it is used throughout the *benefit program.* This doesn't mean they can provide every service that a medical doctor could; it just means that the benefit program will cover expense you incur from them when they're practicing within their specialty the same as if the care were provided by a medical doctor. As with the other terms, be sure to read the definition of "Physician" to determine which providers' services are covered. Only providers listed in the definition are covered as *physicians*. Please note also that certain providers' services are covered only upon referral of an M.D. (medical doctor) or D.O. (doctor of osteopathy). Providers for whom referral is required are indicated in the definition of "physician" by an asterisk (*).

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

Contracting and Non-Contracting Hospitals. As a health care plan, the *claims administrator*, has traditionally contracted with most hospitals to obtain certain advantages for patients covered by Anthem Blue Cross and its affiliates, including Anthem Blue Cross Life and Health.

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

Centers of Medical Excellence and Blue Distinction Centers. The *claims administrator* is providing access to *Centers of Medical Excellence* (CME) network and *Blue Distinction Centers for Specialty Care (BDCSC)*. The facilities included in each of these networks are selected to provide the following specified medical services:

Transplant Services. Approved transplant facilities have been expanded to include Blue Distinction Centers for Specialty Care (BDCSC), in addition to Centers for Medical Excellence (CME).

- **Transplant Facilities.** Transplant facilities have been organized to provide services for the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures). Subject to any applicable co-payments or deductibles, *CME* and *BDCSC* have agreed to a rate they will accept as payment in full for covered services. **These procedures are covered only when performed at a CME or BDCSC.**

Approved bariatric facilities have been revised to include Blue Distinction Centers for Specialty Care (BDCSC). Centers for Medical Excellence (CME) have been removed from the list of eligible facilities to provide bariatric services.

- **Bariatric Facilities.** Hospital facilities have been organized to provide services for bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss programs. **These procedures are covered only when performed at a *BDCSC*.**

Benefits for services performed at a designated *CME* or *BDCSC* will be the same as for *participating providers*. A *participating provider* in the Prudent Buyer Plan or the Blue Cross and/or Blue Shield Plan network is not necessarily a *CME* or *BDCSC* facility.

Care Outside the United States—BlueCard Worldwide

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

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

<u>Payment Information</u>

- **Participating BlueCard Worldwide hospitals.** In most cases, you should not have to pay upfront for inpatient care at participating BlueCard Worldwide *hospitals* except for the out-of-pocket costs you normally pay (non-covered services, deductible, copays, and coinsurance). The *hospital* should submit your claim on your behalf.
- **Doctors and/or non-participating hospitals.** You will have to pay upfront for outpatient services, care received from a *physician*, and inpatient care from a *hospital* that is not a participating BlueCard Worldwide *hospital*. Then you can complete a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).
- **Contracting and Non-Contracting Hospitals.** As a health care plan, the *claims administrator*, has traditionally contracted with most hospitals to obtain certain advantages for patients covered by Anthem Blue Cross and its affiliates, including Anthem Blue Cross Life and Health.

<u>Claim Filing</u>

- **Participating BlueCard Worldwide hospitals will file your claim on your behalf.** You will have to pay the *hospital* for the out-of-pocket costs you normally pay.
- **You must file the claim** for outpatient and *physician* care, or inpatient *hospital* care not provided by a participating BlueCard Worldwide *hospital*. You will need to pay the health care provider and subsequently send an international claim form with the original bills to the *claims administrator*.

<u>Additional Information About BlueCard Worldwide Claims.</u>

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

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

Claim Forms

- International claim forms are available from the *claims administrator*, from the BlueCard Worldwide Service Center, or online at:

  www.bcbs.com/bluecardworldwide.

  The address for submitting claims is on the form.

SUMMARY OF BENEFITS

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

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

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

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

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

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

Telehealth. This *benefit program* provides benefits for covered services that are appropriately provided through telehealth, subject to the terms and conditions of the *benefit program*. In-person contact between a health care provider and the patient is not required for these services, and the type of setting where these services are provided is not limited. “Telehealth” is the means of providing

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

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

The benefits of this *benefit program* are subject to the SUBROGATION AND REIMBURSEMENT section.

IMPORTANT NOTICE ABOUT YOUR MEDICAL BENEFITS

Your *benefit program* has Utilization Review Program requirements. These are explained in the Utilization Review Program section beginning on page 47. **Your benefits may be reduced** if you do not follow the procedures outlined. If you have any questions about the Utilization Review Program requirements, call the *claims administrator* at the toll-free number on your identification card.

WARNING! This benefit program does not pay for services provided in a hospital emergency room for treatment that is not for an *emergency*. See the definition of "emergency" in the DEFINITIONS section.

MEDICAL BENEFITS

DEDUCTIBLES

Calendar Year Deductibles

Member.....**$3,000**

Family **$6,000**

NOTE: Calendar year deductible amounts made for prescription drug benefits covered through **Caremark**, your prescription drug benefits carrier, will also be applied toward the satisfaction of the Calendar Year Deductibles under this *benefit program.*

Additional Deductible

Inpatient Non-Certification Penalty Deductible **$500**

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

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

– The Calendar Year Deductible will not apply to allergy injections provided by a *participating provider*.

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

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

– The Inpatient Non-Certification Penalty Deductible will not apply to *emergency* admissions or services, services provided by a *participating provider* or to *medically necessary* inpatient facility services available to you through the BlueCard Program. See UTILIZATION REVIEW PROGRAM.

– The Inpatient Non-Certification Penalty Deductible will not apply for the remainder of the *year* once your Out-of-Pocket Amount is reached.

CO-PAYMENTS

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

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

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

***Exceptions:**

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

– There will be no Co-Payment for allergy injections provided by a *participating provider*.

– Your Co-Payment for *non-participating providers* will be the same as for *participating providers* for the following services. For non-*emergency services y*ou may be responsible for charges which exceed the *maximum allowed amount*.

a. All *emergency services*;

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

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

d. Clinical Trials.

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

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

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

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

OUT-OF-POCKET AMOUNT **

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

Per Member

- *Participating provider* and *other health care provider* **$5,000**
- *Non-participating provider* **$10,000**

Per Family

- *Participating provider* and *other health care provider* **$10,000****
- *Non-participating provider* **$20,000****

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

Note: Any expense applied to any deductible and any co-payments for prescription drugs (provided under your Caremark drug plan) will apply toward the satisfaction of the Out-of-Pocket Amount.

***Exception:** Expense which is incurred for non-covered services or supplies, or which is in excess of the *maximum allowed amount* or the *prescription drug maximum allowed amount,* will not be applied toward your Out-of-Pocket Amount.

MEDICAL BENEFIT MAXIMUMS

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

Skilled Nursing Facility

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

Home Health Care

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

Ambulatory Surgical Center

- For all covered services and supplies ..... **$350*** per visit

**Non-participating providers* only

Outpatient Hemodialysis

- For all covered services and supplies ..... **$350*** per visit

  **Non-participating providers* only

Hearing Aid Services

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

Prosthetic and Orthotic Devices

- Wigs for alopecia resulting from chemotherapy, radiation therapy or permanent hair loss due to burn injuries ..... **$3,000** during your lifetime

Physical Therapy, Physical Medicine and Occupational Therapy

- For covered outpatient services ..... **25** visits per type of therapy per *calendar year*

Chiropractic Services

- For covered outpatient services ..... **25** visits per *calendar year*

Speech Therapy and Speech-language pathology (SLP) services

- For all covered services ..... **25** visits per *calendar year*

Acupuncture

- For all covered services ..... **25** visits per *calendar year*

Transplant Services

- For covered organ and tissue donor acquisition costs ..... **$10,000** per transplant

Transplant Travel Expense

- For the Recipient and One Companion per Transplant Episode (limited to 6 trips per episode)
  - For transportation to the *CME* or *BDCSC* ..... **$250** per trip for each person for round trip coach airfare
  - For hotel accommodations ..... **$100** per day, for up to 21 days per trip, limited to one room, double occupancy
  - For expenses such as meals ..... **$25** per day for each person, for up to 21 days per trip
- For the Donor per Transplant Episode (limited to one trip per episode)
  - For transportation to the *CME* or *BDCSC* ..... **$250** for round trip coach airfare

Bariatric Travel Expense

- For the *member* (limited to three (3) trips – one pre-surgical visit, the initial surgery and one follow-up visit)
  - For transportation to the *BDCSC* ..... up to **$130** per trip

- For the companion – the initial surgery and one follow-up visit)
  - For transportation to the *BDCSC* ..... **2 trips**

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

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

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

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

Lifetime Maximum

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

DEDUCTIBLE

Calendar Year Deductibles. Under this *benefit program* there is a Calendar Year Deductible that must be satisfied in each *calendar year* before we begin to pay benefits. If only the *member* is covered under this *benefit program*, each *year* such *member* will be responsible for satisfying the Member Deductible before we begin to pay benefits. If the *member* and one or more members of the member's family are enrolled under this *benefit program,* the member of the enrolled family will not satisfy more than the Deductible amount per *member* for any one enrolled family member.

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

NOTE: Calendar year deductible amounts made for prescription drug benefits covered through **Caremark**, your prescription drug benefits carrier, will also be applied toward the satisfaction of the Calendar Year Deductibles under this *benefit program.*

Inpatient Non-Certification Penalty Deductible. Each time you are admitted to a *hospital* without properly obtaining certification, you are responsible for paying the Inpatient Non-Certification Penalty Deductible. This deductible will not apply to services for *emergency* admissions or to *medically necessary* inpatient facility services available to you through the BlueCard Program. Certification is explained in UTILIZATION REVIEW PROGRAM.

Note: You will no longer be responsible for paying any Inpatient Non-Certification Penalty Deductible for the remainder of the *year* once your Out-of-Pocket Amount is reached (see the SUMMARY OF BENEFITS section for details).

OUT-OF-POCKET AMOUNTS

Satisfaction of the Out-of-Pocket Amount. If, after you have met your Calendar Year Deductible, you pay Co-Payments equal to your Out-of-Pocket Amount per *member* during a *calendar year*, you will no longer be required to make Co-Payments for any covered services or supplies during the remainder of that *year*.

Covered charges applied to your Calendar Year Deductible will be applied to both the *participating provider* and *other health care provider* Out-of-Pocket Amount and the *non-participating provider* Out-of-Pocket Amount no matter where such charges are incurred.

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

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

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

Family Maximum Out-of-Pocket Amount. When the member and one other member of the member's family are covered under this *benefit program*, the member of the enrolled family will not satisfy more than the Out-of-Pocket Amount per *member* for any one enrolled family member.

Note: Any expense applied to any deductible and any co-payments for prescription drugs (provided under your Caremark drug plan) will apply toward the satisfaction of the Out-of-Pocket Amount.

Charges Which Do Not Apply Toward the Out-of-Pocket Amount. Charges for services or supplies not covered under this benefit program and charges which exceed the *maximum allowed amount* or the *prescription drug maximum allowed amount* will not be applied toward satisfaction of an Out-of-Pocket Amount.

YOUR MEDICAL BENEFITS

MAXIMUM ALLOWED AMOUNT

General

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

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

Example: The *benefit program* has a *member* Co-Payment of 10% for *participating provider* services after the Deductible has been met.

- The *member* receives services from a *participating* surgeon. The charge is $2,000. The *maximum allowed amount* under this *benefit program* for the surgery is $1,000. The *member's* Co-Payment responsibility when a *participating* surgeon is used is 10% of $1,000, or $100. This is what the *member* pays. The *benefit program* pays 90% of $1,000, or $900. The *participating* surgeon accepts the total of $1,000 as reimbursement for the surgery regardless of the charges.

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

- The *member* receives services from a *non-participating* surgeon. The charge is $2,000. The *maximum allowed amount* under this *benefit program* for the surgery is $1,000. The *member's* Co-Payment responsibility when a *non-participating* surgeon is used is 30% of $1,000, or $300. The *benefit program* pays the remaining 70% of $1,000, or $700. In addition, the *non-participating* surgeon could bill the *member* the difference between $2,000 and $1,000. So the *member's* total out-of-pocket charge would be $300 plus an additional $1,000, for a total of $1,300.

When you receive covered services, the *claims administrator* will, to the extent applicable, apply claim processing rules to the claim submitted. The *claims administrator* uses these rules to evaluate the claim information and determine the accuracy and appropriateness of the procedure and diagnosis codes included in the submitted claim. Applying these rules may affect the *maximum allowed amount* if the *claims administrator* determines that the procedure and/or diagnosis codes used were inconsistent with procedure coding rules and/or reimbursement policies. For example, if your provider submits a claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed, the *maximum allowed amount* will be based on the single procedure code.

Provider Network Status

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

Participating Providers. For covered services performed by a *participating provider* the *maximum allowed amount* for this *benefit program* will be the rate the *participating provider* has agreed with the *claims administrator* to accept as reimbursement for the covered services. Because *participating providers* have agreed to accept the *maximum allowed amount* as payment in full for those covered services, they should not send you a bill or collect for amounts above the *maximum allowed amount.* However, you may receive a bill or be asked to pay all or a portion of the *maximum allowed amount* to

the extent you have not met your Deductible or have a Co-Payment. Please call the customer service telephone number on your ID card for help in finding a *participating provider* or visit www.anthem.com/ca.

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

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

Non-Participating Providers and Other Health Care Providers.*

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

Providers who are not contracted for this product, but are contracted for other products, are also considered *non-participating providers*. For this *plan*, the *maximum allowed amount* for services from these providers will be one of the methods shown above unless the provider's contract specifies a different amount.

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

Please see the "Inter-Plan Programs" provision in the section entitled "GENERAL PROVISIONS" for additional information.

***Exceptions:**

– **Emergency Services.** For *emergency services,* reimbursement is based on the billed charge.

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

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

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

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

COST SHARE

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

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

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

AUTHORIZED REFERRALS

In some circumstances the *claims administrator* may authorize *participating provider* cost share amounts (Deductibles or Co-Payments) to apply to a claim for a covered service you receive from a *non-participating provider*. In such circumstance, you or your *physician* must contact the *claims administrator* in advance of obtaining the covered service. It is your responsibility to ensure that the *claims administrator* has been contacted. If the *claims administrator* authorizes a *participating provider* cost share amount to apply to a covered service received from a *non-participating provider*, you also may still be liable for the difference between the *maximum allowed amount* and the *non-participating provider's* charge. If you receive prior authorization for a *non-participating provider* due to network adequacy issues, you will not be responsible for the difference between the *non-participating provider's* charge and the *maximum allowed amount*. Please call the customer service telephone number on your ID card for *authorized referral* information or to request authorization.

CO-PAYMENTS AND BENEFIT MAXIMUMS

After you satisfy your Deductible, your Co-Payment is subtracted, the *benefit program* will pay benefits up to the *maximum allowed amount,* not to exceed any applicable Medical Benefit Maximum. The Co-Payments, and Medical Benefit Maximums are set forth in the SUMMARY OF BENEFITS.

CO-PAYMENTS

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

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

MEDICAL BENEFIT MAXIMUMS

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

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

CREDITING PRIOR BENEFIT PROGRAM COVERAGE

If you were covered by the *benefit program administrator's prior benefit program* immediately before the *benefit program administrator* signs up with the *claims administrator*, with no lapse in coverage, then you will get credit for any accrued Calendar Year Deductible and, if applicable and approved by the *claims administrator*, Out of Pocket Amounts under the *prior benefit program*. This does not apply to individuals who were not covered by the *prior benefit program* on the day before the *benefit program administrator's* coverage with the *claims administrator* began, or who join the *benefit program* later.

If the *benefit program administrator* moves from one of the *claims administrator's* plans to another, (for example, changes its coverage from HMO to PPO), and you were covered by the other product immediately before enrolling in this product with no break in coverage, then you may get credit for any accrued Calendar Year Deductible and Out of Pocket Amounts, if applicable and approved by the *claims administrator*. Any maximums, when applicable, will be carried over and charged against the Medical Benefit Maximums under this *benefit program*.

If the *benefit program administrator* offers more than one of the *claims administrator's* products, and you change from one product to another with no break in coverage, you will get credit for any accrued Calendar Year Deductible and, if applicable, Out of Pocket Amounts and any maximums will be carried over and charged against Medical Benefit Maximums under this *benefit program*.

If the *benefit program administrator* offers coverage through other products or carriers in addition to the *claims administrator's*, and you change products or carriers to enroll in this product with no break in coverage, you will get credit for any accrued Calendar Year Deductible, Out of Pocket Amount, and any Medical Benefit Maximums under this *benefit program*.

This Section Does Not Apply To You If:

- The *benefit program administrator* moves to this *plan* at the beginning of a *calendar year*;
- You change from one of the *claims administrator's* individual policies to the *benefit program administrator's* plan;
- You change employers; or

- You are a new *member* of the *benefit program administrator* who joins after the *benefit program administrator's* initial enrollment with the *claims administrator*.

CONDITIONS OF COVERAGE

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

1. You must incur this expense while you are covered under this *benefit program*. Expense is incurred on the date you receive the service or supply for which the charge is made.
2. The expense must be for a medical service or supply furnished to you as a result of illness or injury or pregnancy, unless a specific exception is made.
3. The expense must be for a medical service or supply included in MEDICAL CARE THAT IS COVERED. Additional limits on covered charges are included under specific benefits and in the SUMMARY OF BENEFITS.
4. The expense must not be for a medical service or supply listed in MEDICAL CARE THAT IS NOT COVERED. If the service or supply is partially excluded, then only that portion which is not excluded will be covered under this *benefit program*.
5. The expense must not exceed any of the maximum benefits or limitations of this *benefit program*.
6. Any services received must be those which are regularly provided and billed by the provider. In addition, those services must be consistent with the illness, injury, degree of disability and your medical needs. Benefits are provided only for the number of days required to treat your illness or injury.
7. All services and supplies must be ordered by a *physician*.

MEDICAL CARE THAT IS COVERED

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

Acupuncture. The services of a *physician* for acupuncture treatment to treat a disease, illness or injury, including a patient history visit, physical examination, treatment planning and treatment evaluation, electroacupuncture, cupping and moxibustion. The *plan* will pay for up to 25 visits during a *calendar year*

If covered charges are applied toward the Calendar Year Deductible and payment is not provided, that visit is included in the visit maximum (25 visits) for that *year*.

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

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

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

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

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

Coverage includes *medically necessary* treatment of an illness or injury by medical professionals from an ambulance service, even if you are not transported to a *hospital*. Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your *family members* or *physician* are not a covered service.

Other non-covered ambulance services include, but are not limited to, trips to:

- A *physician's* office or clinic;
- A morgue or funeral home.

If provided through the 911 emergency response system*, ambulance services are covered if you reasonably believed that a medical *emergency* existed even if you are not transported to a *hospital*.

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

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

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

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

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

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

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

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

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

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

- Transportation for the *member* to and from the *BDCSC* up to **$130** per trip for a maximum of three (3) trips (one pre-surgical visit, the initial surgery and one follow-up visit).
- Transportation for one companion to and from the *BDCSC* up to a maximum of two (2) trips (the initial surgery and one follow-up visit).
- Hotel accommodations for the *member* and one companion not to exceed **$100** per day for the pre-surgical visit and the follow-up visit, up to two (2) days per trip or as *medically necessary*. Limited to one room, double occupancy.

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

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

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

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

1. Diagnostic mammogram examinations in connection with the treatment of a diagnosed illness or injury. Routine mammograms will be covered initially under the Preventive Care Services benefit.
2. Breast cancer (BRCA) testing, if appropriate, in conjunction with genetic counseling and evaluation. When done as a *preventive care service*, BRCA testing will be covered under the Preventive Care Services benefit.
3. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.
4. Reconstructive surgery of both breasts performed to restore and achieve symmetry following a *medically necessary* mastectomy.
5. Breast prostheses following a mastectomy (see "Prosthetic Devices").

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

Chemotherapy. This includes the treatment of disease using chemical or antineoplastic agents and the cost of such agents in a professional or facility setting.

Christian Science Benefits. The following provisions relate only to charges for Christian Science treatment:

1. A Christian Science sanatorium will be considered a *hospital* under the *benefit program* if it is accredited by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.
2. The term *physician* includes a Christian Science practitioner approved and accredited by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.

Benefits for the following services will be provided when a *member* manifests symptoms of a covered illness or injury and receives Christian Science treatment for such symptoms.

1. Services provided by a Christian Science sanatorium if the *member* is admitted for active care of an illness or injury.
2. Office visits for services of a Christian Science practitioner providing treatment for a diagnosed illness or injury according to the healing practices of Christian Science.

NO BENEFITS ARE AVAILABLE FOR SPIRITUAL REFRESHMENT. All other provisions of **MEDICAL CARE THAT IS NOT COVERED** apply equally to Christian Science benefits as to all other benefits and providers of care.

Chiropractic Services. Coverage includes, spinal manipulations, adjunctive therapy, vertebral alignment, subluxation, spinal column adjustments, treatment of the spinal column, x-rays, and related office visits, up to a maximum of 25 visits per *calendar year*:

Clinical Trials. Coverage is provided for routine patient costs you receive as a participant in an approved clinical trial. The services must be those that are listed as covered by this *benefit program* for members who are not enrolled in a clinical trial.

Routine patient care costs include items, services, and drugs provided to you in connection with an approved clinical trial that would otherwise be covered by the *benefit program*.

An "approved clinical trial" is a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or another life-threatening disease or condition, from which death is likely unless the disease or condition is treated. Coverage is limited to the following clinical trials:

1. Federally funded trials approved or funded by one or more of the following:
    a. The National Institutes of Health,
    b. The Centers for Disease Control and Prevention,
    c. The Agency for Health Care Research and Quality,
    d. The Centers for Medicare and Medicaid Services,
    e. A cooperative group or center of any of the four entities listed above or the Department of Defense or the Department of Veterans Affairs,
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants, or
    g. Any of the following departments if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines (1) to be comparable to the system of peer review of investigations and studies used by the National Institutes of Health, and (2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
        i. The Department of Veterans Affairs,
        ii. The Department of Defense, or
        iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration.
3. Studies or investigations done for drug trials that are exempt from the investigational new drug application.

Participation in the clinical trial must be recommended by your physician after determining participation has a meaningful potential to benefit you. All requests for clinical trials services, including requests that are not part of approved clinical trials, will be reviewed according to the *benefit program*'s Clinical Coverage Guidelines, related policies and procedures.

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

1. The investigational item, device, or service.
2. Any item or service provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.

3. Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

4. Any item, device, or service that is paid for, by the sponsor of the trial or is customarily provided by the sponsor free of charge for any enrollee in the trial.

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

Dental Care

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

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

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

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

5. **Orthognathic surgery.** Orthognathic surgery for a physical abnormality that prevents normal function of the upper or lower jaw and is *medically necessary* to attain functional capacity of the affected part.

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

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

1. The following equipment and supplies:

   a. Blood glucose monitors, including monitors designed to assist the visually impaired, and blood glucose testing strips.

   b. Insulin pumps.

   c. Pen delivery systems for insulin administration (non-disposable).

   d. Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin.

   e. Podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes-related complications.

Items a through d above are covered under your *benefit program's* benefits for durable medical equipment (see “Durable Medical Equipment”). Item e above is covered under your *benefit program's* benefits for prosthetic devices (see "Prosthetic and Orthotic Devices").

2. Diabetes education program which:

   a. Is designed to teach a *member* who is a patient and covered members of the patient's family about the disease process and the daily management of diabetic therapy;

   b. Includes self-management training, education, and medical nutrition therapy to enable the *member* to properly use the equipment, supplies, and medications necessary to manage the disease; and

   c. Is supervised by a *physician*.

   Diabetes education services are covered under your *benefit program's* benefits for office visits to *physicians*.

3. The following items are covered as medical supplies:

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

   b. Testing strips, lancets, and alcohol swabs.

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

Diagnostic Services. Outpatient diagnostic imaging and laboratory services. This does not include services covered under the "Advanced Imaging Procedures" provision of this section.

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

1. Of no further use when medical needs end (but not disposable);

2. For the exclusive use of the patient;

3. Not primarily for comfort or hygiene;

4. Not for environmental control or for exercise; and

5. Manufactured specifically for medical use.

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

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

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

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

3. Visits for fitting, counseling, adjustments and repairs for a one year period after receiving the covered hearing aid.

Benefits are provided for two hearing aids every thirty-six (36) months.

No benefits will be provided for the following:

1. Charges for a hearing aid which exceeds specifications prescribed for the correction of hearing loss, or for more than two hearing aids every thirty-six (36) months.

2. Surgically implanted hearing devices (i.e., cochlear implants, audient bone conduction devices). *Medically necessary* surgically implanted hearing devices may be covered under your *benefit program's* benefits for prosthetic devices (see "Prosthetic and Orthotic Devices").

Hemodialysis Treatment. This includes services related to renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis home continuous cycling peritoneal dialysis and home continuous ambulatory peritoneal dialysis.

The following renal dialysis services are covered:

- Outpatient maintenance dialysis treatments in an outpatient dialysis facility;
- Home dialysis; and
- Training for self-dialysis at home including the instructions for a person who will assist with self-dialysis done at a home setting.

Treatment provided by a freestanding outpatient hemodialysis center which is a *non-participating provider* is limited to **$350** per visit.

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

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

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

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

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

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

1. Interdisciplinary team care with the development and maintenance of an appropriate plan of care.
2. Short-term inpatient *hospital* care when required in periods of crisis or as respite care. Coverage of inpatient respite care is provided on an occasional basis and is limited to a maximum of five consecutive days per admission.

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

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

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

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

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

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

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

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

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

Hospital

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

2. Services in *special care units*.

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

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

Infusion Therapy. The following services and supplies, when provided in your home by a *home infusion therapy provider* or in any other outpatient setting by a qualified health care provider, for the intravenous administration of your total daily nutritional intake or fluid requirements, including but not limited to Parenteral Therapy and Total Parenteral Nutrition (TPN), medication related to illness or injury, chemotherapy, antibiotic therapy, aerosol therapy, tocolytic therapy, special therapy, intravenous hydration, or pain management:

1. Medication, ancillary medical supplies and supply delivery, (not to exceed a 14-day supply); however medication which is delivered but not administered is not covered;

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

3. Rental and purchase charges for durable medical equipment; maintenance and repair charges for such equipment;

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

5. Total Parenteral Nutrition (TPN), Enteral Nutrition Therapy, antibiotic therapy, pain management, chemotherapy, and may also include injections (intra-muscular, subcutaneous, or continuous subcutaneous).

Please note: Only specified *participating providers* have been approved by the *claims administrator* to provide medications to treat hemophilia. To find an approved *participating provider* who can provide medications to treat hemophilia, please call the toll-free number printed on your identification card if you have any questions about making this determination. *Drugs* to treat hemophilia that you receive from a provider other than a *participating provider* approved by the *claims administrator* will be considered *non-participating provider* charges subject to the cost shares and any limitations associated with those services.

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

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

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

Mental or Nervous Disorders or Substance Abuse. Covered services shown below for the *medically necessary* treatment of *mental or nervous disorders* or substance abuse.

1. Inpatient *hospital* services and services from a *residential treatment center* as stated in the "Hospital" provision of this section, for inpatient services, and supplies.
2. Partial hospitalization, including intensive outpatient programs and visits to a *day treatment center*. Partial hospitalization is covered as stated in the "Hospital" provision of this section, for outpatient services and supplies.
3. *Physician* visits during a covered inpatient *stay*.
4. *Physician* visits for outpatient psychotherapy or psychological testing for the treatment of *mental or nervous disorders* or substance abuse. This includes nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa.

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

Online Visits. When available in your area, your coverage will include visits from a LiveHealth Online Provider. Covered services include medical consultations using the internet via webcam, chat, or voice. Online visits are covered under this *benefit program* only from providers who contract with LiveHealth Online.

Non-covered services include, but are not limited to, the following:

- Reporting normal lab or other test results.
- Office visit appointment requests or changes.
- Billing, insurance coverage, or payment questions.
- Requests for referrals to other *physicians* or healthcare practitioners.
- Benefit precertification.
- Consultations between *physicians*.
- Consultations provided by telephone, electronic mail, or facsimile machines.

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

Outpatient Private Duty Nursing. We will pay for private duty nursing services of a licensed nurse (R.N., L.P.N. or L.V.N.) for a non-hospitalized acute illness or injury, provided your *physician* orders the services as *medically necessary*.

"Private duty" means a session of four or more hours that continuous nursing care is furnished to you alone.

Outpatient private duty nursing services are subject to pre-service review to determine medical necessity. See UTILIZATION REVIEW PROGRAM for details.

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

1. Nebulizers, including face masks and tubing, inhaler spacers, and peak flow meters. These items are covered under the benefit program*'s* medical benefits and are not subject to any limitations or maximums that apply to coverage for durable medical equipment (see "Durable Medical Equipment").
2. Education for pediatric asthma, including education to enable the *child* to properly use the items listed above. This education will be covered under the *benefit program's* benefits for office visits to a *physician*.

Physical Therapy, Physical Medicine and Occupational Therapy. The following services provided by a *physician* under a treatment plan:

1. Physical therapy and physical medicine provided on an outpatient basis for the treatment of illness or injury including the therapeutic use of heat, cold, exercise, electricity, ultra violet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care which are customarily provided by physical therapists and osteopaths. It does not include massage therapy services at spas or health clubs.)
2. Occupational therapy provided on an outpatient basis when the ability to perform daily life tasks has been lost or reduced by, or has not been developed due to, illness or injury including programs which are designed to rehabilitate mentally, physically or emotionally handicapped persons. Occupational therapy programs are designed to maximize or improve a patient's upper extremity function, perceptual motor skills and ability to function in daily living activities.

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

Up to 25 visits per type of therapy in a *calendar year* for all covered services are payable, if *medically necessary*.

If covered charges are applied toward the Calendar Year Deductible and payment is not provided, that visit will be included in the visit maximum (25 visits per type of therapy) for that *year*.

If you receive *chiropractic services* from a *non-participating provider* and you need to submit a claim to the *claims administrator*, please send it to the address listed below. If you have any questions or are in need of assistance, please call the customer service telephone number listed on your ID card.

American Specialty Health
P.O. Box 509001
San Diego, CA 92150-9002

Pregnancy and Maternity Care

1. All medical benefits for a *member* when provided for pregnancy or maternity care, including the following services:

a. Prenatal, postnatal and postpartum care;

b. Ambulatory care services (including ultrasounds, fetal non-stress tests, *physician* office visits, and other *medically necessary* maternity services performed outside of a *hospital*);

c. Involuntary complications of pregnancy;

d. Diagnosis of genetic disorders in cases of high-risk pregnancy; and

e. Inpatient *hospital* care including labor and delivery.

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

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

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

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

Prescription Drugs Obtained From Or Administered By a Medical Provider. Your *benefit program* includes benefits for *prescription drugs* when they are administered to you as part of a *physician* visit, services from a *home health agency*, or at an outpatient *hospital*. This includes *drugs* for infusion therapy, chemotherapy, blood products and any drug that must be administered by a *physician*. This section describes your benefits when your *physician* orders the medication and administers it to you.

If you receive medications to treat hemophilia, please see the note for your benefits under the "Infusion Therapy or Home Infusion Therapy" provision of this section.

Benefits for *drugs* that you inject or get at a retail *pharmacy* (i.e., self-administered *drugs*) are not covered under this section.

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

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

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

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

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

If you have any questions regarding whether a *specialty pharmacy drug* requires prior authorization, please call 1-800-700-2541 (or TTY/TDD 1-800-905-9821).

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

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

1. A *physician's* services for routine physical examinations.
2. Immunizations prescribed by the examining *physician.*
3. Radiology and laboratory services and tests ordered by the examining *physician* in connection with a routine physical examination, excluding any such tests related to an illness or injury. Those radiology and laboratory services and tests related to an illness or injury will be covered as any other medical service available under the terms and conditions of the provision “Diagnostic Services”.
4. Health screenings as ordered by the examining *physician* for the following: breast cancer, including BRCA testing if appropriate (in conjunction with genetic counseling and evaluation), cervical cancer, including human papillomavirus (HPV), prostate cancer, colorectal cancer, and other medically accepted cancer screening tests, blood lead levels, high blood pressure, type 2 diabetes mellitus, cholesterol, obesity, and screening for iron deficiency anemia in pregnant women.
5. Human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.
6. Counseling and risk factor reduction intervention services for sexually transmitted infections, human immunodeficiency virus (HIV), contraception, tobacco use, and tobacco use-related diseases.
7. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:

a. All FDA-approved contraceptive *drugs*, devices and other products for women, including over-the-counter items, if prescribed by a *physician*. This includes contraceptive *drugs*, injectable contraceptives, patches and devices such as diaphragms, intra uterine devices (IUDs) and implants, as well as voluntary sterilization procedures, contraceptive education and counseling. It also includes follow-up services related to the *drugs*, devices, products and procedures, including but not limited to management of side effects, counseling for continued adherence, and device insertion and removal.

   At least one form of contraception in each of the methods identified in the FDA's Birth Control Guide will be covered as preventive care under this section. If there is only one form of contraception in a given method, or if a form of contraception is deemed not medically advisable by a *physician*, the prescribed FDA-approved form of contraception will be covered as preventive care under this section.

   In order to be covered as preventive care, contraceptive *prescription drugs* must be either a *generic* or *single-source brand name drug* (those without a *generic* equivalent). *Multi-source brand name drugs* (those with a *generic* equivalent) will be covered as *preventive care services* when *medically necessary*.

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

c. Gestational diabetes screening.

d. Preventive prenatal care.

8. Preventive services for certain high-risk populations as determined by your *physician*, based on clinical expertise.

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

See the definition of "Preventive Care Services" in the DEFINITIONS section for more information about services that are covered by this *benefit program* as *preventive care services*.

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

https://www.healthcare.gov/what-are-my-preventive-care-benefits

http://www.ahrq.gov

http://www.cdc.gov/vaccines/acip/index.html

Professional Services

1. Services of a *physician*.

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

Prosthetic and Orthotic Devices

1. Breast prostheses following a mastectomy.

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

3. The *benefit program* will pay for other *medically necessary prosthetic devices,* including:

   a. Surgical implants;

b. Artificial limbs or eyes; and

c. The first pair of contact lenses or eye glasses when required as a result of a covered *medically necessary* eye surgery.

d. Scalp hair prostheses when required as a result of hair loss due to alopecia areata or alopecia totalis, chemotherapy, radiation therapy or permanent hair loss due to burn injuries, limited to **$3,000** during your lifetime;

e. Therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications; and

f. Orthopedic footwear used as an integral part of a brace; shoe inserts that are custom molded to the patient.

Radiation Therapy. This includes treatment of disease using x-ray, radium or radioactive isotopes, other treatment methods (such as teletherapy, brachytherapy, intra operative radiation, photon or high energy particle sources), material and supplies used in the therapy process and treatment planning. These services can be provided in a facility or professional setting.

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

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

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

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

If covered charges are applied toward the Calendar Year Deductible and payment is not provided, those days will be included in the 240 days for that *year*.

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

Speech Therapy and Speech-language pathology (SLP) services. Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy that will develop or treat communication or swallowing skills to correct a speech impairment. Speech therapy following injury, illness or other medical condition, as *medically necessary*.

Up to 25 visits in a *calendar year* for all covered services are payable if *medically necessary*.

If covered charges are applied toward the Calendar Year Deductible and payment is not provided, that visit will be included in the visit maximum (25 visits) for that *year*.

Sterilization Services. Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered.

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

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

1. The organ or tissue recipient; or
2. The organ or tissue donor.

Organ and tissue donor acquisition costs are limited to **$10,000** per transplant.

Benefits for an organ donor are as follows:

- When both the person donating the organ and the person getting the organ are covered *members* under this *benefit program*, each will get benefits under their plans.
- When the person getting the organ is a *member* under this *benefit program*, but the person donating the organ is not, benefits under this *benefit program* are limited to benefits not available to the donor from any other source. This includes, but is not limited to, other insurance, grants, foundations, and government programs.
- If a *member* covered under this *benefit program* is donating the organ to someone who is **not** a *member*, benefits are not available under this *benefit program*.

The *maximum allowed amount* does not include charges for services received without first obtaining the *claims administrator's* prior authorization or which are provided at a facility other than a transplant center approved by us. See UTILIZATION REVIEW PROGRAM for details.

To maximize your benefits, you should call the Transplant Department as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation or work-up for a transplant. The *claims administrator* will help you maximize your benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, *Centers of Medical Excellence (CME)* or *Blue Distinction Centers for Specialty Care (BDCSC)* rules, or exclusions apply. Call the customer service phone number on the back of your ID card and ask for the transplant coordinator.

You or your *physician* must call the Transplant Department for pre-service review prior to the transplant, whether it is performed in an inpatient or outpatient setting. Prior authorization is required before the *benefit program* will provide benefits for a transplant. Your *physician* must certify, and the *claims administrator* must agree, that the transplant is *medically necessary*. Your *physician* should send a written request for prior authorization to the *claims administrator* as soon as possible to start this process. Not getting prior authorization will result in a denial of benefits.

Please note that your *physician* may ask for approval for HLA (human leukocyte antigen) testing, donor searches, or collection and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges will be covered as routine diagnostic tests. The collection and storage request will be reviewed for medical necessity and may be approved. However, such an approval for HLA testing, donor search, or collection and storage is NOT an approval for the later transplant. A separate medical necessity decision will be needed for the transplant itself.

Specified Transplants

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

Transplant Travel Expense. The following travel expenses in connection with an approved, specified organ transplant (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures) performed at a specific *CME* or *BDCSC* only when the recipient or donor's home is more than 75 miles from the specific CME or BDCSC, provided the expenses are approved by the *claims administrator* in advance:

1. For the recipient and a companion, per transplant episode, up to six trips per episode:
   - Round trip coach airfare to the *CME* or *BDCSC*, not to exceed **$250** per person per trip.
   - Hotel accommodations, not to exceed **$100** per day for up to 21 days per trip, limited to one room, double occupancy.
   - Other expenses, such as meals, not to exceed **$25** per day for each person, for up to 21 days per trip.
2. For the donor, per transplant episode, limited to one trip:
   - Round trip coach airfare to the *CME* or *BDCSC*, not to exceed **$250**.

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

MEDICAL CARE THAT IS NOT COVERED

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

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

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

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

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

Uninsured. Services received before your *effective date* or after your coverage ends.

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

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

Waived Cost-Shares Non-Participating Provider. For any service for which you are responsible under the terms of this *benefit program* to pay a co-payment or deductible, and the co-payment or deductible is waived by a *non-participating provider*.

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

Government Treatment. Any services you actually received that were provided by a local, state or federal government agency, or by a public school system or school district, except when payment under this *benefit program* is expressly required by federal or state law. The *benefit program* 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 *benefit program*.

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

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

1. It must be internationally known as being devoted mainly to medical research;

2. At least **10%** of its yearly budget must be spent on research not directly related to patient care;

3. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;

4. It must accept patients who are unable to pay; and

5. Two-thirds of its patients must have conditions directly related to the *hospital's* research.

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

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

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

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

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

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

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

This exclusion does not apply to the following:

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

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

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

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

Speech Therapy. Speech therapy except as stated in the "Speech Therapy and Speech language pathology (SLP)" provision of MEDICAL CARE THAT IS COVERED.

Scalp hair prostheses. Scalp hair prostheses, including wigs or any form of hair replacement, except as specifically stated in the "Prosthetic and Orthotic Devices" provision.

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

Commercial Weight Loss Programs. Weight loss programs not approved by the *claims administrator*, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this *benefit program*.

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

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

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

Sterilization Reversal. Reversal of an elective sterilization.

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

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

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

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

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

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

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

Education or Counseling. Educational services or nutritional counseling; however, such services are provided under the "Infusion Therapy", "Pediatric Asthma Equipment and Supplies" or "Diabetes" provisions of MEDICAL CARE THAT IS COVERED; including "Preventive Care Services". This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

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

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this *benefit program* or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

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

Routine Exams or Tests. Routine physical exams or tests required by employment or government authority .

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

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

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

Outpatient Prescription Drugs and Medications. Outpatient *prescription drugs* or medications and insulin, except as specifically stated in the “Prescription Drug for Abortion”, or “Preventive Care Services” provisions of MEDICAL CARE THAT IS COVERED. Non-prescription, over-the-counter patent or proprietary drugs or medicines, except as specifically stated in this *benefit program*. Cosmetics, health or beauty aids. However, health aids that are *medically necessary* and meet the requirements for durable medical equipment as specified under the “Durable Medical Equipment” provision of MEDICAL CARE THAT IS COVERED, are covered, subject to all terms of this *benefit program* that apply to that benefit.

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

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse, except as specifically stated in “Outpatient Private Duty Nursing” provision of MEDICAL CARE THAT IS COVERED.

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

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

SUBROGATION AND REIMBURSEMENT

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

Subrogation

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

- The *benefit program* has first priority from any Recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- You and your legal representative must do whatever is necessary to enable the *benefit program* to exercise the *benefit program*'s rights and do nothing to prejudice those rights.
- In the event that you or your legal representative fail to do whatever is necessary to enable the *benefit program* to exercise its subrogation rights, the *benefit program* shall be entitled to deduct the amount the *benefit program* paid from any future benefits under the *benefit program*.
- The *benefit program* has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the *benefit program*.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the *benefit program*'s subrogation claim and any claim held by you, the *benefit program*'s subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- The *benefit program* is not responsible for any attorney fees, attorney liens, other expenses or costs you incur without the *benefit program*'s prior written consent. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the *benefit program*.

Reimbursement

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

- You must reimburse the *benefit program* from any Recovery to the extent of benefits the *benefit program* paid on your behalf regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- Notwithstanding any allocation or designation of your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the *benefit program* shall have a right of full recovery, in first priority, against any Recovery. Further, the *benefit program*'s rights will not be reduced due to your negligence.
- You and your legal representative must hold in trust for the *benefit program* the proceeds of the gross Recovery (*i.e.*, the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the *benefit program* immediately upon your receipt of the Recovery. You must reimburse the *benefit program*, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the *benefit program*.

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

    1. The amount the *benefit program* paid on your behalf is not repaid or otherwise recovered by the *benefit program*; or

    2. You fail to cooperate.

- In the event that you fail to disclose the amount of your settlement to the *benefit program*, the *benefit program* shall be entitled to deduct the amount of the *benefit program*'s lien from any future benefit under the *benefit program*.

- The *benefit program* shall also be entitled to recover any of the unsatisfied portion of the amount the *benefit program* has paid or the amount of your Recovery, whichever is less, directly from the Providers to whom the *benefit program* has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the *benefit program* will not have any obligation to pay the Provider or reimburse you.

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

Your Duties

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

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

- You must not do anything to prejudice the *benefit program*'s rights.

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

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

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

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

The *benefit program* is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

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

COORDINATION OF BENEFITS

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

DEFINITIONS

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

Allowable Expense is any necessary, reasonable and customary item of expense which is at least partially covered by any 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. An expense that is not covered by any plan covering the person for whom a claim is made is not Allowable Expense.

The following are not Allowable Expense:

1. Use of a private hospital room is not an Allowable Expense unless the patient's stay in a private *hospital* room is *medically necessary* in terms of generally accepted medical practice, or one of the plans routinely provides coverage for *hospital* private rooms.

2. If you are covered by two plans that calculate benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method, any amount in excess of the higher of the reasonable and customary amounts.

3. If a person is covered by two plans that provide benefits or services on the basis of negotiated rates or fees, an amount in excess of the lower of the negotiated rates.

4. If a person is covered by one plan that calculates its benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method and another plan provides its benefits or services on the basis of negotiated rates or fees, any amount in excess of the negotiated rate.

5. The amount of any benefit reduction by the Principal Plan because you did not comply with the plan's provisions is not an Allowable Expense. Examples of these types of provisions include second surgical opinions, utilization review requirements, and network provider arrangements.

6. If you advise us that all plans covering you are high deductible health plans as defined by Section 223 of the Internal Revenue Code, and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code, any amount that is subject to the primary high deductible health plan's deductible.

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

The following criteria are used to create a Benefit Reserve:

1. If this *benefit program* is not the Principal Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed Allowable Expense.

2. The benefits of this *benefit program* will never be greater than the sum of the benefits that would have been paid if you were covered only under this *benefit program.*

3. If this *benefit program* is the Principal Plan, the benefits under this *benefit program* will be determined without taking into account the benefits or services of any Other Plan. When this

benefit program is the Principal Plan, nothing will be applied to this *benefit program's* Benefit Reserve.

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

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage;
2. Group service plan contract, group practice, group individual practice and other group prepayment coverages;
3. Group coverage under labor-management trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.

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

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

This Benefit Program is that portion of this *benefit program* which provides benefits subject to this provision.

EFFECT ON BENEFITS

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

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

EFFECT OF THE BENEFIT RESERVE ON PLAN BENEFITS

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

The Benefit Reserve is determined by subtracting the amount the Principal Plan paid from the amount this *benefit program* would have paid had it been the Principal Plan.

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

ORDER OF BENEFITS DETERMINATION

The first of the following rules which applies will determine the order in which benefits are payable:

1. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision.

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

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

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

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

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

   b. If the parent with custody of that *child* for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:

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

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

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

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

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

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

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

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

OUR RIGHTS UNDER THIS PROVISION

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

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

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

Right of Recovery. If payments made under this *benefit program* exceed the maximum payment necessary to satisfy the intent of this provision, the *claims administrator* has the right to recover that excess amount from any persons or organizations to or for whom those payments were made, or from any insurance company or service plan.

BENEFITS FOR MEDICARE ELIGIBLE MEMBERS

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

1. You are receiving treatment for end-stage renal disease following the first 30 months you are entitled to end-stage renal disease benefits under Medicare; or
2. You are entitled to Medicare benefits as a disabled person, unless you have a current employment status as determined by Medicare rules through a *group* of 100 or more employees (according to federal COBRA legislation).

In cases where exceptions 1 or 2 apply, our payment will be determined according to the provisions in the section entitled COORDINATION OF BENEFITS and the provision "Coordinating Benefits With Medicare", below.

For Retired Employees and Their Spouses. If you are a *retired employee* or the spouse of a *retired employee* and you are not eligible for Medicare because you did not attain the required number of quarters for Social Security, or you are under 65 and not yet eligible for Medicare, you are eligible for benefits under this plan.

Electronic Claims Coordination

If you are covered by Medicare, call the *claims administrator's* Customer Service unit at 1 (877) 359-9654 and give them your Medicare number. The *claims administrator* will load it to their membership system, which will permit the *claims administrator* to electronically receive your Medicare EOB. This will allow the *claims administrator* to generate your LLNS benefit without you having to submit a claim to the *claims administrator*.

UTILIZATION REVIEW PROGRAM

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

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

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

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

This *benefit program* 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. Their *benefit program* requires that covered services be *medically necessary* for benefits to be provided.

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

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

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

UTILIZATION REVIEW REQUIREMENTS AND EFFECT ON BENEFITS

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

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

The appropriate utilization reviews must be performed in accordance with this *benefit program*. When pre-service review is not performed as required for the services listed below, the benefits to which you

would have been otherwise entitled will be subject to the Inpatient Non-Certification Penalty Deductible shown in the SUMMARY OF BENEFITS.

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

  Exceptions: Pre-service review is not required for inpatient *hospital stays* for the following services:

  - Maternity care of 48 hours or less following a normal delivery or 96 hours or less following a cesarean section, and
  - Mastectomy and lymph node dissection.

- Specific non-emergency outpatient services, including diagnostic treatment and other services.
- Specific outpatient surgeries performed in an outpatient facility or a doctor's office.

When pre-service review is performed and the admission, procedure or service is determined to be *medically necessary* and appropriate, benefits will be provided for the following:

- Transplant services, including transplant travel expense. The following criteria must be met for certain transplants, as follows:

  - For bone, skin or cornea transplants, the *physicians* on the surgical team and the facility in which the transplant is to take place must be approved for the transplant requested.
  - For transplantation of heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney or bone marrow/stem cell and similar procedures, the providers of the related preoperative and postoperative services must be approved.

- Air ambulance in a non-medical *emergency*.
- Admissions to a *skilled nursing facility*, if you require daily skilled nursing or rehabilitation, as certified by your attending *physician*.
- Bariatric surgical services, such as gastric bypass and other surgical procedures for weight loss, including bariatric travel expense, if:

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

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

  c. The bariatric surgical procedure will be performed at a *BDCSC* facility.

- Outpatient private duty nursing care services.
- Advanced imaging procedures, including but not limited to: Magnetic Resonance Imaging (MRI), Computerized Tomography (CT scan), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography and Nuclear Cardiac Imaging. You may call the toll-free customer service telephone number on your identification card to find out if an imaging procedure requires pre-service review.

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

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

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

HOW TO OBTAIN UTILIZATION REVIEWS

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

Pre-service Reviews. Penalties will result for failure to obtain required pre-service review, before receiving scheduled services, as follows:

1. For all scheduled services that are subject to utilization review, you or your *physician* must initiate the pre-service review at least five working days prior to when you are scheduled to receive services.

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

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

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

Care Coordination Reviews

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

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

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

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

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

Retrospective Reviews

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

  It may also be performed for the evaluation and audit of medical documentation after services have been provided, whether or not pre-service or care coordination review was performed.
- Such services which have been retroactively determined to not be *medically necessary* and appropriate will be retrospectively denied certification.

DECISION AND NOTICE REQUIREMENTS

The *claims administrator* will review requests for medical necessity according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, the *benefit program* will follow state laws. If you live in and/or get services in a state other than the state where your *benefit program* was issued, other state-specific requirements may apply. You may call the phone number on the back of your identification card for more details.

Request Category	Timeframe Requirement for Decision
Pre-service urgent	72 hours from the receipt of the request
Pre-service non-urgent	5 business days from the receipt of the request
Care coordination review when hospitalized at the time of the request and no previous authorization exists	72 hours from the receipt of the request
Care coordination review urgent when request is received at least 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Care coordination review urgent when request is received less than 24 hours before the end of the previous authorization	72 hours from the receipt of the request
Care coordination review non-urgent	5 business days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If more information is needed to make a decision, the *claims administrator* will follow state and federal law and tell the requesting *physician* and send written notice to you or your authorized representative of the specific information needed to finish the review. If the *benefit program* does not get the specific information it needs or if the information is not complete by the timeframe identified in the written notice, the *claims administrator* will make a decision based upon the information received.

The *claims administrator* will give notice of a decision as required by state and federal law. Notice may be given by the following methods:

- **Verbal:** Oral notice given to the requesting *physician* by phone or by electronic means if agreed to by the *physician*.

- **Written:** Mailed letter or electronic means including email and fax given to, at a minimum, the requesting *physician* and you or your authorized representative.

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

- The information submitted with the claim differs from that given by phone;
- The service is excluded from coverage;
- You must not have exceeded any applicable limits under this *benefit program*; or
- You are not eligible for coverage when the service is actually provided.

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

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

For a copy of the medical necessity review process, please contact customer service at the telephone number on the back of your identification card.

HEALTH PLAN INDIVIDUALCASE MANAGEMENT

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

HOW HEALTH PLAN INDIVIDUALCASE MANAGEMENT WORKS

The health plan individual case management program (Case Management) helps coordinate services for *members* with health care needs due to serious, complex, and/or chronic health conditions. The programs coordinate benefits and educate *members* who agree to take part in the Case Management program to help meet their health-related needs.

The Case Management programs are confidential and voluntary, and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any covered services you are receiving.

If you meet program criteria and agree to take part, then *claims administrator* will help you meet your identified health care needs. This is reached through contact and team work with you and /or your chosen authorized representative, treating *physicians*, and other providers.

In addition, the *claims administrator* may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

Alternative Treatment Plan. In certain cases of severe or chronic illness or injury, the *benefit program* may provide benefits for alternate care that is not listed as a covered service. The *claims administrator* may also extend services beyond the benefit maximums of this *benefit program*. A decision will be made case-by-case, if in the *claims administrator's* discretion the alternate or extended benefit is in the best interest of the *member* and the *benefit program*. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to you or to any other member. The *claims administrator* reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, the *claims administrator* will notify you or your authorized representative in writing.

EXCEPTIONS TO THE UTILIZATION REVIEW PROGRAM

From time to time, the *claims administrator* may waive, enhance, modify, or discontinue certain medical management processes (including utilization management, case management, and disease management) if, in their discretion, such a change furthers the provision of cost effective, value based and quality services. In addition, the *claims administrator* 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. The *claims administrator* may also exempt claims from medical review if certain conditions apply.

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

The *claims administrator* also may identify certain providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a provider is selected under this program, then the *claims administrator* may use one or more clinical utilization management guidelines in the review of claims submitted by this provider, even if those guidelines are not used for all providers delivering services to this *benefit program's members*.

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

QUALITY ASSURANCE

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

HIPAA COVERAGE

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

HIPAA Coverage

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

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

You must apply for HIPAA coverage within 63 days of the date your coverage under the employer's *benefit program* ends. Any carrier or health plan that offers individual medical coverage must make HIPAA coverage available to qualified persons without regard to health status.

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

GENERAL PROVISIONS

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

Independent Contractors. The *claims administrator's* relationship with providers is that of an independent contractor. *Physicians,* and other health care professionals, *hospitals, skilled nursing facilities* and other community agencies are not their agents nor is the *claims administrator*, or any of the employees of the *claims administrator*, an employee or agent of any *hospital,* medical group or medical care provider of any type.

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

Inter-Plan Programs

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

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

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

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

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

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

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

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

3. Non-Participating Health Care Providers Outside Our Service Area

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

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

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

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

Terms of Coverage

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

Nondiscrimination. No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age.

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

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

Transition Assistance for New *Members*: Transition Assistance is a process that allows for completion of covered services for new *members* receiving services from a *non-participating provider*.

If you are a new *member*, you may request Transition Assistance if any one of the following conditions applies:

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

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

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

Continuity of Care after Termination of Provider: Subject to the terms and conditions set forth below, benefits will be provided at the *participating provider* level for covered services (subject to applicable copayments, coinsurance, deductibles and other terms) received from a provider at the time the provider's contract with the *claims administrator* terminates (unless the provider's contract terminates for reasons of medical disciplinary cause or reason, fraud, or other criminal activity).

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

Benefits for the completion of covered services by a terminated provider will be provided only for the following conditions:

- 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 the *claims administrator* in consultation with you and the terminated provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.
- 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 provider's contract terminates.
- Performance of a surgery or other procedure that the *claims administrator* has authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the date the provider's contract terminates.

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

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

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

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

Other forms of payment arrangement are Payment Innovation Programs. These programs may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner. The programs may vary in methodology and subject area of focus and may be modified by the *plan administrator* from time to time, but they will be generally designed to tie a certain portion of a *participating provider's* total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, *participating providers* may be required to make payment to the *benefit program* under the program as a consequence of failing to meet these pre-defined standards. The programs are not intended to affect the *member's* access to health care. The program payments are not made as payment for specific covered services provided to the *member*, but instead, are based on the *participating provider's* achievement of these pre-defined standards. The *member* is not responsible for any co-payment amounts related to payments made by the *benefit program* or to the *benefit program* under the programs and the member does not share in any payments made by *participating providers* to the *benefit program* under the programs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Financial Arrangements with Providers. The *claims administrator* or an affiliate has contracts with certain health care providers and suppliers (hereafter referred to together as "Providers") for the provision of and payment for health care services rendered to its members and *members* entitled to health care benefits under individual certificates and group policies or contracts to which *claims administrator* or an affiliate is a party, including all persons covered under the *benefit program*.

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

Voluntary Clinical Quality Programs. The claims administrator may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from covered services under your *benefit program*. These programs are not guaranteed and could be discontinued at any time. The claims administrator will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards or retailer coupons, which we encourage you to use for health and wellness related activities or items. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may also be offered a home visit appointment to collect such specimens and complete biometric screenings. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit or the home visit. If you have any questions about whether receipt of a gift card or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

New Programs Incentives. The *plan administrator* may offer incentives from time to time at their discretion in order to introduce you to new programs and services available under this *benefit program*. These incentives may be offered in various forms (such as discounts on fees, and/or retailer coupons) and are intended to encourage you to try the new programs and services. Acceptance of these incentives is voluntary as long as the *benefit program* offers the incentives program. The *plan administrator* may discontinue an incentive for a particular new service or program at any time. If you have any questions about whether receipt of an incentive or retailer coupon results in taxable income to you, please consult your tax advisor.

DEFINITIONS

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

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

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

Authorized referral occurs when you, because of your medical needs, require the services of a specialist who is a *non-participating provider,* or require special services or facilities not available at a *contracting hospital*, but only when the referral has been authorized by the *plan administrator* before services are rendered and when the following conditions are met:

1. There is no *participating provider* who practices in the appropriate specialty, or there is no *contracting hospital* which provides the required services or has the necessary facilities; and;
2. That meets the adequacy and accessibility requirements of state or federal law.

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

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

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

Benefit Program refers to the "PPO Plan for Employees."

Blue Distinction Centers for Specialty Care (BDCSC) are health care providers designated by the *claims administrator* as a selected facility for specified medical services. A provider participating in a BDCSC network has an agreement in effect with the *claims administrator* at the time services are rendered or is available through their affiliate companies or our relationship with the Blue Cross and Blue Shield Association. BDCSC agree to accept the *maximum allowed amount* as payment in full for covered services.

Benefits for services performed at a designated *BDCSC* will be the same as for *participating providers*. A *participating provider* in the Prudent Buyer Plan network or the Blue Cross and/or Blue Shield Plan is not necessarily a *BDCSC* facility.

Centers of Medical Excellence (CME) are health care providers designated by the *claims administrator* as a selected facility for specified medical services. A provider participating in a CME network has an agreement in effect with the *claims administrator* at the time services are rendered or is available through their affiliate companies or their relationship with the Blue Cross and Blue Shield Association. CME agree to accept the *maximum allowed amount* as payment in full for covered services.

Benefits for services performed at a designated *CME* will be the same as for *participating providers*. A *participating provider* in the Prudent Buyer Plan network or the Blue Cross and/or Blue Shield Plan is not necessarily a *CME* facility.

Child meets the eligibility requirements for children outlined in the LLNS SPD.

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

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

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

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 *benefit program* is no more than 180 days (not including any waiting period imposed under this *benefit program* by the employer).

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 *benefit program* is no more than 63 days (not including any waiting period imposed under this *benefit program* by the employer).

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

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

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

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

Effective date is the date your coverage begins under this *benefit program*.

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

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

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

Family Member meets the eligibility requirements for family members outlined in the LLNS SPD.

Full-time employee meets the eligibility requirements for full-time employees outlined in the LLNS SPD.

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

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

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

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

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

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

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

LLNL refers to Lawrence Livermore National Laboratory.

LLNS refers to LAWRENCE LIVERMORE NATIONAL SECURITY, LLC.

LLNS SPD refers to LLNS Health and Welfare Benefit Plan for Employees Summary Plan Description or the LLNS Health and Welfare Benefit Plan for Retirees Summary Plan Description, as applicable.

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

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

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease
3. Provided for the diagnosis or direct care and treatment of the medical condition;

4. Within standards of good medical practice within the organized medical community;

5. Not primarily for your convenience, or for the convenience of your *physician* or another provider;

6. Not more costly than an equivalent 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; and

7. The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:

    a. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and

    b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable.

Member is the *subscriber* or *family member*.

Mental or nervous disorders, including substance abuse, for the purposes of this benefit program, are conditions that are listed in the most current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders. Mental or nervous disorders include *severe mental disorders* as defined in this booklet (see definition of "severe mental disorders").

Multi-source brand name drugs are drugs with at least one generic substitute.

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

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

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

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

Other health care provider is one of the following providers:

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

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

Participating provider is one of the following providers or other licensed health care professionals who have a Prudent Buyer Plan Participating Provider Agreement in effect with the *claims administrator* or is participating in a Blue Cross and/or Blue Shield Plan at the time services are rendered:

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

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

Physician means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or
2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license and such license is required to render that service, and is providing a service for which benefits are specified in this booklet:
    - A dentist (D.D.S. or D.M.D.)
    - An optometrist (O.D.)
    - A dispensing optician
    - A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
    - A licensed clinical psychologist
    - A chiropractor (D.C.)
    - An acupuncturist (A.C.)
    - A licensed clinical social worker (L.C.S.W.)
    - A marriage and family therapist (M.F.T.)

- A licensed professional clinical counselor (L.P.C.C.)*
- A physical therapist (P.T. or R.P.T.)*
- A speech pathologist*
- An audiologist*
- An occupational therapist (O.T.R.)*
- A respiratory care practitioner (R.C.P.)*
- A nurse midwife**
- A nurse practitioner
- A physician assistant
- A *psychiatric mental health nurse* (R.N.)*
- Any agency licensed by the state to provide services for the treatment of *mental or nervous disorders* or substance abuse, when required by law to cover those services.
- A registered dietitian (R.D.)* or another nutritional professional* with a master's or higher degree in a field covering clinical nutrition sciences, from a college or university accredited by a regional accreditation agency, who is deemed qualified to provide these services by the referring M.D. or D.O. A registered dietitian or other nutritional professional as described here are covered for the provision of diabetic medical nutrition therapy and nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa only.

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

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

Plan Administrator refers to the Benefits and Investment Committee, the entity responsible for the administration of the *benefit program.*

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

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

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF);

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

3. Preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.

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

https://www.healthcare.gov/what-are-my-preventive-care-benefits

http://www.ahrq.gov

http://www.cdc.gov/vaccines/acip/index.html

Prior benefit program is a benefit program sponsored by us which was replaced by this *benefit program* within 60 days. You are considered covered under the prior benefits program if you: (1) were covered under the prior benefit program on the date that benefit program terminated; (2) properly enrolled for coverage within 31 days of this *benefit program's* effective date; and (3) had coverage terminate solely due to the prior benefit program's termination.

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

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

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

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

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

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

Severe mental disorders include the following psychiatric diagnoses specified in California Insurance Code section 10144.5: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, and bulimia.

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

1. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community and is at risk of being removed from the home or has already been removed from the home or the mental disorder has been present for more than six months or is likely to continue for more than one year without treatment.
2. The child is psychotic, suicidal, or potentially violent.
3. The child meets special education eligibility requirements under California law (Government Code Section 7570).

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

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

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

Spouse meets the eligibility requirements for spouses outlined in the LLNS SPD.

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

Subscriber is the person who, by meeting the eligibility requirements, is allowed to choose coverage under this *benefit program* for himself or herself and his or her eligible *family members*. Such requirements are outlined in your LLNS SPD.

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

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

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

We (us, our) refers to LAWRENCE LIVERMORE NATIONAL SECURITY, LLC (“LLNS”).

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

You (your) refers to the *subscriber* and *family members* who are enrolled for benefits under this *benefit program.*

BINDING ARBITRATION

Note: If you are enrolled in a *benefit program* provided by your employer that is subject to ERISA, any dispute involving an adverse benefit decision must be resolved under ERISA's claims procedure rules, and is not subject to mandatory binding arbitration. You may pursue voluntary binding arbitration after you have completed an appeal under ERISA. If you have any other dispute which does not involve an adverse benefit decision, this BINDING ARBITRATION provision applies.

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

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

The *member* and *plan administrator* agree to be bound by these arbitration provisions and acknowledge that they are giving up their right to trial by jury for both medical malpractice claims and any other disputes.

The *member* and *plan administrator* 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 *plan administrator* and *plan administrator* waives any right to pursue on a class basis any such controversy or claim against the *member*.

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

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

YOUR RIGHT TO APPEALS

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

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

If your claim is denied or if your coverage is rescinded:

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

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

Notice of Adverse Benefit Determination

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

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific *benefit program* provision(s) on which the *claims administrator*'s determination is based;
- a description of any additional material or information needed to perfect your claim;
- an explanation of why the additional material or information is needed;
- a description of the benefit program'*s* review procedures and the time limits that apply to them, including a statement of your right to bring a civil action under ERISA (if applicable) if you appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision;
- information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision; and
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you.

For claims involving urgent/concurrent care:

- the *claims administrator*'s notice will also include a description of the applicable urgent/concurrent review process; and
- the *claims administrator* may notify you or your authorized representative within 72 hours orally and then furnish a written notification.

Appeals

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

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

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

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

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

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

You must include Your Member Identification Number when submitting an appeal.

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

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the benefit program, applied consistently for similarly-situated claimants; or
- is a statement of the benefit program's policy or guidance about the treatment or benefit relative to your diagnosis.

The *claims administrator* will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an

adverse benefit determination on review based on a new or additional rationale, the *claims administrator* will provide you, free of charge, with the rationale.

For Out of State Appeals You have to file Provider appeals with the Host Plan. This means Providers must file appeals with the same plan to which the claim was filed.

How Your Appeal will be Decided

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

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

Notification of the Outcome of the Appeal

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

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

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

Appeal Denial

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

Voluntary Second Level Appeals

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

External Review

If the outcome of the mandatory first level appeal is adverse to you and it was based on medical judgment, or if it pertained to a rescission of coverage, you may be eligible for an independent External Review pursuant to federal law.

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

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

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

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

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

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

You must include Your Member Identification Number when submitting an appeal.

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

Requirement to file an Appeal before filing a lawsuit

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

If your health *benefit program* is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA.

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

ERISA CLAIMS AND APPEALS PROCEDURES

This benefit program is subject to ERISA Claims and Appeals Procedures. Claim forms may be obtained from the benefit program Administrator or from the Claims Administrator. (Note that the Claims Administrator is not the benefit program Administrator.)

FOR YOUR INFORMATION

WEB SITE

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

LANGUAGE ASSISTANCE PROGRAM

Anthem Blue Cross Life and Health introduced its Language Assistance Program to provide certain written translation and oral interpretation services to California *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 Life and Health also sends/receives TDD/TTY messages at **866-333-4823** or by using the National Relay Service through **711.**

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

STATEMENT OF RIGHTS UNDER THE NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

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

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

In addition, a plan or issuer may not, under federal law, require that a *physician* or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to

obtain pre-certification. For information on pre-certification, please call the customer service telephone number listed on your ID card.

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

This *benefit program*, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). If you have any questions about this coverage, please call the customer service telephone number listed on your ID card.

COMPLAINT NOTICE

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

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

Claims Administered by:

ANTHEM BLUE CROSS

on behalf of

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY