Anthem Blue Cross Monterey County EPO Plan

Exclusive Provider Organization (EPO)

Combined Evidence of Coverage
and Disclosure Form

Effective January 1, 2016

Contracted by the CalPERS Board of Administration Under the
Public Employees' Medical & Hospital Care Act (PEMHCA)

CalPERS

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

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This booklet, called the "Combined Evidence of Coverage and Disclosure Form", gives you important information about your health plan. This booklet must be consulted to determine the exact terms and conditions of coverage. If you have special health care needs, you should read those sections of the Evidence of Coverage that apply to those needs.

Many words used in this booklet are explained in the "Definitions" section starting on page 73. When reading through this booklet, check that section to be sure that you understand what these words mean. Each time these words are used they are *italicized*.

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Benefit and Administrative Changes

Administrative and Benefit Changes

- There are no changes to the *plan.*

Welcome to Your Anthem Blue Cross Monterey County Exclusive Provider Organization (EPO) Plan

The Monterey County EPO *plan* is specifically designed for you to use Partners in Health to manage your health care through the selection of *physicians*, *hospitals*, and other specialists who you determine will best meet your needs. **With the exception of an *emergency* or *urgent care*, all care must be provided and/or coordinated by a Monterey County *EPO provider physician* and any hospital care must be provided at a Monterey County EPO hospital.** By becoming familiar with your coverage and using it carefully, you will become a wise health care consumer.

Anthem establishes medical policy for the Monterey County EPO *plan*, processes medical claims, and provides the Partners in Health network of *physicians*, *hospitals*, and other health care professionals and facilities. Anthem also has a relationship with the Blue Cross and Blue Shield Association, which allows you to access the nationwide BlueCard Preferred Provider Network under this *plan*.

Anthem's Review Center provides utilization review of hospitalizations, specified services, and outpatient surgeries to ensure that services are *medically necessary* and efficiently delivered.

Your *plan* includes a 24-hour nurse assessment service to help you make decisions about your medical care. You can reach a specially trained registered nurse to address your health care questions by calling the 24/7 NurseLine toll free at **1-800-700-9185**. Registered nurses are available to answer your medical questions 24 hours a day, seven days a week. Be prepared to provide your name, the patient's name (if you're not calling for yourself), the *subscriber's* identification number, and the patient's phone number.

The Outpatient Prescription Drug Program is administered by CVS Caremark. Please refer to your CVS Caremark Prescription Drug Program Evidence of Coverage booklet for additional details.

Please take the time to familiarize yourself with this booklet. As a Monterey County EPO *plan member*, you are responsible for meeting the requirements of the *plan*. **Lack of knowledge of, or lack of familiarity with, the information contained in this booklet does not serve as an excuse for noncompliance.**

A Summary of Common Services

This is only a brief summary. Refer to the section "Medical and Hospital Benefits" starting on page 15 in this booklet for more information.

REMEMBER

With the exception of an *emergency* or *urgent care*, all care must be provided, or coordinated by a Monterey County *EPO provider physician*.

Covered Services	Member Copayment
Physician Services	
– Office or home visits	$15
– *Physician* visit during a *hospital stay*	No Copayment
– Visit to a *specialist*	$15
– *Urgent care*	$15
Preventive Care Services	
– Preventive care	No Copayment
– Diagnostic X-ray/lab	No Copayment
Online Care Services	$15
Acupuncture and Chiropractic Care (up to a combined maximum of 20 visits per *calendar year*)	$15
Diabetes	$15
Hospital Services	
– Inpatient	No Copayment
– Outpatient	No Copayment
• Upper and lower GI endoscopy, cataract surgery, and spinal injection	$250
• Physical therapy, occupational therapy, speech therapy, respiratory therapy, chemotherapy, radiation therapy or hemodialysis treatment	$15
– *Emergency*	$50 (waived if admitted)
Urgent Care	
– *Physician* services	$15
Skilled Nursing Facility (up to 100 days *per calendar year*)	No Copayment

Home Health Care – Physical therapy, occupational therapy, speech therapy or respiratory therapy	$15
Ambulance	No Copayment
Mental or Nervous Disorders or Substance Abuse – *Physician* services	$15
General Medical Care (in a non-hospital based facility) – Hemodialysis, chemotherapy, and radiation therapy	$15
Rehabilitative Care	$15
Hearing Aid Services (benefits are provided for one hearing aid per ear every three years) – *Physician* services	$15
Infertility Treatment	50%
Smoking Cessation Program (up to a maximum of $100 per class/program per *calendar year*)	No Copayment
Vision Care (for *members* age 18 and over, service is limited to one visit per *calendar year*)	No Copayment
Member Calendar Year Copayment Limits *Member's* maximum *calendar year* Copayment for all covered services* *Copayment for *infertility* services will not apply to the Copayment limits	$1,500 per *member* $3,000 per family

Eligibility and Enrollment

Information pertaining to eligibility, enrollment, and termination of coverage, can be obtained through the CalPERS website at http://www.calpers.ca.gov/index.jsp?bc=/member/health/elig-enroll/home.xml, or by calling CalPERS. Also, please refer to the CalPERS Health Program Guide for additional information about eligibility. Your coverage begins on the date established by CalPERS.

It is your responsibility to stay informed about your coverage. For an explanation of specific enrollment and eligibility criteria, please consult your Health Benefits Officer or, if you are retired, the CalPERS Member Account Management Division at:

CalPERS
Member Account Management Division
P.O. Box 942715
Sacramento, CA 94229-2715
or call:
888 CalPERS (or **888**-225-7377)
(916) 795-3240 9TDD)

Live/Work

If you are an active employee or a working CalPERS retiree, you may enroll in a plan using either your residential or work ZIP Code. When you retire from a CalPERS *employer* and are no longer working for any employer, you must select a health plan using your residential ZIP Code.

If you use your residential ZIP Code, all enrolled dependents must reside in the health plan's service area. When you use your work ZIP Code, all enrolled dependents must receive all covered services (except *emergency* and *urgent care*) within the health plan's service area, even if they do not reside in that area.

Physician/Patient Relations

If you are not satisfied with your relationship with Anthem, then you may submit the matter to CalPERS under the change of enrollment procedure in Section 22841 of the Government Code.

Monthly Rates

State Employees and *Annuitants*

The premiums shown below are effective January 1, 2016, and will be reduced by the amount the State of California contributes toward the cost of your health benefit *plan*. These contribution amounts are subject to change as a result of collective bargaining agreements or legislative action. Any change will be done by the State Controller or affected retirement system without any action on your part. For current contribution information, contact your employing agency or retirement system health benefits officer.

Cost of the Plan:

Type of Enrollment	Monthly Rate
Subscriber	**$** 715.70
Subscriber and one *family member*	**$** 1,431.40
Subscriber and two or more *family members*	**$** 1,860.82

Contracting Agency Employees and *Annuitants*

The rates shown below are effective January 1, 2016, and will be reduced by the amount your contracting agency contributes toward the cost of your health benefit plan. For help on calculating your net contributions, contact your agency or retirement system health benefits officer.

Cost of the Plan:

Type of Enrollment	Monthly Rate
Subscriber	**$** 795.57
Subscriber and one *family member*	**$** 1,591.14
Subscriber and two or more *family members*	**$** 2,068.48

Premium Change

The *plan* rates may be changed as of January 1, 2017, following at least 60 days' written notice to the *Board* prior to such change.

Premium Payment

For direct payment of premiums, contact:

CalPERS EPO Membership Department
Anthem Blue Cross
P.O. Box 629
Woodland Hills, CA 91365-0629
1-877-737-7776

Plan Providers

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

Monterey County EPO Providers (EPO Providers). Anthem has established a network of various types of "Monterey County EPO Providers (EPO Providers)". *EPO providers* for the Monterey County EPO *plan* participate in the Anthem preferred exclusive provider organization and are defined as Partners in Health. *EPO providers* have agreed to a rate they will accept as reimbursement for covered services. See the definition of "EPO Providers" in the "Definitions" section, starting on page 73, for a complete list of the types of providers which may be *EPO providers*.

All care must be provided and/or coordinated by a Monterey County *EPO provider physician* and any hospital care must be provided at a Monterey County EPO hospital.

Monterey County EPO Hospitals. *Hospital* services, unless an *emergency*, can only be provided at the following facilities. For professional services, call customer services at 1-877-737-7776 or use www.anthem.com/ca/calpers to verify if the provider of service is an *EPO provider*.

Community Hospital of the Monterey Peninsula
23625 Holman Hwy
Monterey, CA 93940

(831) 624-5311 or 1-888-45CHOMP

http://www.chomp.org/

Salinas Valley Memorial Hospital
450 E Romie Lane
Salinas, CA 93901

http://www.svmh.com/

Obstetrics and Elective Pediatric/NICU (newborn, or neonatal intensive care unit) can be provided at Community Hospital of Monterey Peninsula, Salinas Valley Memorial Hospital, and Natividad Medical Center.

Anthem publishes a directory of *EPO Providers*. You can get a directory from your plan administrator (usually your *employer*) or from Anthem. You may call customer service at 1-877-737-7776 or you may write to Anthem and ask Anthem to send you a directory. You may also search for an *EPO provider* using the "Find a Doctor, Hospital or Urgent Care" function on Anthem's website at https://www13.anthem.com/cp/web/calpers/find-a-doctor.

Non-EPO Providers. *Non-EPO providers* are providers which have not agreed to participate in Partners in Health. They have not agreed to the reimbursement rates and other provisions of Partners in Health. **Benefits are provided for them under the plan only if you have an *authorized referral,* for an *emergency* or for *urgent care.***

Physicians. "Physician" means more than an M.D. (medical doctor). Certain other practitioners are included in this term as it is used throughout the *plan*. This doesn't mean they can provide every service that a medical doctor could; it just means that the *plan* will cover expense you incur from them when they're practicing within their specialty, the same as if the care were provided by a medical doctor. As with the other terms, be sure to read the definition of "Physician" to determine which providers' services are covered. Only providers listed in the definition are covered as *physicians*. Please note also that certain providers' services are covered only upon referral of an M.D. 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, starting on page 73, for a complete list of those providers. *Other health care providers* are not part of Partners in 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 *plan* contract and that you or your *family member* might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective *physician* or clinic, or call customer service at 1-877-737-7776 to ensure that you can obtain the health care services that you need.

Centers of Medical Excellence. Anthem is providing access to the following separate *Centers of Medical Excellence (CME)* networks. The facilities included in each of these *CME* networks are selected to provide the following specified medical services:

- **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 copayments or deductibles, *CME* have agreed to a rate they will accept as payment in full for covered services. **These procedures are covered only when performed at a *CME*.**
- **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 *CME*.**

An *EPO provider* in Partners in Health is not necessarily a *CME* facility.

Care Outside the United States—BlueCard Worldwide

Prior to travel outside the United States, call customer service at 1-877-737-7776 to find out if your *plan* has BlueCard Worldwide benefits. Your coverage outside the United States is limited and it is recommended:

- Before you leave home, call customer service at 1-877-737-7776 for coverage details. **You have coverage for services and supplies furnished in connection only with *urgent care* or an *emergency* when travelling outside the United States.**
- Always carry your current ID card.
- In an *emergency*, seek medical treatment immediately.

- **The BlueCard Worldwide Service Center is available 24 hours a day, seven days a week toll-free at (800) 810-BLUE (2583) or by calling collect at (804) 673-1177.** An assistance coordinator, along with a medical professional, will arrange a *physician* appointment or hospitalization, if needed.

Payment Information

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

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

Claim Filing

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

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

Additional Information About BlueCard Worldwide Claims.

- 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 Anthem, from the BlueCard Worldwide Service Center, or online at:

  www.bcbs.com/bluecardworldwide.

  The address for submitting claims is on the form.

Maximum Allowed Amount

General

This section describes the term "*maximum allowed amount"* as used in this Combined Evidence of Coverage and Disclosure Form, and what the term means to you when obtaining covered services under this *plan*. The *maximum allowed amount* is the total reimbursement payable under your *plan* for covered services you receive from *EPO providers, non-EPO providers,* or *other health care providers*. It is the *plan's* payment towards the service billed by your provider combined with any applicable Copayment owed by you. In some cases, you may be required to pay the entire *maximum allowed amount.* In addition, if these services are received from a *non-EPO provider* or *other health care provider*, you may be billed by the provider for the difference between their charges and the *plan's maximum allowed amount.* In many situations, this difference could be significant.

When you receive covered services, Anthem will, to the extent applicable, apply claim processing rules to the claim submitted. Anthem 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 Anthem 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 an *EPO provider,* a *non-EPO provider* or an *other health care provider*. Services provided by *non-EPO providers* will only be covered for *emergency services*, urgent care, or with an *authorized referral*.

EPO Providers and CME

For covered services performed by an *EPO provider* or *CME* the *maximum allowed amount* for this *plan* will be the rate the *EPO provider* or *CME* has agreed with Anthem to accept as reimbursement for the covered services. Because *EPO 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, if any, or have a Copayment. Please call customer service at 1-877-737-7776 for help in finding an *EPO provider* or visit www.anthem.com/ca/calpers.

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

Non-EPO Providers (Only with an *authorized referral*, in an *emergency*, or for *urgent care*) and Other Health Care Providers.*

Providers who are not Partners in Health are *non-EPO 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-EPO provider* or *other health care provider,* the *maximum allowed amount* will be based on the applicable Anthem *non-EPO provider* or *other health care provider* rate or fee schedule for this *plan*, an amount negotiated by Anthem or a third party vendor which has been agreed to by the *non-EPO provider* or *other health care provider,* an amount derived from the total charges billed by the *non-EPO provider* or *other health care 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, Anthem 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-EPO 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 *EPO providers*, *non-EPO providers* and *other health care providers* may send you a bill and collect for the amount of the *non-EPO provider's* or *other health care provider's* charge that exceeds Anthem's *maximum allowed amount* under this *plan*. You may be responsible for paying the difference between the *maximum allowed amount* and the amount the *non-EPO provider* or *other health care provider* charges. This amount can be significant. Choosing an *EPO provider* will likely result in lower out of pocket costs to you. Please call customer service at 1-877-737-7776 for help in finding an *EPO provider* or visit Anthem's website at www.anthem.com/ca/calpers. Customer service is also available to assist you in determining this *plan's maximum allowed amount* for a particular covered service from a *non-EPO provider* or *other health care provider*.

Please see the "Out of Area Services" provision in the section "Other General Provisions", on page 67, for additional information.

***Exceptions:**

- **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 an *EPO 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 an *EPO provider* who accepts Medicare assignment, in excess of the approved amount as determined by Medicare; or
  3. By a *physician* who is a *non-EPO provider* or *other health care provider* who accepts Medicare assignment, in excess of the lesser of the *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.

Member Cost Share

For certain covered services, and depending on your *plan* design, you may be required to pay all or a part of the *maximum allowed amount* as your cost share amount (Deductibles, if applicable, or Copayments). Please see those specific benefits under the section "Medical and Hospital Benefits", starting on page 15, for your cost share responsibilities and limitations, or call customer service at 1-877-737-7776 to learn how this *plan's* benefits or cost share amounts may vary by the type of provider you use.

Anthem 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 an *EPO provider, non-EPO provider,* or *other health care provider*. Non-covered services include services specifically excluded from coverage by the terms of your *plan* and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, Medical Benefit Maximums or day/visit limits.

Authorized Referrals

In some circumstances Anthem may authorize you to receive services provided by *non-EPO provider.* In such circumstance, you or your *physician* must contact Anthem in advance of obtaining the covered service you receive from a *non-EPO provider*. It is your responsibility to ensure that Anthem has been contacted. Please call customer service at 1-877-737-7776 for *authorized referral* information or to request authorization.

Copayments, Out-of-Pocket Amounts and Medical Benefit Maximums

After any applicable Copayment is subtracted, benefits will be paid up to the *maximum allowed amount*, not to exceed any applicable Medical Benefit Maximum. Copayments, Out-Of-Pocket Amounts and Medical Benefit Maximums are noted in the section "A Summary of Common Services", on pages 3-4.

Copayments

Your Copayment will be subtracted from the *maximum allowed amount*.

If your Copayment is a percentage, the applicable percentage will apply to the *maximum allowed amount*. This will determine the dollar amount of your Copayment.

Out-of-Pocket Amounts

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

Charges Which Do Not Apply Toward the Out-of-Pocket Amount. The following charges will not be applied toward satisfaction of an Out-of-Pocket Amount:

- Charges which are not covered under this *plan*.
- Charges which exceed the *maximum allowed amount*.
- Charges incurred for services and supplies from a *non-EPO provider* without an *authorized referral* unless in connection with an *emergency* or *urgent care*.

Medical Benefit Maximums

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

Conditions of Coverage

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

1. You must incur this expense while you are covered under this *plan*. Expense is incurred on the date you receive the service or supply for which the charge is made.
2. The expense must be for a medical service or supply furnished to you as a result of illness or injury or pregnancy, unless a specific exception is made.
3. The expense must be for a medical service or supply included in the section "Medical and Hospital Benefits", starting on page 15. Additional limits on covered charges are included under specific benefits and in the section "A Summary of Common Services" on pages 3-4.
4. The expense must not be for a medical service or supply listed in the section "Exclusions" starting on page 43. If the service or supply is partially excluded, then only that portion which is not excluded will be covered under this *plan*.
5. The expense must not exceed any of the maximum benefits or limitations of this *plan*.
6. Any services received must be those which are regularly provided and billed by the *provider*. In addition, those services must be consistent with the illness, injury, degree of disability and your medical needs. Benefits are provided only for the number of days required to treat your illness or injury.
7. All services and supplies must be ordered by an *EPO provider physician* or a *non-EPO provider physician* provided in connection with *emergency services* or with an *authorized referral*.

Medical and Hospital Benefits

Subject to any Medical Benefit Maximums, the requirements set forth under the section "Conditions of Coverage", on page 14, and the exclusions or limitations listed under the section "Exclusions" (starting on page 43), the *plan* will provide benefits for the following services and supplies. Any Copayments you must pay are shown after each benefit.

Abortion

EPO Provider: 100%
Non-EPO Provider: Not covered

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

Services and supplies provided for abortion. Mifepristone is covered when provided under the FDA approved treatment regimen.

Acupuncture and Chiropractic Care

EPO Provider: 100% ($15 Copayment for *physician* office visit)
Non-EPO Provider: Not covered

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

Acupuncture 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, electro acupuncture, cupping and moxibustion.

Chiropractic care is covered for the treatment of illness or injury. Services include, but are not limited to, manipulation of the spine, joints and/or musculoskeletal soft tissue, re-evaluation, and/or other services.

Acupuncture and chiropractic care services are limited to **a combined maximum of 20 visits** per *calendar year*.

Allergy Testing and Treatment

EPO Provider: 100%
Non-EPO Provider: Not covered

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

Physician services and supplies, except for prescription drugs, related to allergy testing and treatment are covered.

Ambulance

EPO Provider: 100%
Non-EPO Provider: Not covered (unless for *emergency*)

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

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 Anthem 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 Anthem 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*. Please refer to section "Utilization Review Program" starting on page 35, for information on how to obtain the proper reviews. When using an air ambulance in a non-emergency situation, Anthem reserves the right to select the air ambulance provider. If you do not use the air ambulance Anthem 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*. 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*. 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.

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 *plan* 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 as 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 Surgery Centers

EPO Provider: 100%
Non-EPO Provider: Not covered

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

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

Ambulatory surgical center services are subject to pre-service review to determine medical necessity. Please refer to section "Utilization Review Program" starting on page 35, for information on how to obtain the proper reviews.

Bariatric Surgery

EPO Provider: 100%
Non-EPO Provider: Not covered

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

Services and supplies in connection with *medically necessary* surgery for weight loss, only for morbid obesity and only when performed at a designated *CME* facility. Please refer to section "Utilization Review Program" starting on page 35, for information on how to obtain the proper reviews.

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

Bariatric Travel Expense

Certain travel expenses incurred in connection with an approved, specified bariatric surgery, performed at a designated *CME* that is fifty (50) miles or more from the *member's* place of residence, are covered, provided the expenses are authorized by Anthem in advance. The fifty (50) mile radius around the *CME* will be determined by the *bariatric CME coverage area* (see "Definitions" on page 73). The *plan* will pay for the following travel expenses incurred by the *member* and/or one companion:

- Transportation for the *member* and/or one companion to and from the *CME*.
- Lodging, limited to one room, double occupancy.
- Other reasonable expenses. Tobacco, alcohol, drug and meal expenses are excluded from coverage.

Customer service will confirm if the "Bariatric Travel Expense" benefit is available in connection with access to the selected bariatric *CME.* Details regarding reimbursement can be obtained by calling customer service at 1-877-737-7776. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

Breast Cancer

EPO Provider: 100%
Non-EPO Provider: Not covered

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

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

1. Diagnostic mammogram examinations in connection with the treatment of a diagnosed illness or injury. Routine mammograms will be covered initially under the Preventive Care Services benefit.
2. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.
3. Reconstructive surgery of both breasts performed to restore and achieve symmetry following a *medically necessary* mastectomy.
4. Breast prostheses following a mastectomy (see the benefit "Prosthetic Devices" on pages 29-30).

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

Blood

EPO Provider: 100%
Non-EPO Provider: Not covered

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

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.

Clinical Trials

EPO Provider: 100%
Non-EPO Provider: Not covered

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

Routine patient costs, as described below, for an approved clinical trial.

Coverage is provided for services you receive as a participant in an approved clinical trial. The services must be those that are listed as covered by this *plan* for *members* who are not enrolled in a clinical trial.

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.

h. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration.

i. Studies or investigations done for drug trials that are exempt from the investigational new drug application.

When a service is part of an approved clinical trial, it is covered even though it may otherwise be an *investigative* service as defined by the *plan* (see "Definitions" on page 73).

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

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

1. The investigational item, device, or service itself.
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, or should have been paid for, by the sponsor of the trial

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

Contraceptives

EPO Provider: 100%
Non-EPO Provider: Not covered

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

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

- Injectable drugs and implants for birth control, administered in a *physician's* office.
- Intrauterine contraceptive devices (IUDs) and diaphragms, dispensed by a *physician*.

- Professional services of a *physician* in connection with the prescribing, fitting, and insertion of intrauterine contraceptive devices or diaphragms.

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

Certain contraceptives are covered under the "Preventive Care Services" benefit on pages 28-29. Please see that benefit for further details.

Dental Care

EPO Provider: 100%
Non-EPO Provider: Not covered

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

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.). Anthem will make the final determination as to whether the dental treatment could have been safely rendered in another setting due to the nature of the procedure or your medical condition. *Hospital stays* for the purpose of administering general anesthesia are not considered necessary and are not covered except as specified in #2, below.

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

3. **Dental Injury.** Services of a *physician* (M.D.) or dentist (D.D.S. 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.

Important: If you decide to receive dental services that are not covered under this *plan*, a *EPO provider* who is a dentist may charge you his or her usual and customary rate for those services. Prior to providing you with dental services that are not a covered benefit, the dentist should provide a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about the dental services that are covered under this *plan*, please call customer at 1-877-737-7776. To fully understand your coverage under this *plan*, please carefully review this Evidence of Coverage document.

Diabetes

EPO Provider: $15 Copayment
Non-EPO Provider: Not covered

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

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

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

   Items a through d above are covered under your *plan's* benefits for durable medical equipment (see "Durable Medical Equipment" benefit on page 22). Item e above is covered under your *plan's* benefits for *prosthetic devices* (see "Prosthetic Devices" benefit on pages 29-30).

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

   Diabetes education services are covered under *plan* benefits for office visits to *physicians*.

3. The following items are covered as medical supplies:
   a. Insulin syringes, disposable pen delivery systems for insulin administration. Charges for insulin and other prescriptive medications are not covered.
   b. Testing strips, lancets, and alcohol swabs.

4. Screenings for gestational diabetes are covered under your Preventive Care Services benefit on pages 28-29. Please see that benefit for further details.

Diagnostic X-Ray and Laboratory

EPO Provider: 100%
Non-EPO Provider: Not covered

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

Benefits are provided for outpatient diagnostic imaging and laboratory services.

Imaging procedures, including, but not limited to, Magnetic Resonance Imaging (MRI), Computerized Tomography (CT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography and nuclear cardiac imaging are subject to pre-service review to determine medical necessity. You may call customer service at 1-877-737-7776 to find out if an imaging procedure requires pre-service review. Please refer to section "Utilization Review Program" starting on page 35, for information on how to obtain the proper reviews.

Durable Medical Equipment

EPO Provider: 100%
Non-EPO Provider: Not covered

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

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;
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.

Specific durable medical equipment is subject to pre-service review to determine medical necessity. Please refer to section "Utilization Review Program" starting on page 35, for information on how to obtain the proper reviews.

Emergency Care Services

EPO Provider or *Non-EPO Provider*: $50 Copayment* (100% after Copayment)

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

* If admitted to the *hospital* on an inpatient basis, the emergency room Copayment is waived.

Inpatient *hospital* services are subject to pre-service review to determine medical necessity. Please refer to section "Utilization Review Program" starting on page 35, for information on how to obtain the proper reviews.

Services in a *physician's* office, outpatient facility or an emergency room of a *hospital* are covered when required for an *emergency*. This benefit includes emergency room *physician* visits.

If a patient is in a *non-EPO provider hospital*, *emergency services* benefits shall be payable until the patient's medical condition permits transfer or travel to an *EPO provider hospital*.

General Medical Care (in a non-hospital based facility)

EPO Provider: 100% ($15 Copayment for hemodialysis, chemotherapy and radiation therapy)
Non-EPO Provider: Not covered

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

- Hemodialysis treatment, including treatment at home
- Medical social services
- Chemotherapy and radiation therapy
- Genetic testing (not including *medically necessary* genetic testing of the fetus or newborn)

Hearing Aid Services

EPO Provider: 100% ($15 Copayment for *physician* office visit)
Non-EPO Provider: Not covered

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

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

1. Audiological evaluations to measure the extent of hearing loss and determine the most appropriate make and model of hearing aid. These evaluations will be covered under *plan* benefits for office visits to *physicians*.
2. Hearing aids (monaural or binaural) including ear mold(s), the hearing aid instrument, batteries, cords and other ancillary equipment.
3. Visits for fitting, counseling, adjustments and repairs for a one year period after receiving the covered hearing aid.

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

No benefits will be provided for the following:

1. Charges for a hearing aid which exceeds specifications prescribed for the correction of hearing loss, or for more than on hearing aid per ear every three year.
2. Surgically implanted hearing devices (i.e., cochlear implants, audient bone conduction devices). *Medically necessary* surgically implanted hearing devices may be covered under your *plan's* benefits for *prosthetic devices* (see "Prosthetic Devices" benefit on pages 29-30).

Home Health Care

EPO Provider: 100% ($15 Copayment for physical therapy, occupational therapy, speech therapy or respiratory therapy)
Non-EPO Provider: Not covered

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

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*.

Home health care services are subject to pre-service review to determine medical necessity. Please refer to section "Utilization Review Program" starting on page 35, for information on how to obtain the proper reviews.

Home health care services are not covered if received while you are receiving benefits under the "Hospice Care" benefit on pages 24-25.

Home Infusion Therapy

EPO Provider: 100%
Non-EPO Provider: Not covered

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

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

1. Medication, ancillary medical supplies and supply delivery, (not to exceed a 14-day supply); however, medication which is delivered but not administered is not covered;
2. Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications;
3. *Hospital* and home clinical visits related to the administration of infusion therapy, including skilled nursing services including those provided for: (a) patient or alternative caregiver training; and (b) visits to monitor the therapy;
4. Rental and purchase charges for durable medical equipment; maintenance and repair charges for such equipment;
5. Laboratory services to monitor the patient's response to therapy regimen.

Home infusion therapy provider services are subject to pre-service review to determine medical necessity. Please refer to section “Utilization Review Program” starting on page 35, for information on how to obtain the proper reviews.

Hospice Care

EPO Provider: 100%
Non-EPO Provider: Not covered

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

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 as certified by your *physician* and submitted to Anthem. 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 *family member's* death. Bereavement services are available to surviving members of the immediate family for a period of one year after the death. Your immediate family means your spouse, children, step-children, parents, and siblings.
10. Palliative care (care which controls pain and relieves symptoms, but does not cure) which is appropriate for the illness.

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 Anthem every 30 days.

Hospital Benefits

EPO Provider: 100% ($250 Copayment for upper and lower gastrointestinal endoscopy, cataract surgery and spinal injection / $15 Copayment for physical therapy, occupational therapy, speech therapy, respiratory therapy, chemotherapy, radiation therapy, or hemodialysis treatment)
Non-EPO Provider: Not covered

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

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 Anthem and the *hospital,* or unless your *physician* orders, and Anthem 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, and the following:
    a. Upper and lower gastrointestinal (GI) endoscopy, cataract surgery, and spinal injection.
    b. Physical therapy, occupational therapy, or speech therapy, chemotherapy, radiation therapy, hemodialysis treatment or infusion therapy.

Certain *hospital* services are subject to pre-service review to determine medical necessity. Please refer to section "Utilization Review Program" starting on page 35, for information on how to obtain the proper reviews.

Infertility Treatments

EPO Provider: 50%
Non-EPO Provider: Not covered

Any Copayments will **NOT** apply toward the satisfaction of the Out-of-Pocket Amount.

Diagnosis and treatment of *infertility*, as *medically necessary*, provided you are under the direct care and treatment of a *physician*.

Jaw Joint Disorders

EPO Provider: 100%
Non-EPO Provider: Not covered

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

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

Mental or Nervous Disorders or Substance Abuse

EPO Provider: 100% ($15 Copayment for *physician* office visit)
Non-EPO Provider: Not covered

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

Covered services shown below for the *medically necessary* treatment of *mental or nervous disorders* or substance abuse, or to prevent the deterioration of chronic conditions.

1. Inpatient *hospital* services and services from a *residential treatment center* as stated in the "Hospital" benefit on page 25, 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” benefit on page 25, 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.
4. Behavioral health treatment for pervasive developmental disorder or autism. **Note:** You must obtain pre-service review for all behavioral health treatment services for the treatment of pervasive developmental disorder or autism in order for these services to be covered by this *plan.* Please refer to section “Utilization Review Program” starting on page 35, for information on how to obtain the proper reviews. No benefits are payable for these services if pre-service review is not obtained.

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

Online Care Services

EPO Provider: $15 Copayment
Non-EPO Provider: Not covered

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

When available in your area, covered services will include medical consultations using the internet via webcam, chat, or voice. Online care services are covered under *plan* benefits for office visits to *physicians*.

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.

Pediatric Asthma Equipment and Supplies

EPO Provider: 100% ($15 Copayment for *physician* office visit)
Non-EPO Provider: Not covered

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

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

1. Nebulizers, including face masks and tubing, inhaler spacers, and peak flow meters. These items are covered under the *plan's* medical benefits and are not subject to any limitations or maximums that apply to coverage for durable medical equipment (see "Durable Medical Equipment" benefit on page 22).
2. Education for pediatric asthma, including education to enable the dependent child to properly use the items listed above. This education will be covered under the *plan's* benefits for office visits to a *physician*.

Physician Services

EPO Provider: $15 Copayment (No Copayment will apply to anesthesia services, *physician* visits during a *hospital stay*, or injectable or infused medications given by the *physician* in the office)
Non-EPO Provider: Not covered (unless an *authorized referral* is obtained)

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

1. Office or home visits for a covered illness, injury or health problem.
2. Services of an anesthetist (M.D. or C.R.N.A.).

3. Injectable or infused medications* given by the *physician* in the office.

   *This does not include immunizations prescribed by your *physician*.

4. *Physician* visits during a *hospital stay*.

5. Visits to a *specialist*.

Pregnancy or Maternity Care

EPO Provider: 100%
Non-EPO Provider: Not covered

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

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

   a. Prenatal and postnatal 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 "For Your Information" on page 80 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 an enrolled *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 on pages 28-29. Please see that provision for further details.

Preventive Care

EPO Provider: 100%
Non-EPO Provider: Not covered

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

Screening services and supplies provided in connection with *preventive care services* as shown below. No Copayment will apply to these services or supplies.

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

2. Immunizations prescribed by an 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 (breast cancer) 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, 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 (HRSA), including the following:
    a. All FDA-approved contraceptive methods for women, including over-the-counter items, if prescribed by a *physician*. In order to be covered as preventive care, contraceptive prescription drugs must be either a generic or single-source brand name drug unless the individual's health care provider considers the generic or single-source brand name drug medically inappropriate. In such instance, the alternative contraceptive prescription drug would also be covered as preventive care. Also covered are sterilization procedures and counseling.
    b. Breast feeding support, supplies, and counseling. One breast pump will be covered per pregnancy under this benefit.
    c. Gestational diabetes screening.
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 HRSA will be covered with no Copayment.

See the definition of "Preventive Care Services" in the section "Definitions" on page 77 for more information about services that are covered by this *plan* as *preventive care services*.

Prosthetic Devices

EPO Provider: 100%
Non-EPO Provider: Not covered

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

1. Breast prostheses following a mastectomy.
2. *Prosthetic devices* to restore a method of speaking when required as a result of a covered *medically necessary* laryngectomy.
3. The *plan* will pay for other *medically necessary prosthetic devices*, including:
    a. Surgical implants;
    b. Artificial limbs or eyes;

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

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

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

Reconstructive Surgery

EPO Provider: 100%
Non-EPO Provider: Not covered

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

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.

Rehabilitative Care

EPO Provider: $15 Copayment
Non-EPO Provider: Not covered (unless an *authorized referral* is obtained.)

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

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.)

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.

3. Outpatient speech therapy.

Benefits are not payable for care provided to relieve general soreness or for conditions that may be expected to improve without treatment.

Skilled Nursing Facility

EPO Provider: 100%
Non-EPO Provider: Not covered

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

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

Skilled nursing facility services and supplies are subject to pre-service review to determine medical necessity. Please refer to section "Utilization Review Program" starting on page 35, for information on how to obtain the proper reviews.

Smoking Cessation Program

EPO Provider: 100%
Non-EPO Provider: Not covered

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

The *plan* will reimburse the *member* **up to a maximum of one hundred dollars ($100) per class/program per *calendar year*** for smoking cessation programs or classes. Smoking cessation drugs that may be purchased over-the-counter without a prescription are not covered. The *plan* will cover *medically necessary* drugs for nicotine dependency that require a prescription.

Special Food Products

EPO Provider: 100%
Non-EPO Provider: Not covered

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

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.

Transgender Surgery Benefit

EPO Provider: 100% ($15 Copayment for *physician* office visit)
Non-EPO Provider: Not covered (unless an *authorized referral* is obtained)

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

Services and supplies provided in connection with gender transition when you have been diagnosed with gender identity disorder or gender dysphoria by a *physician*. This coverage is provided according to the terms and conditions of the *plan* that apply to all other covered medical conditions, including medical necessity requirements, utilization management, and exclusions for cosmetic services. Coverage includes, but is not limited to, *medically necessary* services related to gender transition such as transgender surgery, hormone therapy, psychotherapy, and vocal training.

Coverage is provided for specific services according to *plan* benefits that apply to that type of service generally, if the *plan* includes coverage for the service in question. If a specific coverage is not included, the service will not be covered. For example, transgender surgery would be covered on the same basis as any other covered, *medically necessary* surgery; hormone therapy would be covered under the *plan's* prescription drug benefits (if such benefits are included).

Services that are excluded on the basis that they are cosmetic include, but are not limited to, liposuction, facial bone reconstruction, voice modification surgery, breast implants, and hair removal. Transgender services are subject to prior authorization in order for coverage to be provided. Please refer to section "Utilization Review Program" starting on page 35, for information on how to obtain the proper reviews.

Transplant Benefits

EPO Provider: 100% ($15 Copayment for *physician* office visit)
Non-EPO Provider: Not covered

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

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

1. The recipient; or
2. The donor.

Benefits for an organ donor are as follows:

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

The *maximum allowed amount* for a donor, including donor testing and donor search, is limited to expense incurred for *medically necessary* medical services only. The *maximum allowed amount* for services incident to obtaining the transplanted material from a living donor or a human organ transplant bank will be covered. Such charges, including complications from the donor procedure for up to six weeks from the date of procurement, are covered. Services for treatment of a condition that is not directly related to, or a direct result of, the transplant are not covered.

Covered services are subject to any applicable Copayments and medical benefit maximums. The *maximum allowed amount* does not include charges for services received without first obtaining Anthem's prior authorization or which are provided at a facility other than a transplant center approved by Anthem. Please refer to section "Utilization Review Program" starting on page 35, for information on how to obtain the proper reviews.

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. To reach the Transplant Department, please call customer service at 1-877-737-7776 and ask to speak to the transplant coordinator. You must do this before you have an evaluation or work-up for a transplant. Anthem 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)* rules, or exclusions apply.

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 benefits for a transplant will be provided. Your *physician* must certify, and Anthem must agree,

that the transplant is *medically necessary*. Your *physician* should send a written request for prior authorization to Anthem 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 harvest 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 harvest and storage request will be reviewed for medical necessity and may be approved. However, such an approval for HLA testing, donor search, or harvest 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 Anthem's prior authorization for all services including, but not limited to, preoperative tests and postoperative care related to the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. Specified transplants must be performed at *Centers of Medical Excellence (CME)*. **Charges for services provided for or in connection with a specified transplant performed at a facility other than a *CME* will not be covered.** Call customer service at 1-877-737-7776 for pre-service review 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*. Please refer to section "Utilization Review Program" starting on page 35, for information on how to obtain the proper reviews.

Transplant Travel Expense

Certain travel expenses incurred in connection with an approved, specified transplant (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures) performed at a designated *CME* that is 75 miles or more from the recipient's or donor's place of residence are covered, provided the expenses are authorized by us in advance. The following travel expenses incurred by the recipient and one companion* or the donor will be covered:

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

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

The *plan* will provide benefits for lodging and ground transportation, up to the current limits set forth in the Internal Revenue Code.

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

Details regarding reimbursement can be obtained by calling customer service at 1-877-737-7776. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

Urgent Care

EPO Provider or *Non-EPO Provider*: 100% ($15 Copayment for *physician* office visit or urgent care facility)

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

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 *EPO providers* or *non-EPO providers*.

Vision Care

EPO Provider: 100%
Non-EPO Provider: Not covered

Any Copayments will apply toward the satisfaction of the Out-of-Pocket Amount.

The *plan* will provide services and supplies for eye refraction to determine the need for corrective lenses. This service is limited to one visit per *calendar year* for *members* age 18 and over. There is no limit on the number of visits for *members* under age 18. Eyeglasses are not covered, except when needed after a covered and *medically necessary* surgery.

Utilization Review Program

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

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

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

The utilization review program evaluates the medical necessity and appropriateness of care and the setting in which care is provided. You and your *physician* are advised if Anthem 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 Anthem and monitored so that you know when it is no longer *medically necessary* and appropriate to continue those services.

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

Certain services require pre-service review of benefits in order for benefits to be provided. *EPO providers* will initiate the review on your behalf. A *non-EPO 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 customer services at 1-877-737-7776. Pre-service review criteria are based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem 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/ca/calpers or call customer services at 1-877-737-7776 if you have any questions about making this determination.

It is also your responsibility to see that your *physician* starts the utilization review process before scheduling you for any service subject to the utilization review program. If you receive any such service, and do not follow the procedures set forth in this section, your benefits will be reduced as shown in the "Utilization Review Requirements and Effect on Benefits" on pages 36-38.

Utilization Review Requirements and Effects 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 *plan*. 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:

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

  a. For kidney, bone, skin or cornea transplants if the *physicians* on the surgical team and the facility in which the transplant is to take place are approved for the transplant requested.

  b. For transplantation of liver, heart, heart-lung, lung, kidney-pancreas or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures if the providers of the related preoperative and postoperative services are approved and the transplant will be performed at a *CME* facility.

- Air ambulance in a non-medical *emergency*.
- Specific durable medical equipment.
- Services of a *home infusion therapy provider* if the attending *physician* has submitted both a prescription and a plan of treatment before services are rendered.
- Home health care services if:

  a. The services can be safely provided in your home, as certified by your attending *physician*;

  b. Your attending *physician* manages and directs your medical care at home; and

  c. Your attending *physician* has established a definitive treatment plan which must be consistent with your medical needs and lists the services to be provided by the *home health agency*.

- Admissions to a *skilled nursing facility,* if you require daily skilled nursing or rehabilitation, as certified by your attending *physician*.

- Bariatric surgical services performed at a *CME* facility, such as gastric bypass and other surgical procedures for weight loss if:
  a. The services are to be performed for the treatment of morbid obesity.
  b. The *physicians* on the surgical team and the facility in which the surgical procedure is to take place are approved for the surgical procedure requested; and
  c. The bariatric surgical procedure will be performed at a *CME* facility.
- Transgender surgery If:
  a. The services are *medically necessary* and appropriate; and
  b. The *physicians* on the surgical team and the facility in which the surgery is to take place are approved for the transgender surgery requested.

  Note: You must be diagnosed with gender identity disorder or gender dysphoria by a *physician*.
- Advanced imaging procedures, including but not limited to: MRI, CT scan, PET scan, MRS scan, MRA scan, Echocardiography, and Nuclear Cardiac Imaging. You may call customer service at 1-877-737-7776 to find out if an imaging procedure requires pre-service review.
- Behavioral health treatment for pervasive developmental disorder or autism.

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

Care coordination review determines whether services are *medically necessary* and appropriate when Anthem 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.

Pre-service Reviews

1. For all scheduled services that are subject to utilization review, you or your *physician* must initiate the pre-service review at least five working days prior to when you are scheduled to receive services.
2. You must tell your *physician* that this *plan* requires pre-service review. *Physicians* who are *EPO providers* will initiate the review on your behalf. A *non-EPO provider* may initiate the review for you, or you may call Anthem directly at 1-877-737-7776.
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. Anthem will determine if services are *medically necessary* and appropriate. For inpatient *hospital* and *residential treatment center* stays, Anthem 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 Anthem for care coordination review. For an *emergency* admission or procedure, Anthem must be notified within one working day of the admission or procedure, unless extraordinary circumstances* prevent such notification within that time period.
2. When *EPO providers* have been informed of your need for utilization review, they will initiate the review on your behalf. You may ask a *non-EPO provider* to call Anthem at 1-877-737-7776 or you may call directly.
3. When Anthem determines that the service is *medically necessary* and appropriate, Anthem will, depending upon the type of treatment or procedure, specify the period of time for which the service is medically appropriate. Anthem will also determine the medically appropriate setting.
4. If Anthem determines that the service is not *medically necessary* and appropriate, your *physician* will be notified by telephone no later than 24 hours following Anthem's decision. Anthem will send written notice to you and your *physician* within two business days following Anthem's 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", Anthem may take into account whether or not your condition was severe enough to prevent you from notifying Anthem, or whether or not a member of your family was available to notify Anthem for you. You may have to prove that such "extraordinary circumstances" were present at the time of the *emergency*.

Retrospective Reviews

1. 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*.
2. Retrospective review is performed when Anthem 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.
3. Such services which have been retroactively determined to not be *medically necessary* and appropriate will be retrospectively denied certification.

The Medical Necessity Review Process

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

1. A decision on the medical necessity of a pre-service request will be made no later than five business days from receipt of the information reasonably necessary to make the decision, and based on the nature of your medical condition.

   When your medical condition is such that you face an imminent and serious threat to your health, including the potential loss of life, limb, or other major bodily function and the normal five day timeframe described above would be detrimental to your life or health or could jeopardize your ability to regain maximum function, a decision on the medical necessity of a pre-service request will be made no later than 72 hours after receipt of the information reasonably necessary to make the decision (or within any shorter period of time required by applicable federal law, rule, or regulation).

2. A decision on the medical necessity of a care coordination request will be made no later than one business day from receipt of the information reasonably necessary to make the decision, and based on the nature of your medical condition. However, care will not be discontinued until your *physician* has been notified and a plan of care that is appropriate for your needs has been agreed upon.

3. A decision on the medical necessity of a retrospective review will be made and communicated in writing no later than 30 days from receipt of the information necessary to make the decision to you and your *physician*.

4. If Anthem does not have the information Anthem needs, Anthem will make every attempt to obtain that information from you or your *physician*. If Anthem is unsuccessful, and a delay is anticipated, Anthem will notify you and your *physician* of the delay and what Anthem needs to make a decision. Anthem will also inform you of when a decision can be expected following receipt of the needed information.

5. All pre-service, care coordination, and retrospective reviews for medical necessity are screened by clinically experienced, licensed personnel (called "Review Coordinators") using pre-established criteria and Anthem's medical policy. These criteria and policies are developed and approved by practicing providers not employed by Anthem, and are evaluated at least annually and updated as standards of practice or technology change. Requests satisfying these criteria are certified as *medically necessary*. Review Coordinators are able to approve most requests.

6. For pre-service and care coordination requests, written confirmation including the specific service determined to be *medically necessary* will be sent to you and your provider no later than two business days after the decision, and your provider will be initially notified by telephone within 24 hours of the decision for pre-service and care coordination reviews.

7. If the request fails to satisfy these criteria or medical policy, the request is referred to a Peer Clinical Reviewer. Peer Clinical Reviewers are health professionals clinically competent to evaluate the specific clinical aspects of the request and render an opinion specific to the medical condition, procedure and/or treatment under review. Peer Clinical Reviewers are licensed in California with the same license category as the requesting provider. When the Peer Clinical Reviewer is unable to certify the service, the requesting *physician* is contacted by telephone for a discussion of the case. In many cases, services can be certified after this discussion. If the Peer Clinical Reviewer is still unable to certify the service, your provider will be given the option of having the request reviewed by a different Peer Clinical Reviewer.

8. Only the Peer Clinical Reviewer may determine that the proposed services are not *medically necessary* and appropriate. Your *physician* will be notified by telephone within 24 hours of a decision not to certify and will be informed at that time of how to request reconsideration. Written notice will be sent to you and the requesting provider within two business days of the decision. This written notice will include:
   - an explanation of the reason for the decision,
   - reference of the criteria used in the decision to modify or not certify the request,
   - the name and phone number of the Peer Clinical Reviewer making the decision to modify or not certify the request,
   - how to request reconsideration if you or your provider disagree with the decision.
9. Reviewers may be plan employees or an independent third party Anthem chooses at Anthem's sole and absolute discretion.
10. You or your *physician* may request copies of specific criteria and/or medical policy by writing to the address shown on your plan identification card. Anthem discloses their medical necessity review procedures to health care providers through provider manuals and newsletters.

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

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

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

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

Personal Case Management

The personal case management program enables Anthem 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, Anthem has the right to recommend an alternative plan of treatment which may include services not covered under this *plan*. It is not your right to receive personal case management, nor does Anthem have an obligation to provide it; Anthem provides these services at Anthem's sole and absolute discretion.

HOW PERSONAL CASE MANAGEMENT WORKS

The personal 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.

Members may be identified for possible personal case management through the *plan's* utilization review procedures, by the attending *physician*, *hospital* staff, or Anthem claims reports. The *member* or the *member's* family may also call Anthem.

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

1. You require extensive long-term treatment;
2. Anthem anticipates that such treatment utilizing services or supplies covered under this *plan* will result in considerable cost;
3. Anthem's cost-benefit analysis determines that the benefits payable under this *plan* for the alternative plan of treatment can be provided at a lower overall cost than the benefits you would otherwise receive under this *plan* while maintaining the same standards of care; and
4. You (or your legal guardian) and your *physician* agree, in a letter of agreement, with Anthem's recommended substitution of benefits and with the specific terms and conditions under which alternative benefits are to be provided.

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

Anthem makes treatment recommendations only; any decision regarding treatment belongs to you and your *physician*. CalPERS will, in no way, compromise your freedom to make such decisions.

EFFECT ON BENEFITS

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

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

Disagreements with Medical Management Decisions

1. If you or your *physician* disagree with a decision, or question how it was reached, you or your *physician* may request reconsideration. Requests for reconsideration (either by telephone or in writing) must be directed to the reviewer making the determination. The address and the telephone number of the reviewer are included on your written notice of determination. Written requests must include medical information that supports the medical necessity of the services.
2. If you, your representative, or your *physician* acting on your behalf find the reconsidered decision still unsatisfactory, a request for an appeal of a reconsidered decision may be submitted in writing to Anthem.

Exceptions to the Utilization Review Program

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

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

Anthem 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 Anthem 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 *plan's members*.

You may determine whether a health care provider participates in certain programs by checking our online provider directory on Anthem's website at www.anthem.com/ca/calpers or by calling customer service at 1-877-737-7776.

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. Anthem'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.

Exclusions

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

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

2. **Birth Control Devices.** Any devices needed for birth control which can be obtained without a *physician's* prescription such as condoms.

3. **Blood.** Benefits are not provided for the collection, processing and storage of self-donated blood except as specifically provided under the "Blood" benefit on page 18.

4. **Braces or Other Appliances or Services.** Braces and other orthodontic appliances or services, except as specifically stated in the "Reconstructive Surgery" benefit on page 30 or "Dental Care" benefit on page 20.

5. **Care Not Approved.** Care you got from a health care provider without an authorization from an *EPO provider physician*, except for an *emergency* or for *urgent care.*

6. **Care Not Covered.** Services received before your effective date or after your coverage ends, except as specifically stated under the section "Extension of Benefits" on pages 61-62.

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

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

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

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

   This exclusion does not apply to *medically necessary* treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as stated in the "Bariatric Surgery" benefit on page 17.

10. **Consultations.** Consultations provided using telephone, facsimile machine, or electronic mail.

11. **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.

12. **Custodial Care or Rest Cures.** Inpatient room and board charges in connection with a *hospital stay* primarily for environmental change or physical therapy. *Custodial care* or rest cures, except as specifically provided under the "Hospice Care" benefit on pages 24-25 or "Home Infusion Therapy" benefit on page 24. 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" benefit on page 31.

13. **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.

14. **Educations or Academic Services.** This *plan* does not cover:

- Educational or academic counseling, remediation, or other services that are designed to increase academic knowledge or skills.
- Educational or academic counseling, remediation, or other services that are designed to increase socialization, adaptive, or communication skills.
- Academic or educational testing.
- Teaching skills for employment or vocational purposes.
- Teaching art, dance, horseback riding, music, play, swimming, or any similar activities.
- Teaching manners and etiquette or any other social skills.
- Teaching and support services to develop planning and organizational skills such as daily activity planning and project or task planning.

This exclusion does not apply to the *medically necessary* treatment of pervasive developmental disorder or autism.

15. **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.

16. **Eye Exercises or Services and Supplies for Correcting Vision.** Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, except as specifically provided under the "Preventive Care" benefit on pages 28-29 and the "Vision Care" benefit on page 34. Eyeglasses or contact lenses, except as specifically stated in the "Prosthetic Devices" benefit on pages 29-30.

17. **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.

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

19. **Government Treatment.** Any services actually given to you by a local, state, or federal government agency, or by a public school system or school district, except when payment under this *plan* is expressly required by federal or state law. The *plan* will not cover payment for these services if you are not required to pay for them or they are given to you for free. You are not required to seek any such services prior to receiving *medically necessary* health care services that are covered by this *plan*.

20. **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.

21. **Infertility Treatment.** Services or supplies furnished in connection with the diagnosis and treatment of *infertility*, except as specifically stated in the "Infertility Treatments" benefit on page 26.

22. **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 Anthem.

23. **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 Anthem. This exclusion does not apply to the *medically necessary* treatment of pervasive developmental disorder or autism.

24. **Non-EPO Providers.** Services or supplies that are provided by a *non-EPO provider* without an *authorized referral*, except *emergency services* or *urgent care*.

25. **Non-Prescription Drugs.** Non-prescription, over-the-counter patent or proprietary drugs or medicines. Cosmetics, health or beauty aids.

26. **Orthopedic Supplies.** Orthopedic shoes (other than shoes joined to braces) or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications as specifically stated in the "Prosthetic Devices" benefit on pages 29-30.

27. **Outpatient Drugs.** Outpatient drugs or medications including insulin except drugs for abortion or contraception when taken in the *physician's* office or as specifically stated in the "Home Infusion Therapy" on page 24, "Abortion" on page 15, or "Preventive Care" on pages 28-29.

28. **Personal Items.** Services for your personal care, such as: help in walking, bathing, dressing, feeding, or preparing food. Any supplies for comfort, hygiene or beautification.

29. **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.

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

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

32. **Sexual Problems.** Treatment of any sexual problems unless due to a medical problem, physical defect or disease.

33. **Sterilization Reversal.** Reversal of sterilization.

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

35. **Transgender Services.** Services and supplies in connection with transgender services, except as specifically stated in the "Transgender Surgery" benefit on pages 31-32.

36. **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:

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

37. **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.

Medical Claims Review and Appeals Process

The procedures outlined below are designed to ensure you have a full and fair consideration of claims submitted to the *plan*.

The following procedures shall be used to resolve any dispute which results from any act, failure to act, error, omission or medical judgment determination by Anthem's review with respect to any medical claim filed by you or on your behalf. The procedures should be followed carefully and in the order listed.

The cost of copying and mailing medical records required for Anthem to review its determination is your or your Authorized Representative's responsibility.

1. Objection to Claim Processing

You or your Authorized Representative may object by writing to Anthem's customer service department within sixty (60) days of the discovery of any act, failure to act, error, or omission with regard to a properly submitted claim. The objection must set forth all reasons in support of the proposition that an act with regard to the claim, failure to act on the claim, error, or omission occurred. The objection should be sent to:

Anthem Blue Cross
Attention: Grievance and Appeals
P.O. Box 60007
Los Angeles, CA 90060-0007
Telephone: 1-877-737-7776
Fax#: 818-234-3824

Anthem will acknowledge receipt of the objection by written notice to you and/or your Authorized Representative within five (5) days of receipt of the objection. Anthem will then either affirm its decision regarding the claim, take action on the claim or resolve the error or omission within thirty (30) days of receipt of the objection.

If Anthem affirms its decision regarding the claim or fails to respond within thirty (30) days after receiving the request for review, and you and/or your Authorized Representative still objects to Anthem's act, failure to act, error, or omission as stated above, you and/or your Authorized Representative may proceed to Administrative Review as outlined in item 6 below.

2. Notice of Claim Denial – Adverse Benefit Determination (ABD)

In the event any claim for benefits is denied, in whole or in part, Anthem will notify you and/or your Authorized Representative of such denial in writing within 30 days. Any denial of a claim for benefits is considered an "adverse benefit determination" (ABD) and can be based on the fact that it is not a covered benefit, the treatment is not *medically necessary*, or the treatment is *experimental/investigational*. The denial can be the result of Utilization Review for a prospective service, a service that is currently being pursued, or a service that has already been provided. (See "Utilization Review Program" section starting on page 35.) The ABD shall contain specific reasons for the denial and an explanation of the *plan's* review and appeal procedure. Any ABD is subject to Internal Review upon request.

3. Internal Review

You and/or your Authorized Representative may request a review of an ABD by writing or calling Anthem's customer service department within one hundred and eighty (180) days of receipt of an ABD. Your appeal or grievance must clearly state your issue, such as the reasons you disagree with the ABD or why you are dissatisfied with the services you received. If you would like Anthem to consider your grievance on an urgent basis, please write "urgent" on your request and provide your rationale. (See definition of "Urgent Review" on page 55.) Requests for review should be sent to:

Anthem Blue Cross
Attention: Grievance and Appeals
P.O. Box 60007
Los Angeles, CA 90060-0007
Telephone: 1-877-737-7776
Fax#: 818-234-3824

You and/or your Authorized Representative may submit written comments, documents, records, scientific studies, and other information relating to the claim that resulted in an ABD in support of the request for Internal Review. You and/or your Authorized Representative will be provided, upon request and free of charge, reasonable access to records and other information relevant to your claim for benefits, including the right to review the claim file and submit evidence.

Anthem will acknowledge receipt of a request for Internal Review by written notice to you and/or your Authorized Representative within five (5) business days. Anthem will then either uphold or reject the ABD within thirty (30) days of the request for Internal Review if it involves an authorization of services (pre-service appeal or concurrent appeal) or within sixty (60) days for services that have already been provided (post-service appeal).

If Anthem upholds the ABD within the timeframes described above, that decision becomes a "Final Adverse Benefit Determination" (FABD), and you and/or your Authorized Representative may pursue the independent External Review process described in section 5 below. You and/or your Authorized Representative may also request an independent External Review if Anthem fails to render a decision within the timelines specified above for Internal Review.

4. Urgent Review

An urgent grievance is resolved within 72 hours upon receipt of the request, but only if Anthem determines the grievance meets one of the following:

- The standard appeal timeframe could seriously jeopardize your life, health, or ability to regain maximum function; **OR**
- The standard appeal timeframe would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment; **OR**
- A physician with knowledge of your medical condition determines that your grievance is urgent.

If Anthem determines the grievance request does not meet one of the above requirements, the grievance will be processed as a standard request. If your situation is subject to an urgent review, you and/or your Authorized Representative can simultaneously request an independent External Review described below.

5. Request for Independent External Review

If the FABD includes a decision based on Medical Judgment, the FABD will include the *plan's* standard for medical necessity or other Medical Judgment related to that determination, and describes how the treatment fails to meet the *plan's* standard. You and/or your Authorized Representative will be notified that you may request an independent External Review of that determination by an Independent Review Organization (IRO). This review is at no cost to you. Examples of Medical Judgment include, but are not limited to:

- The appropriate health care setting for providing medical care to an individual (such as outpatient versus inpatient care or home care versus rehabilitation facility; or
- Whether treatment by a specialist is *medically necessary* or appropriate pursuant to the *plan's* standard for medical necessity or appropriateness); or
- Whether treatment involved "emergency care" or "urgent care", affecting coverage or the level of coinsurance.

For more information about the *plan's* standard for medical necessity, please see page 75 in the section entitled Definitions.

You and/or your Authorized Representative may request an independent External Review no later than four (4) months from the date of receipt of the FABD. The type of services in dispute must be a covered benefit. For cases involving Medical Judgment, you and/or your Authorized Representative must exhaust the independent External Review prior to requesting a CalPERS Administrative Review. (See CalPERS Administrative Review and Administrative Hearing on pages 50-51.)

You and/or your Authorized Representative may also request an independent External Review if Anthem fails to render a decision within the timelines specified above for Internal Review. For a more complete description of independent External Review rights, please see 45 Code of Federal Regulations section 147.136.

6. Request for CalPERS Administrative Review Process

If you remain dissatisfied after exhausting the Internal Review process for benefit decisions and the independent External Review in cases involving Medical Judgment, you and/or your Authorized Representative may request a CalPERS Administrative Review. You and/or your Authorized Representative may also request Administrative Review in connection with an objection to the processing of a claim by Anthem. Please see section 1 above.

CalPERS Administrative Review and Administrative Hearing

1. Administrative Review

If you remain dissatisfied after exhausting the Internal Review process for benefit decisions and the independent External Review in cases involving Medical Judgment, you and/or your Authorized Representative may submit a request for CalPERS Administrative Review. You must exhaust Anthem's internal grievance process, and the independent External Review process, when applicable, prior to submitting a request for CalPERS Administrative Review.

This request must be submitted in writing to CalPERS within thirty (30) days from the date of the FABD for benefit decisions or the independent External Review decision in cases involving Medical Judgment. For objections to claim processing, the request must be submitted within thirty (30) days of Anthem affirming its decision regarding the claim or within sixty (60) days from the date you and/or your Authorized Representative sent the objection regarding the claim to Anthem and Anthem failed to respond within thirty (30) days of receipt of the objection.

The request must be mailed to:

CalPERS Health Plan Administration Division
Health Appeals Coordinator
P.O. Box 1953
Sacramento, CA 95812-1953

If you are planning to submit information Anthem may have regarding your dispute with your request for Administrative Review, please note that Anthem may require you to sign an authorization form to release this information. In addition, if CalPERS determines that additional information is needed after Anthem submits the information it has regarding your dispute, CalPERS may ask you sign an Authorization to Release Health Information (ARHI) form.

If you have additional medical records from providers that you believe are relevant to CalPERS review, those records should be included with the written request. You should send **copies** of documents, not originals, as CalPERS will retain the documents for its files. You are responsible for the cost of copying and mailing medical records required for the Administrative Review. Providing supporting information to CalPERS is voluntary. However, failure to provide such information may delay or preclude CalPERS in providing a final Administrative Review determination.

CalPERS cannot review claims for medical malpractice, i.e. quality of care.

CalPERS will attempt to provide a written determination within 60 days from the date all pertinent information is received by CalPERS. For claims involving urgent care, CalPERS will make a decision as soon as possible, taking into account the medical exigencies, but no later than three (3) business days from the date all pertinent information is received by CalPERS.

2. Administrative Hearing

You must complete the CalPERS Administrative Review process prior to being offered the opportunity for an Administrative Hearing. Only claims involving covered benefits are eligible for an Administrative Hearing.

You and/or your Authorized Representative must request an Administrative Hearing in writing within thirty (30) days of the date of the Administrative Review determination. Upon satisfactory showing of good cause, CalPERS may grant additional time to file a request for an Administrative Hearing, not to exceed thirty (30) days.

The request for an Administrative Hearing must set forth the facts and the law upon which the request is based. The request should include any additional arguments and evidence favorable to your case not previously submitted for Administrative Review or External Review.

If CalPERS accepts the request for an Administrative Hearing, it will be conducted in accordance with the Administrative Procedure Act (Government Code section 11500 et seq.). An Administrative Hearing is a formal legal proceeding held before an Administrative Law Judge (ALJ); you and/or your Authorized Representative may, but is not required to, be represented by an attorney. After taking testimony and receiving evidence, the ALJ will issue a Proposed Decision. The CalPERS Board of Administration (Board) will vote regarding whether to adopt the Proposed Decision as its own decision at an open (public) meeting. The Board's final decision will be provided in writing to you and/or your Authorized Representative within two weeks of the Board's open meeting.

3. Appeal Beyond Administrative Review and Administrative Hearing

If you are still dissatisfied with the Board's decision, you may petition the Board for reconsideration of its decision, or may appeal to the Superior Court.

You may not begin civil legal remedies until after exhausting these administrative procedures.

Summary of Process and Rights of Members under the Administrative Procedure Act

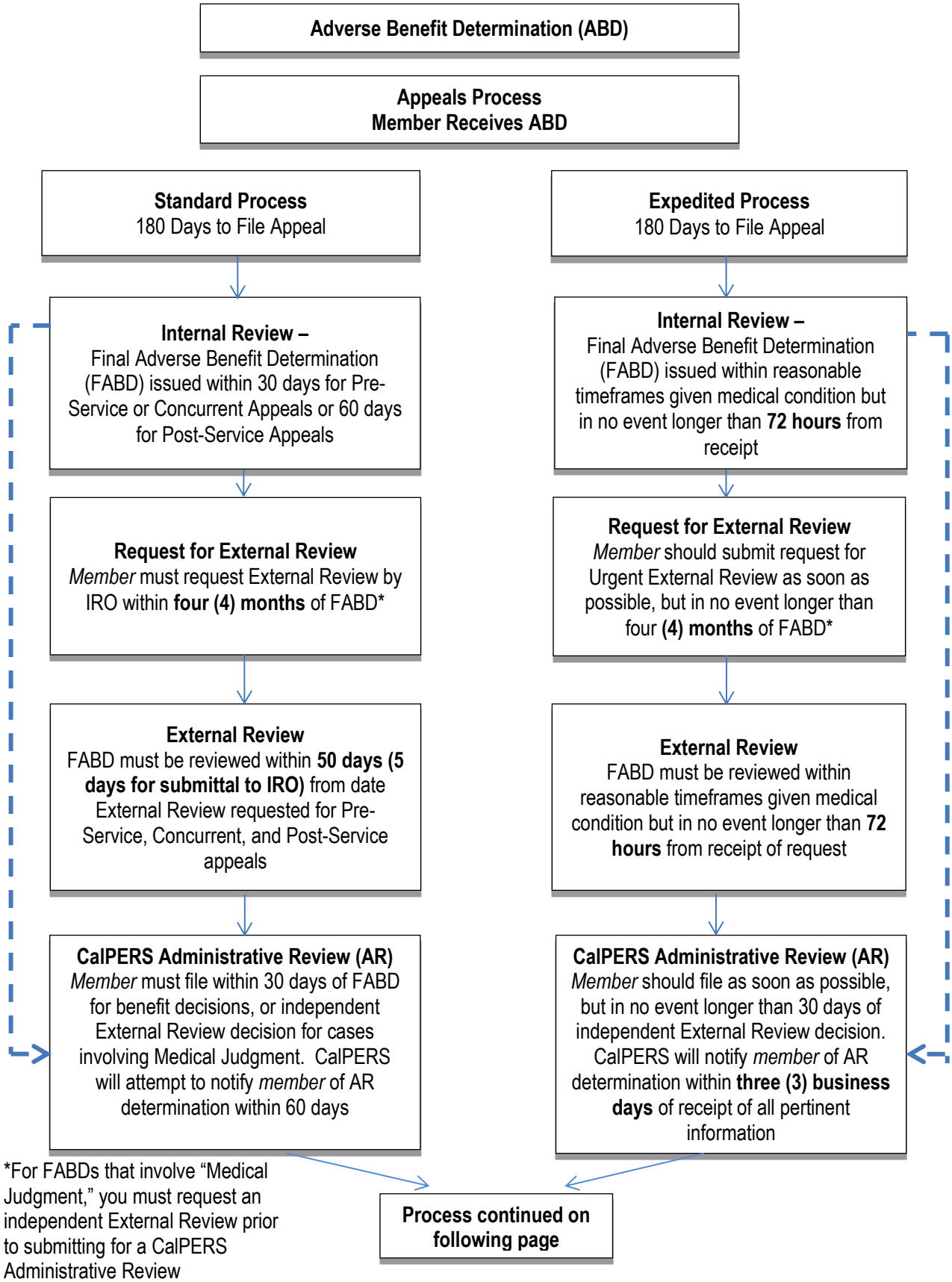
- **Right to records, generally.** You may, at your own expense, obtain copies of all non-medical and non-privileged medical records from Anthem and/or CalPERS, as applicable.
- **Records subject to attorney-client privilege.** Communication between an attorney and a client, whether oral or in writing, will not be disclosed under any circumstances.
- **Attorney Representation.** At any state of the appeal proceedings, you may be represented by an attorney. If you choose to be represented by an attorney, you must do so at your own expense. Neither CalPERS nor Anthem will provide an attorney or reimburse you for the cost of an attorney even if you prevail on appeal.
- **Right to experts and consultants.** At any state of the proceedings, you may present information through the opinion of an expert, such as a physician. If you choose to retain an expert to assist in presentation of a claim, it must be at your own expense. Neither CalPERS nor Anthem will reimburse you for the costs of experts, consultants or evaluations.

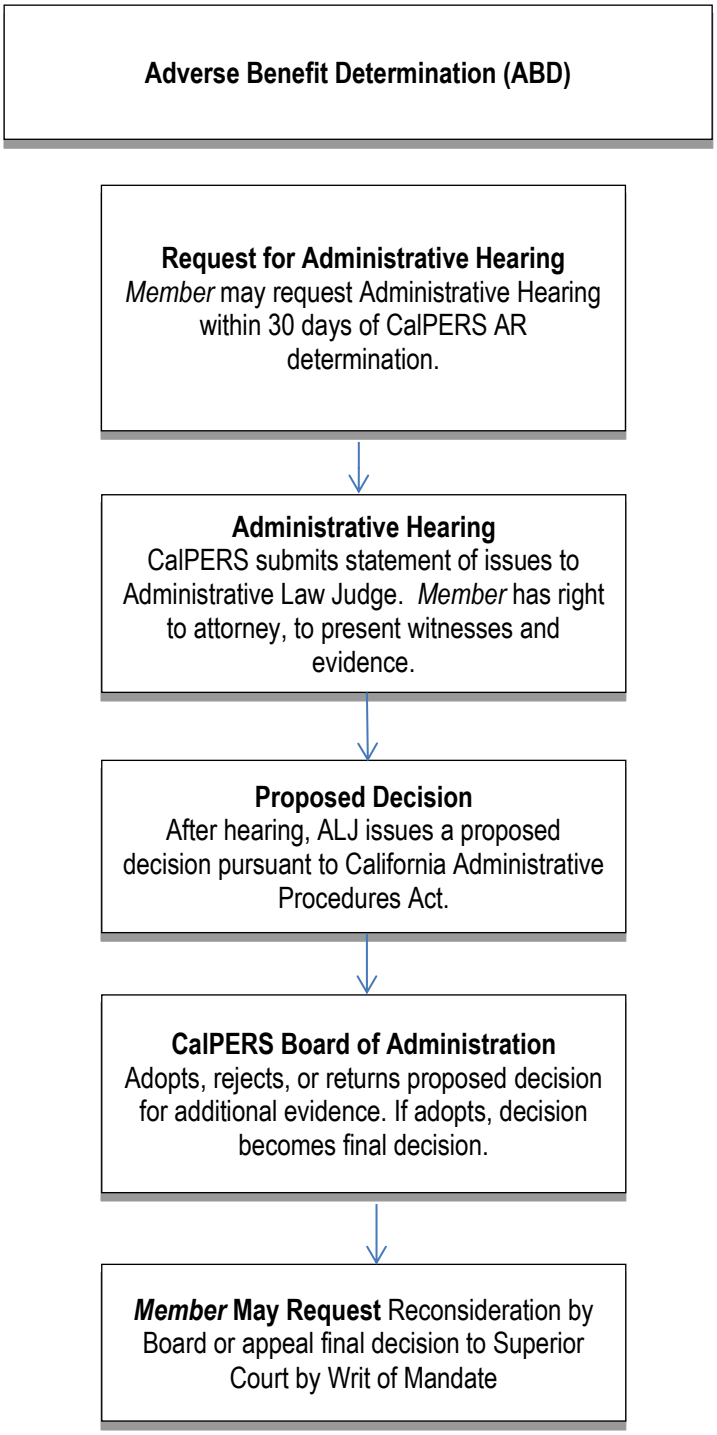
Service of Legal Process

Legal process or service upon CalPERS must be served in person at:

CalPERS Legal Office
Lincoln Plaza North
400 "Q" Street
Sacramento, CA 95814

Adverse Benefit Determination (ABD) Chart




Adverse Benefit Determination (ABD)
Request for Administrative Hearing
Member may request Administrative Hearing within 30 days of CalPERS AR determination.
Administrative Hearing
CalPERS submits statement of issues to Administrative Law Judge. Member has right to attorney, to present witnesses and evidence.
Proposed Decision
After hearing, ALJ issues a proposed decision pursuant to California Administrative Procedures Act.
CalPERS Board of Administration
Adopts, rejects, or returns proposed decision for additional evidence. If adopts, decision becomes final decision.
Member May Request Reconsideration by Board or appeal final decision to Superior Court by Writ of Mandate

Adverse Benefit Determination (ABD)
Appeals Process
Definitions

The flow chart above and definitions below are included to assist you with understanding your rights and the provisions of this *plan* related to Internal Claims and Appeals, and the independent External Review process available in the event a denial is based on Medical Judgment. The information provided here is general and simplified, consistent with accuracy, but is not intended to be the definitive statement of state or federal law.

Administrative Hearing (AH) – A legal hearing conducted by the Office of Administrative Hearings and governed by the rules established in the California Administrative Procedure Act, (Government Code section 11370). You may avail yourself of these administrative rights by appealing a FABD or independent External Review decision to CalPERS for Administrative Review. If CalPERS upholds the FABD or independent External Review decision, CalPERS will notify you that you may formally appeal that decision and request an Administrative Hearing.

Administrative Review (AR) – A review conducted by CalPERS after Anthem's Internal Review process or after you elect to participate in the independent External Review process. If you wish to appeal an independent External Review decision, you must submit your appeal to CalPERS for Administrative Review to proceed to Administrative Hearing and exhaust your administrative rights under California law.

Adverse Benefit Determination (ABD) – Any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment based on a determination of your eligibility to participate in a plan, and any denial, reduction or termination of, or failure to provide or make payment for, a benefit resulting from the application of any Utilization Review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

Authorized Representative – A person or entity you designate to act on your behalf regarding your appeal or grievance, AR or AH.

Concurrent Appeal – An appeal of a claim for approval of medical care, treatment or medication during the time such care, treatment or medication is being rendered.

External Review – A *member* who receives a Final Adverse Benefit Determination (FABD) is eligible to submit the FABD to an independent External Review if the plan's decision involved making a medical judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of health care service or treatment requested. You will receive notice of your right to request an independent External Review at the time the *plan* issues the FABD. The independent External Review is conducted by an Independent Review Organization (IRO), as defined below; the IRO's independent External Review decision is binding on the *plan*. An independent External Review decision that upholds the FABD, or denial of benefit, may be submitted to CalPERS for Administrative Review. The independent External Review process is optional and must be elected by you within four (4) months of the FABD (defined below).

Final Adverse Benefit Determination (FABD) – An ABD that has been upheld by a plan or issuer at the completion of the Internal Review process.

Independent Review Organization (IRO) – An entity that is accredited by a nationally recognized private accrediting organization that conducts Independent External Reviews of FABDs.

Internal Review – The review conducted by Anthem for an ABD.

Medical Judgment – An ABD or FABD that is based on the *plan's* requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or its determination that a treatment is experimental or investigational, or a rescission of coverage (retroactive cancellation of coverage due to a reduction in time base).

Pre-Service Appeal – An appeal of a claim for approval of medical care, treatment or medication prior to the time such care, treatment or medication is rendered.

Post-Service Appeal – An appeal of a claim for approval of medical care, treatment or medication after the time such care, treatment or medication has been rendered.

Urgent Review – The process to review a claim for medical care, treatment or Medication with respect to which the application of the time period for making non-urgent care determinations could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function; or, in the opinion of a physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Decisions regarding these claims must be made as soon as possible consistent with the medical exigencies involved, but in no event longer than 72 hours upon receipt of the request by Anthem Blue Cross, or three (3) business days upon receipt of all pertinent information by CalPERS for the Administrative Review.

Continuation of Coverage

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

DEFINITIONS

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

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

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

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

1. **For Subscribers and Family Members:**
   a. The *subscriber's* termination of employment, for any reason other than gross misconduct; or
   b. A reduction in the *subscriber's* work hours.
2. **For Retired Employees and their Family Members.** Cancellation or a substantial reduction of retiree benefits under the *plan* due to the *employer* filing for Chapter 11 bankruptcy, provided that:
   a. The *plan* expressly includes coverage for retirees; and
   b. Such cancellation or reduction of benefits occurs within one year before or after the *employer's* filing for bankruptcy.
3. **For Family Members:**
   a. The death of the *subscriber;*
   b. The spouse's divorce or legal separation from the *subscriber;*
   c. The end of a domestic partner's partnership with the *subscriber;*
   d. The end of a child's status as a dependent child, as defined by *PEMHCA;* or
   e. The *subscriber's* entitlement to Medicare.

ELIGIBILITY FOR COBRA CONTINUATION

A *subscriber* or *family member* may choose to continue coverage under the *plan* if your coverage would otherwise end due to a Qualifying Event.

TERMS OF COBRA CONTINUATION

Notice. The *employer* will notify either the *subscriber* or *family member* of the right to continue coverage under COBRA, as provided below:

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

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

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

Notice of continued coverage, along with the initial premium, must be delivered to Anthem by the *employer* within 45 days after you elect COBRA continuation coverage.

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

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

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

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

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

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

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

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

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

1. The end of 18 months from the Qualifying Event, if the Qualifying Event was termination of employment or reduction in work hours;*
2. The end of 36 months from the Qualifying Event, if the Qualifying Event was the death of the *subscriber,* divorce or legal separation, the end of a domestic partnership, or the end of dependent child status;*
3. The end of 36 months from the date the *subscriber* became entitled to Medicare, if the Qualifying Event was the *subscriber's* entitlement to Medicare. If entitlement to Medicare does not result in coverage terminating and Qualifying Event 1 occurs within 18 months after Medicare entitlement, coverage for Qualified Beneficiaries other than the *subscriber* will end 36 months from the date the *subscriber* became entitled to Medicare;
4. The date the agreement with CalPERS terminates;
5. The end of the period for which premiums are last paid;
6. The date, following the election of COBRA, the *member* first becomes covered under any other group health plan; or
7. The date, following the election of COBRA, the *member* first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

*For a *member* whose COBRA continuation coverage began under a prior plan, this term will be dated from the time of the Qualifying Event under that prior plan. Additional note: If your COBRA continuation under this *plan* began on or after January 1, 2003 and ends in accordance with item 1, you may further elect to continue coverage for medical benefits only under CalCOBRA for the balance of 36 months (COBRA and CalCOBRA combined). All COBRA eligibility must be exhausted before you are eligible to further continue coverage under CalCOBRA.

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

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 or at www.coveredca.com.

EXTENSION OF CONTINUATION DURING TOTAL DISABILITY

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

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

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

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

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

Cost of Coverage. For the 19th through 29th months that the total disability continues, the cost for the extended continuation coverage must be remitted to Anthem. This cost (called the "premium") shall be subject to the following conditions:

1. If the disabled *member* continues coverage during this extension, this charge shall be **150%** of the applicable rate for the length of time the disabled *member* remains covered, depending upon the number of covered dependents. If the disabled *member* does not continue coverage during this extension, this charge shall remain at **102%** of the applicable rate.
2. The cost for extended continuation coverage must be remitted to Anthem each month during the period of extended continuation coverage. Anthem must receive timely payment of the premium in order to maintain the extended continuation coverage in force.
3. You may be required to pay the entire cost of the extended continuation coverage.

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

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

1. The end of the month following a period of 30 days after the Social Security Administration's final determination that you are no longer totally disabled;
2. The end of 29 months from the Qualifying Event*;
3. The date the *plan* terminates;
4. The end of the period for which premiums are last paid;

5. The date, following the election of COBRA, the *member* first becomes covered under any other group health plan; or

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

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

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

CalCOBRA Continuation of Coverage

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

1. 18 months after the qualifying event, if the qualifying event was termination of employment or reduction in work hours; or

2. 29 months after the qualifying event, if you qualified for the extension of COBRA continuation during total disability.

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

TERMS OF CALCOBRA CONTINUATION

Notice. Within 180 days prior to the date federal COBRA ends, the *employer* will notify you of your right to further elect coverage under CalCOBRA. If you choose to elect CalCOBRA coverage, you must notify the *employer* in writing within 60 days of the date your coverage under federal COBRA ends or when you are notified of your right to continue coverage under CalCOBRA, whichever is later.

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

Additional Dependents. A spouse or child acquired during the CalCOBRA continuation period is eligible to be enrolled as a dependent. The standard enrollment provisions of the *plan* apply to enrollees during the CalCOBRA continuation period.

Cost of Coverage. You may be required to pay the entire cost of your CalCOBRA continuation coverage (this is the “premium”). This cost must be remitted to the *employer* each month during the CalCOBRA continuation period. This cost will be:

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

2. 150% of the applicable rate if your coverage under federal COBRA ended after 29 months.

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

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

For dependents properly enrolled during the CalCOBRA continuation, coverage begins according to the enrollment provisions of the *plan*.

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

1. The date that is 36 months after the date of your qualifying event under federal COBRA*;
2. The date the *plan* terminates;
3. The date the *employer* no longer provides coverage to the class of *subscribers* to which you belong;
4. The end of the period for which the premium is last paid;
5. The date you become covered under any other health plan;
6. The date you become entitled to Medicare; or
7. The date you become covered under a federal COBRA continuation.

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

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

Extension of Benefits

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

1. If you are confined as an inpatient in a *hospital* or *skilled nursing facility*, you are considered totally disabled as long as the inpatient *stay* is *medically necessary*, and no written certification of the total disability is required. If you are discharged from the *hospital* or *skilled nursing facility*, you may continue your total disability benefits by submitting written certification by your *physician* of the total disability within 90 days of the date of your discharge. Thereafter, Anthem must receive proof of your continuing total disability at least once every 90 days while benefits are extended.
2. If you are not confined as an inpatient but wish to apply for total disability benefits, you must do so by submitting written certification by your *physician* of the total disability. Anthem must receive this certification within 90 days of the date coverage ends under this *plan*. At least once every 90 days while benefits are extended, Anthem must receive proof that your total disability is continuing.
3. Your extension of benefits will end when any one of the following circumstances occurs:
    a. You are no longer totally disabled.

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

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

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

General Provisions

Notice of Claim

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

Third-Party Liability

If you receive medical services covered by the *plan* for injuries caused by the act or omission of another person (a "third party"), you agree to:

1. promptly assign your rights to reimbursement from any source for the costs of such covered services; and
2. reimburse the *plan*, to the extent of benefits provided, immediately upon collection of damages by you for such injury from any source, including any applicable automobile uninsured or underinsured motorist coverage, whether by action of law, settlement, or otherwise; and
3. provide the *plan* with a lien, to the extent of benefits provided by the *plan*, upon your claim against or because of the third party. The lien may be filed with the third party, the third party's agent, the insurance company, or the court; and
4. the release of all information, medical or otherwise, which may be relevant to the identification of and collection from parties responsible for your illness or injury; and
5. notify Anthem of any claim filed against a third party for recovery of the cost of medical services obtained for injuries caused by the third party; and
6. cooperate with CalPERS and Anthem in protecting the lien rights of the *plan* against any recovery from the third party; and
7. obtain written consent from CalPERS prior to settling any claim with the third party that would release the third party from the lien or limit the rights of the *plan* to recovery.

   Pursuant to Government Code section 22947, a *member* (or his/her attorney) must immediately notify the *plan*, via certified mail, of the existence of any claim or action against a third party for injuries allegedly caused by the third party. Notices of third party claims and actions must be sent to:

   Anthem Blue Cross
   P.O. Box 60007
   Los Angeles, CA 90060-0007

   The *plan* has the right to assert a lien for costs of health benefits paid on behalf of a plan *member* against any settlement with, or arbitration award or judgment against, a third party. The *plan* will be entitled to collect on its lien even if the amount you or anyone recovered for you (or your estate, parent or legal guardian) from or for the account of such third party as compensation for the injury, illness or condition is less than the actual loss you suffered.

Coordination of Benefits

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

DEFINITIONS

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

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

Other Plan is any of the following:

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

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

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

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

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

EFFECT ON BENEFITS

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

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

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. This would include Medicare in all cases, except when the law requires that This Plan pays before Medicare.
2. A plan which covers you as a *subscriber* pays before a plan which covers you as a dependent. But, if you are retired and eligible for Medicare, Medicare pays (a) after the plan which covers you as a dependent of an active employee, but (b) before the plan which covers you as a retired *subscriber*.

   For example: You are covered as a retired *subscriber* under this plan 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 *subscriber* would pay last.

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

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

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

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

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

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

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

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

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

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

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

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

ANTHEM'S RIGHTS UNDER THIS PROVISION

Responsibility For Timely Notice. Anthem 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 Anthem's liability reduced accordingly.

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

Right of Recovery. If payments made under This Plan exceed the maximum payment necessary to satisfy the intent of this provision, Anthem 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

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

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

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

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

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

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

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

Any charges paid by Medicare will be applied for services covered under this *plan* toward your *plan* deductible, if any.

Other General Provisions

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-EPO 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 Anthem in consultation with you and the *non-EPO provider* and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time you enroll with Anthem.
3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.
4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.
5. The care of a newborn child between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the time the child enrolls with Anthem.

6. Performance of a surgery or other procedure that Anthem 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 time you enroll with Anthem.

Please contact customer service at 1-877-737-7776 to request Transition Assistance or to obtain a copy of the written policy. Eligibility is based on your clinical condition and is not determined by diagnostic classifications. Transition Assistance does not provide coverage for services not otherwise covered under the *plan*.

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

Continuity of Care after Termination of Provider

Subject to the terms and conditions set forth below, Anthem will provide benefits at the *EPO 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 Anthem 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 *EPO 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 Anthem prior to termination. The provider must also agree in writing to accept the terms and reimbursement rates under his or her agreement with Anthem prior to termination. If the provider does not agree with these contractual terms and conditions, Anthem is not required to continue the provider's services beyond the contract termination date.

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

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Anthem in consultation with you and the terminated provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.

3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

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

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

6. Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the date the 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 1-877-737-7776 to request continuity of care or to obtain a copy of the written policy. Eligibility is based on the *member's* clinical condition and is not determined by diagnostic classifications. Continuity of care does not provide coverage for services not otherwise covered under the *plan*.

Anthem will notify you by telephone, and the provider by telephone and fax, as to whether or not your request for continuity of care is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the *plan*. Financial arrangements with terminated providers are negotiated on a case-by-case basis. Anthem will request that the terminated provider agree to accept reimbursement and contractual requirements that apply to *EPO providers*, including payment terms. If the terminated provider does not agree to accept the same reimbursement and contractual requirements, Anthem is not required to continue that provider's services. If you disagree with Anthem's determination regarding continuity of care, you may file a grievance with Anthem by following the procedures described in the section entitled "Medical Claims Review and Appeals Process" starting on page 47.

Terms of Coverage

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

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

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

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. Anthem does not have the right to cancel your coverage under this *plan* while:

1. This *plan* is in effect;

2. You are eligible; and

3. Your premiums are paid according to the terms of the *plan*.

Provider Reimbursement

Physicians and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. A participating *physician* may, after notice from Anthem, be subject to a reduced negotiated rate in the event the participating *physician* fails to make routine referrals to *EPO 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.

Inter-Plan Programs

- **Out of Area Services**

  Anthem 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 Anthem's 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 Anthem and other Blue Cross and Blue Shield Licensees.

  Typically, when accessing care outside our 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. Anthem's payment practices in both instances are described below.

- **BlueCard® Program.** Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, Anthem 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 Anthem's 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 Anthem.

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

  Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However such adjustments will not affect the price Anthem 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 your calculation. If any federal or any state laws mandate other liability calculation methods, including a surcharge, Anthem would then calculate your liability for any covered healthcare services according to applicable law.

- **Non-Participating Health Care Providers Outside Anthem 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 we will make for the covered services as set forth in this paragraph.

Exceptions. In certain situations, Anthem may use other payment bases, such as billed covered charges, the payment Anthem 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 Anthem 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 Anthem 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 at 1-877-737-7776 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 Anthem. If you have any questions or complaints about the BlueCard Program, please call customer service at 1-877-737-7776.

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

Independent Contractors. Anthem'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 Anthem's agents nor is Anthem, or any of their employees, an employee or agent of any *hospital,* medical group or medical care provider of any type.

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

Payment to Providers

Anthem will pay the benefits of this *plan* directly to *EPO providers*, *CME* and medical transportation providers. If you or one of your *family members* receives services from *non-EPO providers,* payment will be made directly to the *subscriber* and you will be responsible for payment to the provider. Any assignment of benefits, even if assignment includes the providers right to receive payment, is void. Anthem will pay *non-EPO providers* and other providers of service directly when *emergency services* and care are provided to you or one of your *family members.* Anthem will continue such direct payment until the emergency care results in stabilization. If you are a MediCal beneficiary and you assign benefits in writing to the State Department of Health Services, Anthem will pay the benefits of this *plan* to the State Department of Health Services. These payments will fulfill the *plan's* obligation to you for those covered services.

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

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

Right of Recovery

Whenever payment has been made in error, Anthem 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 Anthem recovers a payment made in error from the provider, except in cases of fraud or misrepresentation on the part of the provider, Anthem will only recover such payment from the provider within 365 days of the date

payment was made on a claim submitted by the provider. Anthem reserves the right to deduct or offset any amounts paid in error from any pending or future claim.

Under certain circumstances, if Anthem pays your healthcare provider amounts that are your responsibility, such as deductibles, copayments or coinsurance, Anthem may collect such amounts directly from you. You agree that Anthem has the right to recover such amounts from you.

Anthem has oversight responsibility for compliance with provider and vendor and subcontractor contracts. Anthem 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.

Anthem 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. Anthem will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. Anthem may not provide you with notice of overpayments made by them or you if the recovery method makes providing such notice administratively burdensome.

Plan Administrator - COBRA. In no event will Anthem be plan administrator for the purposes of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA). The term "plan administrator" refers either to the CalPERS or to a person or entity, other than Anthem, engaged by CalPERS to perform or assist in performing administrative tasks in connection with CalPERS' health plan. CalPERS is responsible for satisfaction of notice, disclosure and other obligations of administrators. In providing notices and otherwise performing under the "Continuation of Coverage" section starting on page 56, CalPERS is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as your agent.

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

Renewal Provisions. CalPERS' agreement with Anthem is subject to renewal at certain intervals. Anthem may change the premiums or other terms of the *plan* from time to time.

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

Anthem may release your medical information to professional peer review organizations and to CalPERS for purposes of reporting claims experience or conducting an audit of Anthem's operations, provided the information disclosed is reasonably necessary for CalPERS to conduct the review or audit.

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

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 "Definition" 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.

Annuitant is defined in accordance with the definition currently in effect in *PEMHCA* and *Regulations*.

Anthem Blue Cross (Anthem) is the claims administrator responsible for administering medical benefits and providing utilization review services under this *plan*. As used in this Evidence of Coverage booklet, the term "Anthem" shall be used to refer to both Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company. Anthem Blue Cross, as defined, is a separate and distinct entity from references to the Blue Cross and Blue Shield Association or Blue Cross and/or Blue Shield Plan providers.

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

- There is no *EPO provider* who practices in the appropriate specialty, which provides the required services, or which has the necessary facilities within a 30-mile radius of your residence or within the county in which your residence is located, whichever is less; and
- You are referred in writing to the *non-EPO provider* by the *physician* who is an *EPO provider;* and
- Anthem has authorized the referral before services are rendered.

You or your *physician* must call customer service at 1-877-737-7776 prior to scheduling an admission to, or receiving the services of, a *non-EPO provider*.

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

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

Board is the Board of Administration of the California Public Employees' Retirement System (CalPERS).

Calendar Year (Year) is a 12 month period starting January 1 at 12:01 a.m. Pacific Standard Time.

Centers of Medical Excellence (CME) are health care providers designated by Anthem as a selected facility for specified medical services. A provider participating in a CME network has an agreement in effect with Anthem at the time services are rendered or is available through Anthem's affiliate companies or Anthem's relationship with the Blue Cross and Blue Shield Association. CME agree to accept the *maximum allowed amount* as payment in full for covered services. An *EPO provider* in Partners in Health is not necessarily a *CME*.

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*.

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 Anthem.

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

Employer is defined in accordance with the definition currently in effect in *PEMHCA* and *Regulations*.

EPO Provider is a provider or other licensed health care professional who participates in the Anthem preferred exclusive provider organization and are defined as Partners in Health.

EPO providers agree to accept the *maximum allowed amount* as payment for covered services. For a list of EPO hospitals, please see "Monterey County EPO Hospitals" listed under the section entitled "Plan Providers". To find an *EPO provider physician*, call customer service at 1-877-737-7776 or use the "Find a Doctor, Hospital or Urgent Care" function on Anthem's website at https://www13.anthem.com/cp/web/calpers/find-a-doctor.

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

Family Member is defined in accordance with the definition currently in effect with *PEMHCA* and *Regulations*.

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

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

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

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

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

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

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

Maximum Allowed Amount is the maximum amount of reimbursement Anthem will allow for covered medical services and supplies under this *plan*. See "Maximum Allowed Amount" starting on page 10.

Medically Necessary procedures, supplies, equipment or services are those determined to be:

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

Member is any *subscriber*, *annuitant* or *family member* enrolled in the *plan*.

Mental or Nervous Disorders, including substance abuse, for the purposes of this *plan*, 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 *plan* (see definition of "severe mental disorders" on page 78).

Non-EPO Provider is a provider that (1) do not participate the Anthem preferred exclusive provider organization and are not defined as Partners in Health, or (2) do not participate in a Blue Cross and/or Blue Shield Plan network outside California, at the time services are rendered.

They are not *EPO providers*. Remember that the *maximum allowed amount* may only represent a portion of the amount which a *non-EPO provider* charges for services. See "Maximum Allowed Amount" starting on page 10.

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.

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 licensed educational psychologist for the provision of behavioral health treatment services for the treatment of pervasive developmental disorder or autism only
    - A chiropractor (D.C.)
    - An acupuncturist (A.C.)
    - A nurse midwife
    - A nurse practitioner
    - A physician assistant
    - 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 *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 the *plan* is 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.

Plan is the set of benefits described in this booklet and in the amendments to this booklet (if any). The plan is a self-funded health plan established and administered by CalPERS (the plan administrator and insurer) through contracts with Anthem Blue Cross.

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 customer service number at 1-877-737-7776 for additional information about services that are covered by this *plan* as preventive care services. You may also refer to the following websites that are maintained by the U.S. Department of Health & Human Services.

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

http://www.ahrq.gov

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

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 facilities are acute 24-hour facilities 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 the 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.

Public Employees' Medical and Hospital Care Act (PEMHCA) — Title 2, Division 5, Part 5 (sections 22750 and following) of the Government Code of the State of California.

Regulations — the Public Employees' Medical and Hospital Care Act Regulations as adopted by the CalPERS Board of Administration and set forth in Subchapter 3, Chapter 2, Division 1, Title 2 of the California Code of Regulations.

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 Health and Safety Code section 1374.72: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, and bulimia.

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

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

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

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

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

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

Stay is an inpatient confinement of a *member* which begins when the *member* is admitted to a facility and ends when the *member* is discharged from that facility.

Subscriber is the person enrolled who is responsible for payment of premiums to the *plan*, and whose employment or other status, except family dependency, is the basis for eligibility for enrollment under this *plan*.

Totally Disabled Family Members are *family member*s who are unable to perform all activities usual for persons of that age.

Totally Disabled Subscribers are *subscriber*s who, because of illness or injury, are unable to work for income in any job for which they are qualified or for which they become qualified by training or experience, and who are in fact unemployed.

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 at 1-877-737-7776 or you can also search online using the "Find a Doctor, Hospital or Urgent Care" function on the website at https://www13.anthem.com/cp/web/calpers/find-a-doctor. 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.

For Your Information

Your Rights and Responsibilities as a Monterey County EPO Plan Member

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

You have the right to:

- Speak freely and privately with your doctors and other health professionals about all health care options and treatment needed for your condition, no matter what the cost or whether it's covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect, dignity, and the right to privacy.
- Privacy, when it comes to your personal health information, as long as it follows state and Federal laws, and our privacy rules.
- Get information about Anthem's company and services, and Anthem's network of doctors and other health care providers.
- Get more information about your rights and responsibilities and provide your thoughts and ideas about them.
- Provide your thoughts and ideas about any of the rules of your health care plan and in the way your plan works.
- Make a complaint or file an appeal about:
    - Your health care plan
    - Any care you get
    - Any covered service or benefit ruling that your health care plan makes
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future; and the right to have your doctor tell you how that may affect your health now and in the future
- Get all of the most up-to-date information about the cause of your illness, your treatment and what may result from that illness or treatment from a doctor or other health care professional. When it seems that you will not be able to understand certain information, that information will be given to someone else that you choose.
- Get help at any time, by contacting your local insurance department.

You have the responsibility to:

- Choose any primary care physician (doctor), also called a PCP, who is in our network if your health care plan says that you have to have a PCP.
- Treat all doctors, health care professionals and staff with courtesy and respect.

- Keep all scheduled appointments with your health care providers and call their office if you have a delay or need to cancel.
- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- To the extent possible, understand your health problems and work with your doctors or other health care professionals to make a treatment plan that you all agree on.
- Follow the care plan that you have agreed on with your doctors or health care professionals.
- Tell your doctors or other health care professionals if you don't understand any care you're getting or what they want you to do as part of your care plan.
- Follow all health care plan rules and policies.
- Let customer service department know if you have any changes to your name, address or *family members* covered under your *plan*.
- Give your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health care plans and insurance benefits you have in addition to your coverage with Anthem.

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

Organ Donation

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

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

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

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

www.donatelifecalifornia.org/

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

Language Assistance Program

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

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

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

- Spanish
- Chinese
- Vietnamese
- Korean
- Tagalog

Oral interpretation services are available in additional languages.

Requesting a written or oral translation is easy. Just contact customer service at 1-877-737-7776 to update your language preference to receive future translated documents or to request interpretation assistance. Anthem Blue Cross also sends/receives TDD/TTY messages at **866-333-4823** or by using the National Relay Service through **711.**

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

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 doctor, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

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

Statement of Rights Under the Women's Health and Cancer Rights Act of 1998

This plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). If you have any questions about this coverage, please contact customer service at 1-877-737-7776.

Partners in Health

EPO providers participate in the Anthem Blue Cross PPO and are defined as Partners in Health. Providers participating in Partners in Health can be found on-line at www.anthem.com/ca/calpers, however you should confirm before seeking services, show your identification card, or contact Anthem for confirmation of participation in the Monterey County EPO at 1-877-737-7776.

For claims and customer service, contact:

Anthem Blue Cross

P.O. Box 60007

Los Angeles, CA 90060-0007

Website: www.anthem.com/ca/calpers