Anthem Blue Cross
Health. Join In.℠

Dear Small Group Member,

We would like to welcome you to Anthem Blue Cross and extend our thanks for choosing our health plan.

This booklet provides a complete statement of all the benefits available to you. Please read it carefully to be sure you fully understand your benefits, coverage, limitations and exclusions. For your convenience, at the front of this Combined Evidence of Coverage and Disclosure Form is a brief summary of the benefits provided by this booklet. This is only a summary; the Agreement contains the exact terms and conditions of coverage.

Additionally, please keep this booklet in a convenient place so you may refer to it whenever you have a question about your coverage.

If you have any questions regarding your eligibility or membership please feel free to contact our customer service department toll free at (800) 627-8797 or you may write to us at Anthem Blue Cross, P.O. Box 9062, Oxnard, CA 93031-9062.

If you have any questions regarding claims status or your benefits under this Combined Evidence of Coverage and Disclosure Form, please feel free to contact our customer service department toll free at (800) 627-8797 or you may write to us at Anthem Blue Cross, P.O. Box 60007, Los Angeles, CA 90060-0007.

Thank you for choosing Anthem Blue Cross.

ANTHEM BLUE CROSS

Pam Kehaly
President
Anthem Blue Cross

Kathy Kiefer
Corporate Secretary
Anthem Blue Cross

HOW TO CONTACT US

Our web site **(www.anthem.com/ca)** provides convenient online information regarding your health coverage. Within the "Members" section of our site, many of your questions can be answered quickly and easily. For instance, you can:

- Locate Participating Providers
- Review your health plan's benefits
- Check status of your claims and download claim forms
- Learn about Pharmacy benefits
- Find out about health programs offered by your plan
- Access premium health content and tools from Subimo™ and WebMD®.

If you want secure access to all features the web site has to offer, simply log on to **www.anthem.com/ca**, select "Members" and follow the prompts for registering. You will need your member ID number, which is located on your health card.

For information about…	Phone Number	Address
Enrollment and Membership	(800) 627-8797	Anthem Blue Cross P.O. Box 9062 Oxnard, CA 93031-9062
Medical Claims and Benefits	(800) 627-8797	Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007
Participating Providers in California	(800) 627-8797	www.anthem.com/ca
Providers outside California (Out-of-Area Services)	(800) 810-BLUE (2583)	www.bcbs.com
Hearing and Speech Impaired Customer Service	TDY (800) 735-2929	Anthem Blue Cross P.O. Box 9062 Oxnard, CA 93031-9062
Preservice Review	(800) 274-7767	
HealthyCheck Services Members age 7 to adult (PPO Plans Only)	(800) 274-WELL (9355)	Anthem Blue Cross Attn: Preventive Care Services P.O. Box 9078 Oxnard, CA 93031-9078
Pharmacy (Retail Pharmacy and Prior Authorization)	(800) 700-2533	Pharmacy Benefits Manager Prescription Drug Program P.O. Box 66583 St. Louis, MO 63166-6583
Pharmacy (Mail Service)	(866) 274-6825	Pharmacy Benefits Manager Mail Service Prescription Drug Program P.O. Box 66558 St. Louis, MO 63166-6558 www.anthem.com/ca

IMPORTANT INFORMATION

At the back of your Combined Evidence of Coverage and Disclosure Form there are important mandated notices required by either state or federal law, including information on Language Assistance.

HEALTH PLAN BENEFITS AND COVERAGE MATRIX

CONTRACT CODE: 5031, 06Z2
PPO $30 COPAY

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

This is an overview of coverage. The Combined Evidence of Coverage and Disclosure Form contains the exact terms and conditions of coverage. You have a right to view the EOC prior to enrollment. To obtain a copy of the EOC, please call toll free (800) 627-8797.

Benefit	Your Copayment/Responsibility		Special Limitations
	In-Network	**Out-of-Network**	
Annual Deductible	$500 per Member per Year, 2-Member family maximum		Payments for Covered Services apply toward the annual Deductible **except** for the following: Office Visit Copayments (Participating Providers only); emergency room Copayments; Copayments for not obtaining Preservice Review; the Copayment for Infertility services; and amounts you pay for Prescription Drugs. The annual Deductible applies toward your maximum Copayment limit for Participating Providers. The annual Deductible does not apply to the Anthem Blue Cross maximum payment limit.
Lifetime Maximums	N/A		Does not include charges over our allowance. Payments for Covered Services apply to the maximum payment limits **except** for the following: amounts you pay for Prescription Drugs; payments for services received for Acupuncture/ Acupressure; payments for services received for Mental or Nervous Disorders and Substance Abuse (except for treatment of Severe Mental Illness and Serious Emotional Disturbances of a Child); the Copayment for Infertility services; and Copayments for not obtaining Preservice Review. Maximum payment limits for in-network and out-of-network providers are applied separately each Year.
	Yearly Maximum: Maximum Copayment limit: $4,500 per Member per Year, two-Member family maximum	Yearly Maximum: Maximum payment limit: Once Anthem Blue Cross pays $10,000 per Member for Covered Services in a Year, Member pays nothing for Covered Expense for the rest of the Year. Member is responsible for any charges over the allowed amounts for out-of-network providers.	

Benefit	Your Copayment/Responsibility		Special Limitations
	In-Network	**Out-of-Network**	
Professional Services • Office Visits • Other Services	 $30 Copayment Office Visits are not subject to the annual Deductible. 30% of the Maximum Allowed Amount	 50% of the Maximum Allowed Amount plus any charges in excess of the Maximum Allowed Amount 50% of the Maximum Allowed Amount plus any charges in excess of the Maximum Allowed Amount	Certain professional services require Preservice Review. See the Part in the EOC entitled "UTILIZATION AND PRESERVICE REVIEW" for additional information.
Outpatient Services	30% of the Maximum Allowed Amount	50% of the Maximum Allowed Amount plus any charges in excess of our maximum payment of $380 per admit Additional $250 Copayment if Preservice Review is not obtained. This Copayment will not apply toward the maximum payment limit.	Preservice Review required. See the Part in the EOC entitled "UTILIZATION AND PRESERVICE REVIEW" for additional information. No benefits payable for care furnished in Non-Contracting Hospitals, except in Medical Emergencies.
Hospitalization Services	30% of the Maximum Allowed Amount	50% of the Maximum Allowed Amount plus any charges in excess of our maximum payment of $650 per day Additional $250 Copayment per admission if Preservice Review is not obtained. This Copayment will not apply toward the maximum payment limit and is not required for Medical Emergency admissions.	Preservice Review required. See the Part in the EOC entitled "UTILIZATION AND PRESERVICE REVIEW" for additional information. No benefits payable for care furnished in Non-Contracting Hospitals, except in Medical Emergencies.

Benefit	Your Copayment/Responsibility		Special Limitations
	In-Network	**Out-of-Network**	
Emergency Health Coverage	30% of the Maximum Allowed Amount	For Medical Emergencies within CA you pay 30% of the Reasonable and Customary Value	Emergency room services for both Participating and Non-Participating Providers are subject to an additional $150 Copayment per emergency room visit, which is waived if the visit results in an inpatient admission into a Hospital immediately following the emergency room services. This Copayment will not apply toward the annual Deductible. The $150 emergency room Copayment and Copayment(s) paid on eligible charges will be applied toward the Member's maximum Copayment limit for Participating Providers and will not be applied to the Anthem Blue Cross maximum payment limit for Non-Participating Providers. Refer to the EOC for your payment responsibility outside CA.
Ambulance Services Other than in a Medical Emergency (Without an Authorized Referral)	30% of the Maximum Allowed Amount	50% of the Maximum Allowed Amount plus any charges in excess of the Maximum Allowed Amount	Refer to the EOC for your payment responsibility in a Medical Emergency, or other than in a Medical Emergency (with an Authorized Referral).

Benefit	Your Copayment/Responsibility		Special Limitations
	In-Network	**Out-of-Network**	
Prescription Drug Coverage • Retail Pharmacies (30-day supply)	$150 Prescription Drug Deductible per Member per Year, except this Deductible is waived for Tier 1 Drugs **Tier 1 Drugs:** $10 Copayment* **Tier 2 Drugs:** $30 Copayment* **Tier 3 Drugs:** $50 Copayment* **Tier 4 Drugs:** 30% of the Prescription Drug Maximum Allowed Amount up to a maximum $150 Copayment	$150 Prescription Drug Deductible per Member per Year, except this Deductible is waived for Tier 1 Drugs Reimbursement will be 50% of the Prescription Drug Maximum Allowed Amount if the Prescription is filled within CA. If the Prescription is filled outside CA, reimbursement will be the Prescription Drug Maximum Allowed Amount, less the Copayment as stated for Participating Pharmacies.	Prescription Drug Copayments, the Prescription Drug Deductible and the Tier 4 Prescription Drug out-of-pocket maximum will not apply toward the medical Deductible or the maximum payment limits for medical services. Your Tier 4 Prescription Drug out-of-pocket maximum is $3,500 per Member per Year. Please refer to the EOC for more information including details on the following items: • *The Preferred Generic Program. Under this program, your payment responsibility may be significantly higher if you purchase a Brand Name Drug when a Generic Drug equivalent exists. • Specialty Drugs which must be obtained through the specialty pharmacy program and are subject to the terms of the program. • Other benefits such as flu vaccines and diabetic supplies. • Prescription Drug exclusions and limitations.

Benefit	Your Copayment/Responsibility		Special Limitations
	In-Network	**Out-of-Network**	
Prescription Drug Coverage (continued) • Mail Service Prescription Drug Program (Copayment up to a 90-day supply)	$150 Prescription Drug Deductible per Member per Year, except this Deductible is waived for Tier 1 Drugs **Tier 1 Drugs:** $10 Copayment* **Tier 2 Drugs:** $60 Copayment* **Tier 3 Drugs:** $100 Copayment*	Not Applicable	Some Prescription Drugs and/or medicines may not be available or are not covered for purchase through the mail service prescription drug program, including, but not limited to: antibiotics; Specialty Drugs; Drugs and medications for the treatment of Infertility, impotence and/or sexual dysfunction; and injectables, including Self-Administered Injectables except Insulin. Prescription Drug Copayments, the Prescription Drug Deductible and the Tier 4 Prescription Drug out-of-pocket maximum will not apply toward the medical Deductible or the out-of-pocket maximum for medical services. Please refer to the EOC for more information including details on the following items: • *The Preferred Generic Program. Under this program, your payment responsibility may be significantly higher if you purchase a Brand Name Drug when a Generic Drug equivalent exists. • Specialty Drugs which must be obtained through the specialty pharmacy program and are subject to the terms of the program. • Prescription Drug exclusions and limitations.
Durable Medical Equipment (Medical Supplies & Equipment)	50% of the Maximum Allowed Amount	50% of the Maximum Allowed Amount plus any charges in excess of the Maximum Allowed Amount	Preservice Review required for certain services. See the Part in the EOC entitled “UTILIZATION AND PRESERVICE REVIEW” for additional information.

Benefit	Your Copayment/Responsibility		Special Limitations
	In-Network	**Out-of-Network**	
Mental Health Services (except for treatment of Severe Mental Illness and Serious Emotional Disturbances of a Child)			Benefits for Covered Services and supplies provided for the treatment of specific Severe Mental Illness and Serious Emotional Disturbances of a Child are provided on the same basis, at the same Copayments, as any other medical condition.
• Facility Based Treatment	30% of the Maximum Allowed Amount	50% of the Maximum Allowed Amount plus any charges in excess of our maximum payment of $175 per day Facility Based Treatment: Additional $250 Copayment per admission if Preservice Review is not obtained. This Copayment will not apply toward the maximum payment limit and is not required for Medical Emergency admissions.	Facility Based Treatment: 30 days per Year maximum, combined with Chemical Dependency services, Participating and Non-Participating Providers combined. Preservice Review required. See the Part in the EOC entitled "UTILIZATION AND PRESERVICE REVIEW" for additional information.
• Professional Services	30% of the Maximum Allowed Amount	50% of the Maximum Allowed Amount plus any charges in excess of our maximum payment of $25 per visit	Professional Services: Limited to one visit per day and 20 visits per Year, combined with Chemical Dependency services, Participating and Non-Participating Providers combined. Facility Based Treatment and Professional Services: Copayments do not apply toward the maximum payment limits.

Benefit	Your Copayment/Responsibility		Special Limitations
	In-Network	**Out-of-Network**	
Chemical Dependency Services (Substance Abuse)			
• Facility Based Treatment	30% of the Maximum Allowed Amount	50% of the Maximum Allowed Amount plus any charges in excess of our maximum payment of $175 per day Facility Based Treatment: Additional $250 Copayment per admission if Preservice Review is not obtained. This Copayment will not apply toward the maximum payment limit and is not required for Medical Emergency admissions.	Facility Based Treatment: 30 days per Year maximum, combined with Mental Health services, Participating and Non-Participating Providers combined. Preservice Review required. See the Part in the EOC entitled "UTILIZATION AND PRESERVICE REVIEW" for additional information.
• Professional Services	30% of the Maximum Allowed Amount	50% of the Maximum Allowed Amount plus any charges in excess of our maximum payment of $25 per visit	Professional Services: Limited to one visit per day and 20 visits per Year, combined with Mental Health services, Participating and Non-Participating Providers combined. Facility Based Treatment and Professional Services: Copayments do not apply toward the maximum payment limits.

Benefit	Your Copayment/Responsibility		Special Limitations
	In-Network	**Out-of-Network**	
Home Health Services	30% of the Maximum Allowed Amount	50% of the Maximum Allowed Amount plus any charges in excess of our maximum payment of $75 per visit Additional $250 Copayment per admission if Preservice Review is not obtained. This Copayment will not apply toward the maximum payment limit.	Maximum of 100 visits per Year, up to 4 hours each visit, Participating and Non-Participating Providers combined. Preservice Review required. See the Part in the EOC entitled "UTILIZATION AND PRESERVICE REVIEW" for additional information.
Preventive Care • Includes annual pap; breast exams; mammogram; ovarian, colorectal and cervical cancer screening tests, including the human papillomavirus (HPV) test for cervical cancer; prostate cancer screenings including prostate specific antigen (PSA) study; and Office Visits associated with these services.	No Copayment Preventive care services, including Office Visits, are not subject to the annual Deductible.	50% of the Maximum Allowed Amount plus any charges in excess of the Maximum Allowed Amount	Includes Physical Exam, HealthyCheck, Well Baby, Well Child and Adult Preventive Services
Outpatient diagnostic radiology and laboratory • Services other than advanced imaging procedures • Advanced imaging procedures	30% of the Maximum Allowed Amount 30% of the Maximum Allowed Amount	50% of the Maximum Allowed Amount plus any charges in excess of the Maximum Allowed Amount 50% of the Maximum Allowed Amount plus any charges in excess of our maximum payment of $800 per procedure*	Preservice Review required for certain services. See the Part in the EOC entitled "UTILIZATION AND PRESERVICE REVIEW" for additional information. *If the procedure is received at an outpatient Hospital facility or Ambulatory Surgical Center, benefits are covered under "OUTPATIENT HOSPITAL, AMBULATORY SURGICAL CENTERS AND EMERGENCY ROOM." Refer to the EOC for details.
Physical Therapy, Occupational Therapy, Chiropractic Care	30% of the Maximum Allowed Amount	50% of the Maximum Allowed Amount plus any charges in excess of our maximum payment of $25 per visit	Provided for an aggregate of 24 visits per Year for Participating and Non-Participating Providers combined; additional visits as authorized by Anthem Blue Cross if Medically Necessary.

Benefit	Your Copayment/Responsibility		Special Limitations
	In-Network	**Out-of-Network**	
Skilled Nursing Facility	30% of the Maximum Allowed Amount	50% of the Maximum Allowed Amount plus any charges in excess of our maximum payment of $150 per day. Additional $250 Copayment per admission if Preservice Review is not obtained. This Copayment will not apply toward the maximum payment limit.	Limited to 100 days per Year, Participating and Non-Participating Providers combined. Preservice Review required. See the Part in the EOC entitled "UTILIZATION AND PRESERVICE REVIEW" for additional information.
Infusion Therapy	30% of the Maximum Allowed Amount	50% of the Maximum Allowed Amount plus any charges in excess of our maximum payment of $50 per day for all expenses except Drugs; plus all charges in excess of the Average Wholesale Price for Infusion Therapy Drugs; and any charges in excess of our combined maximum payment of $500 per day for all Infusion Therapy services. Additional $250 Copayment if Preservice Review is not obtained. This Copayment will not apply toward the maximum payment limit.	Preservice Review required. See the Part in the EOC entitled "UTILIZATION AND PRESERVICE REVIEW" for additional information. Specialty Drugs must be obtained through the specialty pharmacy program and are subject to the terms of the program.
Acupuncture/Acupressure	30% of the Maximum Allowed Amount plus any charges in excess of our maximum payment of $30 per visit	50% of the Maximum Allowed Amount plus any charges in excess of our maximum payment of $30 per visit	Limited to 24 visits per Year for Participating and Non-Participating Providers combined. This Copayment will not be applied to the maximum payment limits.
Infertility Services	$500 Copayment plus 30% of the balance of the Maximum Allowed Amount	$500 Copayment plus 50% of the balance of the Maximum Allowed Amount plus any charges in excess of the Maximum Allowed Amount	Medical Infertility services are limited to our lifetime maximum payment of $2,000 per Member for Participating and Non-Participating Providers combined. Drugs and medications for Infertility are limited to our lifetime maximum payment of $1,500. Infertility Copayments do not apply toward the maximum payment limits. Specialty Drugs for Infertility must be obtained through the specialty pharmacy program and are subject to the terms of the program.

Benefit	Your Copayment/Responsibility		Special Limitations
	In-Network	**Out-of-Network**	
Outpatient Speech Therapy	30% of the Maximum Allowed Amount	30% of the Maximum Allowed Amount plus any charges in excess of the Maximum Allowed Amount	50 visits per Year maximum; additional visits are covered as authorized by Anthem Blue Cross if Medically Necessary. Refer to the EOC for additional information.
Urgent Care			
• Office Visits	$30 Copayment Office Visits are not subject to the annual Deductible	50% of the Maximum Allowed Amount plus any charges in excess of the Maximum Allowed Amount	
• Other Professional Services	30% of the Maximum Allowed Amount	50% of the Maximum Allowed Amount plus any charges in excess of the Maximum Allowed Amount	
• Urgent Care Facility	30% of the Maximum Allowed Amount	50% of the Maximum Allowed Amount plus any charges in excess of our maximum payment of $380 per admit	

TABLE OF CONTENTS

INTRODUCTION

Blue Cross of California, doing business as Anthem Blue Cross (hereinafter referred to as "Anthem Blue Cross" or "Anthem"), has a Group Benefit Agreement (the "Agreement") with your Employer (Group). The benefits of this Combined Evidence of Coverage and Disclosure Form (EOC) are provided while Medically Necessary for the Subscriber and enrolled Family Members for a covered illness, injury or condition, subject to all of the terms and conditions of the Group Benefit Agreement.

For your convenience, at the front of this Combined Evidence of Coverage and Disclosure Form is a brief matrix summarizing the benefits provided. **This Combined Evidence of Coverage and Disclosure Form constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage.** The Group Benefit Agreement, which is the health plan contract, contains the exact terms and conditions of coverage. You can request a copy of the Group Benefit Agreement by calling our customer service department toll free at (800) 627-8797.

Please read this Combined Evidence of Coverage and Disclosure Form completely and carefully. Individuals with special health care needs should carefully read those sections that apply to them. YOU HAVE THE RIGHT TO VIEW THE COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM PRIOR TO ENROLLMENT.

You also have the right to receive a copy of the Member Rights and Responsibilities Statement and/or the Notice of Privacy Practices. You may obtain either document by calling our customer service department toll free at (800) 627-8797 or by accessing our web site at **www.anthem.com/ca.**

Physicians and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. A Participating Provider may, after notice from us, be subject to a reduced Maximum Allowed Amount in the event the Participating Provider fails to make routine referrals to Participating Providers, except as otherwise allowed (such as for Medical Emergency services). Hospitals and other health care facilities may be paid either a fixed fee or on a discounted fee-for-service basis. For additional information you may contact us toll free at (800) 627-8797 or you may contact your Participating Provider.

Some Hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your Family Member might need:

- **Family planning;**
- **Contraceptive services, including emergency contraception;**
- **Sterilization, including tubal ligation at the time of labor and delivery;**
- **Infertility treatments; or**
- **Abortion.**

You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call customer service toll free at (800) 627-8797 to ensure that you can obtain the health care services that you need.

In this Combined Evidence of Coverage and Disclosure Form, "we," "us" and "our" mean Anthem Blue Cross. You are the eligible Subscriber. "You" and "your" shall also mean any eligible Family Members who were listed on your application and were accepted by us for coverage under this Combined Evidence of Coverage and Disclosure Form. When we use the word "Member" in this Combined Evidence of Coverage and Disclosure Form, we mean you and any eligible Family Member covered under this Combined Evidence of Coverage and Disclosure Form.

The benefits of this Combined Evidence of Coverage and Disclosure Form are provided only for those services that Anthem Blue Cross determines are Medically Necessary and a Covered Service. If you have any question as to whether a service is covered, consult this Combined Evidence of Coverage and Disclosure Form or feel free to call our customer service department toll free at (800) 627-8797. Our customer service representatives can assist you in determining the benefits of your plan and, if necessary, help you obtain Preservice Review for the types of benefits that require Preservice Review.

Your personal financial costs when using Non-Participating Providers may be considerably higher than when you use Participating Providers. Utilizing Participating Providers will enable you to maximize your plan benefits and minimize out-of-pocket expenses. While it is your responsibility to determine if the provider you choose is a Participating Provider, our customer service representatives can also assist you with the selection of a Participating Provider in your area from our Participating Provider Directory. A Participating Provider Directory, or information on Participating Providers, may be obtained by calling our customer service department toll free at (800) 627-8797 or by accessing our web site at **www.anthem.com/ca**. Click on 'Provider Finder' and follow the directions to find a Participating Provider in your area. The Participating Provider Directory is updated quarterly and lists providers that have a Prudent Buyer Plan Participating Provider agreement in effect with us. Working together as partners in your health care can make your medical experiences less stressful and more cost-effective to you.

CHOICE OF CONTRACTING HOSPITAL, SKILLED NURSING FACILITY, ATTENDING PHYSICIAN AND OTHER PROVIDERS OF CARE: Nothing contained in this Combined Evidence of Coverage and Disclosure Form restricts or interferes with your right to select the Contracting Hospital, Skilled Nursing Facility, attending Physician or other providers of your choice.

If your provider has been terminated and you feel you qualify for continuation of services, you must request that services be continued. This can be done by calling our customer service department toll free at (800) 627-8797. Please refer to "Continuation of Care after Termination of Provider" in the Part entitled "GENERAL PROVISIONS."

In addition, Transition Assistance is available to provide for continuity of care for new Members receiving services from a Non-Participating Provider. Please see "Transition Assistance for New Members" under the Part entitled "GENERAL PROVISIONS."

TRIAGE OR SCREENING SERVICES: Should you have questions about a particular condition or you need someone to help you determine whether or not care is needed, triage or screening services are available to you from us by telephone. Triage or screening services are the evaluation of a Member's health by a doctor or nurse who is trained to screen or triage for the purpose of determining the urgency of the Member's need for care. Please contact the 24/7 NurseLine at the telephone number listed on your Anthem Blue Cross identification (ID) card 24 hours a day, 7 days a week.

Throughout this Combined Evidence of Coverage and Disclosure Form, you will find key terms which appear with the first letter of each word capitalized. When you see these capitalized words you should refer to the Part of this Combined Evidence of Coverage and Disclosure Form entitled "DEFINITIONS," where the meanings of these terms or words are defined. Some key terms may be defined within a specific benefit description.

BECAUSE WE CARE ABOUT THE QUALITY OF THE SERVICE PROVIDED TO OUR CUSTOMERS, YOUR TELEPHONE CALL TO US MAY BE RANDOMLY OBSERVED OR RECORDED.

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

PART I WHO IS COVERED AND WHEN

A. ELIGIBILITY

1. Subscriber's Eligibility

a. The person eligible to enroll as a Subscriber is any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the Employer with a normal work week of at least thirty (30) hours, at the Employer's regular place of business and who has met any applicable waiting period requirements.

b. Sole proprietors, partners of a partnership, and corporate officers are also eligible to enroll as Subscribers if they are actively engaged on a full-time basis, work at least twenty (20) hours a week in the Employer's business and are included as employees under a health care plan contract of the Employer.

c. Permanent part-time employees who work at least twenty (20), but not more than twenty-nine (29), hours per week are deemed to be eligible employees if all four (4) of the following apply:

i. They otherwise meet the definition of an eligible employee except for the number of hours worked.
ii. The Employer offers the employees health coverage under a health benefit plan.
iii. All similarly situated individuals are offered coverage under the health benefit plan.
iv. The employee must have worked at least twenty (20) hours per normal work week for at least fifty percent (50%) of the weeks in the previous calendar quarter.

Note: This applies only if your Employer elects to offer coverage to part-time employees and has notified us accordingly. Additional part-time eligibility is available to part-time employees who work fifteen (15) to nineteen (19) hours per week only if this option is selected by the Group.

d. The employees must be in an enrollment class for which the Group makes application to us and which we accept.

e. An eligible person may apply for coverage as a Subscriber within thirty-one (31) days before the first day of the month following the completion of the waiting period chosen by the Group and agreed to by Anthem Blue Cross. The waiting period is indicated on the Employer application.

2. Family Member's Eligibility

The following persons are eligible to apply for coverage as Family Members of the Subscriber: (a) either the Subscriber's Spouse or Domestic Partner; and (b) a Child of the Subscriber, Spouse or the Domestic Partner. Coverage will be provided equally to a Spouse or a Domestic Partner including children of a Spouse or a Domestic Partner, providing eligibility requirements are met. The Effective Date will be determined by us. For information on Effective Dates, please see section D., "Effective Dates."

Definition of Family Member

a. **Spouse** is the Subscriber's Spouse under a legally valid marriage. Spouse does not include any person who is covered as a Subscriber or Domestic Partner.

b. **Domestic Partner** is the Subscriber's Domestic Partner, subject to the following:

   The Subscriber and Domestic Partner have completed and filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code, or have been issued an equivalent document by a local agency of California, another state, or a local agency of another state under which the partnership was created, and the domestic partnership has not terminated.

   Domestic Partner does not include any person who is covered as a Subscriber or Spouse.

c. **Child** is the Subscriber's, Spouse's or Domestic Partner's natural Child, stepchild, legally adopted Child, or Child for whom the Subscriber, Spouse or Domestic Partner has been appointed permanent legal guardian by a final court decree or order, subject to the following:

   i. Children of the Subscriber, the Subscriber's enrolled Spouse, or the Subscriber's enrolled Domestic Partner to the twenty-sixth (26^{th}) birthday.

   ii. Newborns of the Subscriber, the Subscriber's enrolled Spouse, or the Subscriber's enrolled Domestic Partner for the first thirty-one (31) days of life. FOR COVERAGE TO CONTINUE BEYOND THAT TIME, WE MUST RECEIVE, WITHIN THIRTY-ONE (31) DAYS OF THE NEWBORN'S BIRTH, AN APPLICATION TO ENROLL THE NEWBORN.

      NEWBORNS OF THE SUBSCRIBER'S DEPENDENT CHILDREN ARE **NOT** COVERED UNDER THE AGREEMENT.

   iii. A Child who is in the process of being adopted is considered a legally adopted Child if we receive legal evidence of both: (1) the intent to adopt; and (2) that the Subscriber, Spouse or Domestic Partner has either (a) the right to control the health care of the Child; or (b) assumed a legal obligation for full or partial financial responsibility for the Child in anticipation of the Child's adoption.

      Legal evidence to control the health care of the Child means a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or relinquishment form, signed by the Child's birth parent or other appropriate authority or, in the absence of a written document, other evidence of the Subscriber's, Spouse's or Domestic Partner's right to control the health care of the Child.

   iv. A Child for whom the Subscriber, Spouse or Domestic Partner has been appointed permanent legal guardian, provided we have received proper court documentation in the form of "Letters of Guardianship," showing filed date and county court seal.

v. Unmarried children of the Subscriber, the Subscriber's enrolled Spouse, or the Subscriber's enrolled Domestic Partner from the twenty-sixth (26th) birthday and older, if the Child is:

- Covered under this plan or was covered under a prior plan immediately before being covered under this plan, and
- Incapable of self-sustaining employment due to a physically or mentally disabling injury, illness or condition, and
- At least one-half dependent on the Subscriber for support and maintenance.

A Physician must certify this physically or mentally disabling injury, illness or condition in writing.

We will notify the Subscriber that the dependent Child's coverage will terminate upon attainment of the limiting age of twenty-six (26) unless the Subscriber submits proof of the criteria described above within sixty (60) days of the date of receipt of the notification. We will send this notification to the Subscriber at least ninety (90) days before the Child attains the limiting age. Upon receipt of a request by the Subscriber for continued coverage of the Child and proof of the criteria described above, we will determine whether the Child meets that criteria before the date the Child attains the limiting age. If we fail to make the determination by that date, coverage for the Child shall be continued pending our determination. After two (2) years of continued enrollment after attaining the limiting age, we may request proof of continuing dependency and that a physically or mentally disabling injury, illness or condition still exists, but not more often than yearly.

For a dependent unmarried Child from the twenty-sixth (26th) birthday and older who is replacing other prior coverage with Anthem Blue Cross coverage, we will request information that the Child meets the criteria for coverage as described above. The Subscriber must submit the information within sixty (60) days of receiving the request. We will determine whether the Child meets the criteria for continued coverage. We may request information about the dependent Child initially and not more frequently than annually thereafter to determine if the Child continues to satisfy the criteria described above.

Note: See section D., "Effective Dates," for more information on how to apply for, add or continue coverage for Family Members.

Note: Dependents of the children of the Subscriber, the Subscriber's enrolled Spouse, or the Subscriber's enrolled Domestic Partner are **not** covered under the Agreement.

B. APPLICATION FOR ENROLLMENT

Note: Applications for enrollment, including applications for those declining coverage, **must** be submitted and received prior to the Effective Date. An application must be approved by us in order for coverage to come into effect.

Note: Subscription charges may change when Family Members are enrolled in or removed from coverage.

1. **Filing of Applications**

   a. Every person eligible to enroll as a Subscriber must file an application with the Employer within a time period of thirty-one (31) days after becoming eligible for coverage. This application must include any eligible Family Members for whom application is being filed.

   b. The Subscriber must file an application with the Employer to enroll a new Spouse or a new Domestic Partner within a time period ending thirty-one (31) days after marriage or a registered Domestic Partnership.

   c. The Subscriber must file an application with the Employer to enroll a newly acquired Child within a time period ending thirty-one (31) days after the birth or acquisition of the Child, or final court decree or order of permanent legal guardianship.

   d. If the person eligible to enroll as a Subscriber does not elect to be covered, or does not elect coverage for his or her Spouse, Domestic Partner or children, under the Agreement, the person eligible to enroll as a Subscriber and/or his or her Spouse, Domestic Partner or children may have to wait up to twelve (12) months from any future election of coverage for another opportunity to obtain such coverage. Please see the section entitled "Effective Dates" for an explanation of when coverage may begin. However, in certain circumstances, as described under the section entitled "Special Enrollment Periods" below, this twelve (12) month period may not apply.

2. The Employer is responsible for forwarding all enrollment applications to us and for notifying us of any change in the Subscriber's place of residence.

3. If the number of Subscribers falls below the Anthem Blue Cross specified guidelines of such eligible persons, we may cancel the Agreement.

C. **SPECIAL ENROLLMENT PERIODS.** An individual otherwise eligible to enroll except for a failure to enroll on time may enroll without waiting twelve (12) months if any one of the circumstances set forth below applies:

1. The individual meets all of the following requirements:

   a. He or she was covered under another employer health benefit plan, the Healthy Families Program, the California Access for Infants and Mothers (AIM) Program or Medi-Cal at the time he or she was first eligible to enroll.

   b. He or she, or the Subscriber on behalf of an eligible dependent, certified at the time of the initial enrollment that coverage under another employer health benefit plan, the Healthy Families Program, the California Access for Infants and Mothers Program (AIM) or Medi-Cal was the reason for declining enrollment, provided that, the individual covered under the other employer health benefit plan, the Healthy Families Program, the AIM program or Medi-Cal or the Subscriber on behalf of an eligible dependent, was given the opportunity to make this certification and was notified that failure to do so could result in later treatment as a late enrollee.

c. He or she has lost or will lose coverage under the other employer health benefit plan as a result of: termination of employment or change in employment status of the individual or the person through whom the individual was covered as a dependent; termination of the other plan's coverage; cessation of an employer's contribution toward an employee's or dependent's coverage; death of, or legal separation or divorce from, the person through whom the individual was covered as a dependent or loss of coverage under the Healthy Families Program, the California Access for Infants and Mothers Program or Medi-Cal.

d. He or she requests enrollment by filing an application within thirty-one (31) days after termination of coverage or termination of employer contribution toward coverage provided under another employer health benefit plan. This does not apply to Healthy Families, the AIM Program or Medi-Cal coverage; please see items 7. and 8. in this section for additional information.

2. The Group offers multiple health benefit plans and the Subscriber elects a different plan during an open enrollment period.

3. A court has ordered coverage be provided for a Spouse or minor Child under your employee health benefit plan. We must receive a copy of the court order, or receive a request from the district attorney, either parent or the person having custody of the Child, the Employer, or Group administrator. An application must be filed within thirty-one (31) days from the date the court order is issued.

4. A court has ordered coverage be provided under your employee health benefit plan for an unmarried dependent Child who has attained the limiting age, if the dependent Child is incapable of self-sustaining employment due to a physically or mentally disabling injury, illness or condition, and is at least one-half dependent on the Subscriber for support and maintenance. A Physician must certify this physically or mentally disabling injury, illness or condition in writing.

   Anthem Blue Cross will request information that the Child meets the criteria for coverage as described above. The Subscriber must submit the information within sixty (60) days of receiving the request. We will determine whether the Child meets the criteria for continued coverage. We may request information about the dependent Child initially and not more frequently than annually thereafter to determine if the Child continues to satisfy the criteria above.

   We must receive a copy of the court order, or receive a request from the district attorney, either parent or the person having custody of the Child, the Employer, or group administrator. An application must be filed within thirty-one (31) days from the date the court order is issued.

5. In the case of an eligible employee, we cannot produce a written statement from the Group stating that the eligible employee, prior to declining coverage was provided with and signed acknowledgment of an explicit written notice in bold face type specifying that failure to elect coverage during the initial enrollment period permits us to impose, at the time of a later decision to elect coverage, an exclusion from coverage for a period of twelve (12) months as well as a six (6) month Preexisting Condition exclusion, unless the individual meets the criteria specified in items 1., 2., 3., or 4. above.

6. The individual meets the criteria described in paragraph 1 of this section C. and was under a COBRA or Cal-COBRA continuation provision and the coverage under that provision has been exhausted.

7. The individual, who is an eligible employee, or his or her dependent, was covered under Medi-Cal, Healthy Families, or the California Access for Infants and Mothers Program and that coverage ended because of loss of eligibility. An application must be filed within sixty (60) days after the date that coverage ended.

8. The individual, who is an eligible employee, or his or her dependent, while covered under Medi-Cal or Healthy Families, becomes eligible for state premium assistance with respect to coverage under this plan. An application must be filed within sixty (60) days after the date eligibility for assistance has been determined.

9. The individual (a) is an eligible employee who previously declined coverage as a Subscriber under the Agreement, (b) has subsequently acquired a dependent who would be eligible for coverage as a dependent through marriage, birth, adoption, or placement for adoption, and (c) enrolls for coverage under the Agreement on his or her behalf, and on behalf of his or her dependent, within thirty-one (31) days following the date of marriage, birth, adoption, or placement for adoption.

10. The individual is an eligible employee who has previously declined coverage under the Agreement for himself or herself, or for his or her dependents during a previous enrollment period because his or her dependents were covered by another employer health benefit plan at the time of the previous enrollment period. That individual may enroll himself or herself, or his or her dependents for coverage under the plan during a special open enrollment opportunity if his or her dependents have lost or will lose coverage under the other employer health benefit plan. You must request the special open enrollment opportunity not more than thirty-one (31) days after the date the other health coverage is exhausted or terminated.

D. EFFECTIVE DATES

If the Employer pays the charges required for an eligible person to us when they are due, the Effective Date of coverage for that person is as follows:

1. Subscriber's Effective Date

a. For a person who files an application to enroll as a Subscriber within the time limits stated above under the section entitled "Application for Enrollment," coverage begins on the first of the month following Anthem Blue Cross' approval of the application.

"takeover" exception:

For a person who is enrolled as a Subscriber on the Employer Effective Date and who, immediately prior to that date, was covered under the Employer's health plan which is replaced by this Combined Evidence of Coverage and Disclosure Form, coverage begins on the Employer Effective Date. Any waiting period related to a Preexisting Condition will be reduced by the number of months the Subscriber was covered without interruption under the Group's prior health plan.

b. For a person who does not file an application to enroll as a Subscriber within the time limits stated under the section entitled "Application for Enrollment," coverage will be deferred for a period of twelve (12) months from any future election of coverage.

c. Effective Dates for certain Special Enrollment Periods:

i. If the Subscriber may enroll without waiting under the terms described in section C., "Special Enrollment Periods," paragraph 9., the Effective Date of the Subscriber's coverage shall be the first day of the month following the date we receive the completed application for enrollment in the case of marriage, or the date of birth, or the date of adoption or placement for adoption, whichever applies.

ii. If the Subscriber may enroll without waiting under the terms described in section C., "Special Enrollment Periods," paragraph 10., upon enrollment, coverage shall be effective not later than the first day of the first month beginning after the date we receive the application for enrollment.

COVERAGE ONLY FOR ELIGIBLE SUBSCRIBERS:

We will provide coverage only for eligible Subscribers.

2. **Family Member's Effective Date**

a. If the application of a person enrolling as a Subscriber includes application for an eligible Spouse, Domestic Partner or Child, coverage for that Spouse, Domestic Partner or Child begins on the Subscriber's Effective Date.

b. For a new Spouse or a new Domestic Partner of a Subscriber who is already enrolled under this Combined Evidence of Coverage and Disclosure Form, coverage begins on the first day of the month following marriage or a registered Domestic Partnership, but only if we receive, within thirty-one (31) days of the marriage or registration, an application to enroll the Spouse or Domestic Partner.

c. For a Child born (newborn) to a Subscriber, Spouse or Domestic Partner who is already enrolled under this Combined Evidence of Coverage and Disclosure Form, coverage will be automatic for the first thirty-one (31) days of life. For coverage to continue beyond that time, we must receive, within thirty-one (31) days of the Child's birth, an application to enroll the Child.

d. For a newly acquired Child (except a newborn) of a Subscriber who is already enrolled under this Combined Evidence of Coverage and Disclosure Form, coverage begins on the date of adoption or placement for adoption of the Child and will continue for a period of thirty-one (31) days. For coverage to continue beyond that time, we must receive, within thirty-one (31) days of acquiring the Child, an application to enroll the Child.

e. For a newly acquired Child (except a newborn) of a Subscriber who is the permanent legal guardian and already enrolled under this Combined Evidence of Coverage and Disclosure Form, coverage begins on the date of the final court decree or order of legal guardianship and will continue for a period of thirty-one (31) days. For coverage to continue beyond that time, we must receive, within thirty-one (31) days of issuance of the final court decree or order of legal guardianship, an application to enroll the Child.

"takeover" exception:

If the Spouse, Domestic Partner or Child is enrolled on the Employer Effective Date and if, immediately prior to that date, he or she was covered under the Employer's health plan which is replaced by this Combined Evidence of Coverage and Disclosure Form, then coverage begins on the Employer's Effective Date. (Under these "takeover" circumstances, the Spouse's, Domestic Partner's or Child's Effective Date is not subject to the terms outlined under COVERAGE FOR SPOUSES, DOMESTIC PARTNERS AND CHILDREN ONLY OF ELIGIBLE SUBSCRIBERS, though the effective date of any increase in benefits is.) Any waiting period related to a Preexisting Condition will be reduced by the number of months the Member was covered without interruption under the Group's prior health plan.

f. For a Spouse, Domestic Partner or Child for whom the Subscriber does not file an application within the time limits stated under the section entitled "Application for Enrollment," coverage begins on the first day of the month following Anthem Blue Cross' approval of the application. Please refer to the sections entitled "Application for Enrollment" and "Special Enrollment Periods" for further information.

g. If the Subscriber may enroll his or her dependents without waiting under the terms described in section C., "Special Enrollment Periods," paragraph 10., upon enrollment, coverage shall be effective not later than the first day of the first month beginning after the date we receive the application for enrollment.

COVERAGE FOR SPOUSES, DOMESTIC PARTNERS AND CHILDREN ONLY OF ELIGIBLE SUBSCRIBERS (Please see the definition of Domestic Partners under the Part entitled "DEFINITIONS."):

We will provide coverage for the Spouses, Domestic Partners and children of eligible Subscribers. If, at the time a Subscriber's coverage or an increase in benefits would begin, the Subscriber is not an eligible employee of the Employer (please see the sections entitled "Eligibility" and "Special Enrollment Periods" for additional information regarding eligibility and enrollment), we will not provide coverage for the Subscriber's Spouse, Domestic Partner or children. However, if the Subscriber subsequently does become such an eligible employee of the Employer, we will begin coverage for the Subscriber's Spouse, Domestic Partner and children effective the first day of the month following receipt of information from the Employer that the Subscriber meets the eligibility requirements.

E. LEAVE OF ABSENCE

1. Temporary Personal Leave of Absence

Enrolled Subscribers are eligible to continue Group coverage for themselves and their enrolled Family Members for a maximum period as elected by the Employer on the Employer application, but in no event more than three (3) months, provided that the Subscriber continues on an Employer approved personal leave of absence and the Employer continues to pay the required monthly subscription charges.

2. Temporary Medical Leave of Absence

Enrolled Subscribers are eligible to continue Group coverage for themselves and their enrolled Family Members for a maximum period as elected by the Employer on the Employer application, but in no event more than six (6) months, provided that the Subscriber continues an Employer approved medical leave of absence and the Employer continues to pay the required monthly subscription charges.

Note: Continuation for items 1. and 2. above will occur only following receipt by us of written request to continue coverage within thirty (30) days of the event. Notification within thirty (30) days of the event is required when the leave of absence begins or ends.

3. Temporary Military Leave of Absence

Enrolled Subscribers who are members of the United States Military Reserve and National Guard who terminate coverage as a result of being ordered to active duty on or after January 1, 2007 may have their coverage reinstated without waiting periods or exclusion of coverage for preexisting conditions. Please contact customer service at (800) 627-8797 for information on how to apply for reinstatement of coverage following active duty as a reservist.

Note: Notification within thirty (30) days of the event is required when the leave of absence begins or ends.

Any leave of absence, continuation of coverage and/or reinstatement is subject to all of the other terms, conditions and limitations of this Combined Evidence of Coverage and Disclosure Form.

If a Member becomes Totally Disabled please refer to the Part entitled “EXTENSION OF BENEFITS.”

F. WHEN YOUR COVERAGE ENDS/TERMINATION OF BENEFITS

We are not required to send a notice to the Member when termination of coverage is initiated by the Member or the Group.

A Member's coverage ends under the following conditions:

1. **Subscriber**

   a. On the date the Agreement between the Group and Anthem Blue Cross is terminated, or

   b. On the next subscription charge due date after the Subscriber no longer meets the eligibility requirements established by the Group and Anthem Blue Cross, or

   c. On the next subscription charge due date after we receive from the Group or the Subscriber written notice of the Subscriber's voluntary cancellation of coverage, or

   d. On the first of the month following the month the Subscriber is no longer considered an eligible employee or ceases to be a member of a Guaranteed Association (but only if coverage is terminated without regard to any health status-related factor), or

   e. At the end of the three (3) month period for a personal leave of absence unless the Subscriber returns to active employment, or

   f. At the end of the six (6) month period for a medical leave of absence unless the Subscriber returns to active employment, or

   g. At the end of the period for a military leave of absence for Members who terminated coverage as a result of being ordered to active duty on or after January 1, 2007 unless the Subscriber returns to active employment, or

   h. When the required subscription charges are not paid, Anthem Blue Cross may terminate the Group's coverage upon first mailing a written Notice of Cancellation to the Group at least thirty (30) days, or if longer, the period required by federal law, prior to that termination. The coverage will end as of 12:00 midnight on the thirtieth (30^{th}) day after the date on which the Notice of Cancellation is sent. The Notice of Cancellation shall state that the Agreement shall not be terminated if the Group makes appropriate payment in full within thirty (30) days after Anthem Blue Cross issues the Notice of Cancellation. If payment is not received within thirty (30) days of issuance, the Agreement will be cancelled for non-payment of premium and Anthem Blue Cross will send a notice to the Group confirming that the Agreement has been cancelled. The Notice of Cancellation shall also state that, if the Agreement is terminated for nonpayment and the Group wishes to apply for reinstatement, the Group will be required to submit a new application for coverage and will be required to submit any premiums that are owed, in addition to a $50 reinstatement fee and any other administrative fee payable. Reinstatement is not guaranteed, and the Group's request for reinstatement may be declined.

2. **Spouse**

   a. On the date the Subscriber's coverage is canceled or terminated, or

   b. On the next subscription charge due date after final decree of divorce, annulment or dissolution of marriage.

3. **Domestic Partnership**

   On the next subscription charge due date after the Domestic Partner no longer satisfies all eligibility requirements specified for Domestic Partners.

4. **Child**

   a. On the date the Subscriber's coverage is canceled, or

   b. On the next subscription charge due date after the Child reaches age twenty-six (26), or on the date permanent legal guardianship ends, or

   c. On the next subscription charge due date after the Child reaches the limiting age of twenty-six (26) unless the unmarried Child is, upon reaching the limiting age, at least one-half dependent upon the Subscriber for support and maintenance, and is incapable of self-sustaining employment due to a physically or mentally disabling injury, illness or condition. A Physician must certify this disability in writing. Anthem Blue Cross will notify the Subscriber that the dependent Child's coverage will terminate upon attainment of the limiting age unless the Subscriber submits proof of the criteria described above within sixty (60) days of the date of receipt of notification. We will send this notification to the Subscriber at least ninety (90) days before the Child attains the limiting age. Upon receipt of a request by the Subscriber for continued coverage of the Child and proof of the criteria described above, we will determine whether the Child meets that criteria before the date the Child attains the limiting age. If we fail to make the determination by that date, coverage for the Child shall be continued pending our determination. After two (2) years of continued enrollment after attaining the limiting age, we may request proof of continuing dependency and that a physically or mentally disabling injury, illness or condition still exists, but not more often than yearly, or

   d. For a Child born to a Subscriber, Spouse or Domestic Partner who is already enrolled under this Combined Evidence of Coverage and Disclosure Form, coverage ends on the day following the thirty-first (31st) day of life if we do not receive an application to enroll the Child.

5. **Any Member**

Anthem Blue Cross may terminate coverage for any of the following:

a. Any material misrepresentation discovered on an application or health statement (upon first mailing a written notice at least fifteen (15) days prior to that termination), or

b. An act of fraud that has been committed (in this instance, termination is effective on the date of mailing the written notice), or

c. A Member who lives in a foreign country for more than six (6) consecutive months (upon first mailing a written notice at least fifteen (15) days prior to that termination).

The Group is responsible for notifying us of all changes affecting the Member's place of residence.

Subscription Charges:
Your Employer will pay all subscription charges to us. Your Employer will let you know the part that you must pay.

Effect of non-payment of subscription charges:
Benefits under the Agreement shall cease as described above if subscription charges have not been paid. **Exception:** If a Member is Totally Disabled, the Member is entitled to an extension of benefits in accordance with the Part entitled "EXTENSION OF BENEFITS."

Improper cancellation or non-renewal (requests for review):
If you believe that your coverage has been improperly canceled or not renewed, you may request a review of the matter by the Department of Managed Health Care (DMHC) in accordance with the grievance process outlined in the Part entitled "GRIEVANCE PROCEDURES."

G. RENEWAL PROVISIONS

Anthem Blue Cross will provide benefits under the Agreement for as long as it is in effect. The Agreement remains in effect subject to Anthem Blue Cross' right to terminate, decline to renew or amend the Agreement, or to change subscription charges. Anthem Blue Cross may amend the Agreement or, to the extent permitted by law, change subscription charges upon sixty (60) days prior written notice to your Employer. Anthem Blue Cross will not increase the subscription charges payable by your Employer or decrease benefits and coverage except after at least sixty (60) days prior written notice to your Employer.

PART II ANNUAL DEDUCTIBLE, COPAYMENTS, MAXIMUM ALLOWED AMOUNT AND ANNUAL MAXIMUM PAYMENT LIMITS

ANNUAL DEDUCTIBLE

Your annual Deductible is $500 per Member per Year. Before we pay for most medical benefits you must satisfy the $500 annual Deductible per Member per Year. **Please note that the annual Deductible does not apply to certain medical benefits as specifically stated in this Combined Evidence of Coverage and Disclosure Form.** During each Year, each Member is responsible for all Covered Expense incurred for Covered Services up to the Deductible amount. This amount must be recorded in our files as payable by the Member to the provider of service. A claim must be submitted in order for us to record your eligible covered Deductible expense. We will record your Deductible in our files in the order in which your claims are processed, not necessarily in the order in which you receive the service or supply. The first two (2) Members of an enrolled family to satisfy their individual Deductibles in full will satisfy the Deductible for the entire family. Once the family Deductible is satisfied, no further Deductible is required for the remainder of that Year. Any claim amounts applied toward an individual Member's Deductible prior to the family Deductible being met will not be adjusted if the family Deductible maximum is met by two other enrolled Family Members. However, these amounts, if any, will apply toward the maximum payment limits.

If you submit a claim for services which have a maximum payment limit and your Deductible has not been satisfied, we will apply only the allowed per visit or per day amount, whichever applies, toward your Deductible amount.

Certain Covered Services have maximum visit and/or day limits per Year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your Deductible has been met.

Payments you make for Covered Services apply toward your annual Deductible **except** for the following:

- Office Visit Copayments (Participating Providers only)
- Emergency room Copayments
- Copayments for not obtaining Preservice Review
- Copayment for Infertility services
- Amounts you pay for Prescription Drugs under the Part entitled "YOUR PRESCRIPTION DRUG BENEFITS" (although these amounts may apply to your separate Prescription Drug Deductible)

Amounts you pay that are applied to your annual Deductible for Covered Services received from Participating Providers **will apply** to your annual maximum Copayment limit for Participating Providers. Amounts you pay that are applied to your annual Deductible for Covered Services received from Non-Participating Providers **will not** apply to your annual maximum Copayment limit for Participating Providers or to the Anthem Blue Cross maximum payment for Non-Participating Providers.

Note: The benefits listed below are not subject to the annual Deductible when Covered Services are received from Participating Providers.

- Office Visits
- Retail Health Clinic Visits
- Online Clinic Visits
- Preventive Care
- Hospice Care

COPAYMENTS

You will be required to pay a Copayment for services received while you are covered under this Combined Evidence of Coverage and Disclosure Form. **Your Copayment may be a fixed dollar amount per day or visit, or it may be a percentage of Covered Expense. It could also be a combination of a fixed dollar amount and a percentage of Covered Expense.**

Certain Copayments (e.g., emergency room Copayments and Copayments for not obtaining Preservice Review) **will not** be applied toward your annual Deductible. See the section in this Part entitled "ANNUAL DEDUCTIBLE."

Some Copayments (e.g., Copayments for acupuncture/acupressure services) **will not** be applied toward your maximum Copayment limit for Participating Providers and **will continue to be required** even after your maximum Copayment limit for Participating Providers has been reached. Amounts you pay for Covered Services received from Non-Participating Providers **will not** apply to the Maximum Payment Limit for Non-Participating Providers or to the Maximum Copayment Limit for Participating Providers. Some Copayments (e.g., Copayments for not obtaining Preservice Review) **will continue to be required** even after the Anthem Blue Cross annual maximum payment limit has been reached. **See the Parts entitled "PARTICIPATING PROVIDER COMPREHENSIVE BENEFITS AND COPAYMENT LIST" and "NON-PARTICIPATING PROVIDER COMPREHENSIVE BENEFITS AND COPAYMENT LIST" to determine your Copayment responsibility for Covered Services.**

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 your plan. The Maximum Allowed Amount is the total reimbursement payable under your plan for Covered Services you receive from Participating Providers, Non-Participating Providers and Other Eligible Providers. It is our payment towards the services billed by your provider combined with any Deductible, Copayment or coinsurance owed by you. In some cases, you may be required to pay the entire Maximum Allowed Amount. For instance, if you have not met your Deductible under your plan, then you could be responsible for paying the entire Maximum Allowed Amount for Covered Services. In addition, if these services are received from a Non-Participating Provider or Other Eligible Provider, you may be billed by the provider for the difference between their charges and our Maximum Allowed Amount. In many situations, this difference could be significant.

We have provided two examples, below, which illustrate how the Maximum Allowed Amount works. These examples are for illustration purposes only.

Example: The plan has a Member coinsurance cost share of 30% for Participating Provider services after the Deductible has been met.

- The Member receives services from a Participating surgeon. The charge is $2,000. The Maximum Allowed Amount under the plan for the surgery is $1,000. The Member's coinsurance responsibility when a Participating surgeon is used is 30% of $1,000, or $300. This is what the Member pays. We pay 70% of $1,000, or $700. The Participating surgeon accepts the total of $1,000 as reimbursement for the surgery regardless of the charges.

Example: The plan has a Member coinsurance cost share of 50% for Non-Participating Provider services after the Deductible has been met.

- The Member receives services from a Non-Participating surgeon. The charge is $2,000. The Maximum Allowed Amount under the plan for the surgery is $1,000. The Member's coinsurance responsibility when a Non-Participating surgeon is used is 50% of $1,000, or $500. We pay the remaining 50% of $1,000, or $500. In addition, the Non-Participating surgeon could bill the Member the difference between $2,000 and $1,000, so the Member's total out-of-pocket charge would be $500 plus an additional $1,000, for a total of $1,500.

When you receive Covered Services, we will, to the extent applicable, apply claim processing rules to the claim submitted. We use 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 we determine 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 one single code that includes all of the procedures performed, the Maximum Allowed Amount will be based on the single procedure code.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Provider, Non-Participating Provider or Other Eligible Provider.

Participating Providers: For Covered Services performed by a Participating Provider, the Maximum Allowed Amount for your plan is the rate the provider has agreed with Anthem Blue Cross to accept as reimbursement for the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or coinsurance. Please call customer service toll free at (800) 627-8797 for help in finding a Participating Provider or visit **www.anthem.com/ca**.

Non-Participating Providers and Other Eligible Providers: For Covered Services you receive from a Non-Participating Provider or Other Eligible Provider other than Medical Emergency care, the Maximum Allowed Amount will be based on the applicable Anthem Blue Cross Non-Participating Provider or Other Eligible Provider rate or fee schedule for your plan, an amount negotiated by us or a third party vendor which has been agreed to by the Non-Participating Provider or Other Eligible Provider, an amount derived from the total charges billed by the Non-Participating Provider or Other Eligible Provider, or an amount based on information provided by a third party vendor.

Unlike Participating Providers, Non-Participating Providers and Other Eligible Providers may send you a bill and collect for the amount of the Non-Participating Provider's or Other Eligible Provider's charge that exceeds the Maximum Allowed Amount under this plan or the Reasonable and Customary Value except those charges related to Medical Emergencies within California. This amount can be significant. Choosing a Participating Provider will likely result in lower out-of-pocket costs to you. Please call customer service toll free at (800) 627-8797 for help in finding a Participating Provider or visit our website at **www.anthem.com/ca**. Customer service is also available to assist you in determining your plan's Maximum Allowed Amount for a particular Covered Service from a Non-Participating Provider or Other Eligible Provider.

Please see the "Out-of-Area Services" section in the Part entitled "GENERAL PROVISIONS" for additional information.

Please see the Part entitled "NON-PARTICIPATING PROVIDER COMPREHENSIVE BENEFITS AND COPAYMENT LIST" for your payment responsibility.

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 (Deductible, Copayment, and/or coinsurance). Your cost share amount and out-of-pocket limits may be different depending on whether you received Covered Services from a Participating Provider, Non-Participating Provider or Other Eligible Provider. Specifically, you may be required to pay higher cost-sharing amounts or may have limits on your benefits when using Non-Participating Providers or Other Eligible Providers. Please see the Parts entitled "PARTICIPATING PROVIDER COMPREHENSIVE BENEFITS AND COPAYMENT LIST" and "NON-PARTICIPATING PROVIDER COMPREHENSIVE BENEFITS AND COPAYMENT LIST" in this Combined Evidence of Coverage and Disclosure Form for your cost share responsibilities and limitations, or call customer service toll free at (800) 627-8797 to learn how this plan's benefits or cost share amounts may vary by the type of provider you use.

Anthem Blue Cross will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your provider for non-Covered Services, regardless of whether such services are performed by a Participating Provider, Non-Participating Provider or Other Eligible 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, benefit caps or day/visit limits.

In some instances you may only be asked to pay the lower Participating Provider cost share percentage when you use a Non-Participating Provider. For example, if you go to a Participating Hospital or facility and receive Covered Services from a Non-Participating Provider such as a radiologist, anesthesiologist or pathologist providing services at the Hospital or facility, you will pay the Participating Provider cost share percentage of the Maximum Allowed Amount for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge.

Authorized Referrals

In some circumstances, we may authorize Participating Provider cost share amounts (Deductible, Copayment, and/or coinsurance) to apply to a claim for a Covered Service you receive from a Non-Participating Provider. In such circumstance, you or your Physician must contact us in advance of obtaining the Covered Service. It is your responsibility to ensure that we have been contacted. If we authorize a Participating Provider cost share amount to apply to a Covered Service received from a Non-Participating Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge. Please contact customer service toll free at (800) 627-8797 for Authorized Referral information or to request authorization.

ANNUAL MAXIMUM PAYMENT LIMITS

Maximum Copayment Limit for Participating Providers

Note: Amounts you pay that are applied to your annual Deductible for Covered Services received from Participating Providers will also apply to your maximum Copayment limit for Participating Providers.

- Your maximum Copayment limit is $4,500 per Member per Year. Once a Member has met his or her maximum Copayment limit of $4,500 per Member per Year, no further Copayment, except as specified in the "Exception" paragraph below, will be required for Participating Providers for the remainder of that Year.
- For a family, when two (2) Members of an enrolled family have each met their maximum Copayment limit of $4,500 per Member per Year, no further Copayment, except as specified in the "Exception" paragraph below, will be required for Participating Providers for the remainder of that Year.

Exception: Copayments for the following services and supplies rendered by Participating Providers **will not** accumulate toward satisfying the maximum Copayment limit for Participating Providers, and you will be required to continue to pay for these services and supplies even after your maximum Copayment limit has been reached.

- Prescription Drugs under the Part entitled "YOUR PRESCRIPTION DRUG BENEFITS"
- Acupuncture/Acupressure
- Mental or Nervous Disorders and Substance Abuse (except for treatment of Severe Mental Illness and Serious Emotional Disturbances of a Child)
- Copayment for Infertility services

Maximum Payment Limit for Non-Participating Providers

Note: Amounts you pay for Covered Services received from Non-Participating Providers will not apply toward the annual maximum payment limit for Non-Participating Providers or to the maximum Copayment limit for Participating Providers. Only Anthem Blue Cross payments made to Non-Participating Providers will apply to the maximum payment limit for Non-Participating Providers. In addition, Anthem Blue Cross payments made to Participating Providers will not apply toward the Anthem Blue Cross annual maximum payment limit for Non-Participating Providers.

You are responsible to pay Copayments and any charges over what we allow as Covered Expense until Anthem Blue Cross payments reach **$10,000** for a Member in a Year for Covered Services received from Non-Participating Providers. Once Anthem Blue Cross payments reach $10,000, no further Copayment, except as specified in the "Exception" paragraph below, will be required for Non-Participating Providers for that Member for the remainder of that Year. However, the Member will always have to continue to pay any charges over what we allow as Covered Expense for Non-Participating Providers.

Exception: Amounts you pay for the following services and supplies rendered by Non-Participating Providers **will continue to be required** even after the Anthem Blue Cross annual maximum payment limit has been reached:

- Copayments for not obtaining Preservice Review
- Prescription Drugs under the Part entitled "YOUR PRESCRIPTION DRUG BENEFITS"
- Acupuncture/Acupressure
- Mental or Nervous Disorders and Substance Abuse (except for treatment of Severe Mental Illness and Serious Emotional Disturbances of a Child)
- Copayment for Infertility services

PART III PARTICIPATING PROVIDER COMPREHENSIVE BENEFITS AND COPAYMENT LIST

Covered Expense for Participating Providers is based on our Maximum Allowed Amount. Participating Providers have agreed **NOT** to charge you and Anthem Blue Cross more than the Anthem Blue Cross Maximum Allowed Amount. In addition, Participating Providers will file claims with us for you.

A directory of local Anthem Blue Cross Participating Providers is available by calling our customer service department toll free at (800) 627-8797, or through our web site, **www.anthem.com/ca**.

For a detailed description of what is covered, please see the Part entitled "WHAT IS COVERED."

The following require Preservice Review: All inpatient Hospital admissions (except for the delivery of a Child or mastectomy surgery, including the length of Hospital stays associated with mastectomy), Facility Based Treatment for Mental or Nervous Disorders and Substance Abuse, Skilled Nursing Facility admissions, Infusion Therapy (in any setting) inclusive of Specialty Drugs through the specialty pharmacy program, and Home Health Care. (**Important:** Please note there are other services, not listed above, that require Preservice Review. In addition, there are other Preservice Review requirements. Please see the Part entitled "UTILIZATION AND PRESERVICE REVIEW" for details.)

BENEFITS	**YOUR PAYMENT RESPONSIBILITY**
INPATIENT HOSPITAL	
Participating Hospital	You pay 30% of the Maximum Allowed Amount.

A Center of Medical Excellence (CME) Network has been established for transplants and bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss. These procedures are covered only at a CME, except for Medical Emergencies. For more information, please see the section entitled "CENTERS OF MEDICAL EXCELLENCE (CME) FOR TRANSPLANTS AND BARIATRIC SURGERY" under the Part entitled "WHAT IS COVERED."

OUTPATIENT HOSPITAL, AMBULATORY SURGICAL CENTERS AND EMERGENCY ROOM	
Participating Provider	You pay 30% of the Maximum Allowed Amount.

Emergency room services are subject to an additional $150 Copayment per visit, which is waived if the visit results in an inpatient admission into a Hospital immediately following the emergency room services. The emergency room Copayment **will not** be applied toward the Member's annual Deductible.

OFFICE VISITS, ONLINE CLINIC VISITS AND RETAIL HEALTH CLINIC VISITS	
Participating Provider	You pay $30 per visit.

Note: Office Visits, Online Clinic Visits and Retail Health Clinic Visits are not subject to the annual Deductible.

BENEFITS	YOUR PAYMENT RESPONSIBILITY
OTHER PROFESSIONAL SERVICES ***(except Office Visits)***	
Participating Provider	You pay 30% of the Maximum Allowed Amount.
URGENT CARE	
Participating Provider	**Office Visits:** You pay $30 per visit, not subject to the annual Deductible. **Other Professional Services:** You pay 30% of the Maximum Allowed Amount. **Urgent Care Facility:** You pay 30% of the Maximum Allowed Amount.
OUTPATIENT DIAGNOSTIC RADIOLOGY AND LABORATORY ***(includes advanced imaging procedures)***	
Participating Provider	You pay 30% of the Maximum Allowed Amount.
PREVENTIVE CARE ***(includes Physical Exam, HealthyCheck, Well Baby, Well Child and Adult Preventive Services)***	
Participating Provider	You pay no Copayment for all Covered Services, including Office Visits.

Note: Preventive care services, including Office Visits, are not subject to the annual Deductible.

PHYSICAL and/or OCCUPATIONAL THERAPY/MEDICINE and CHIROPRACTIC CARE ***(provided for an aggregate of 24 visits per Year for Participating and Non-Participating Providers combined)***	
Participating Provider	You pay 30% of the Maximum Allowed Amount.

Note: Additional visits will be covered as authorized by us, but only if we determine that additional treatment is Medically Necessary. We will authorize a specific number of additional visits. To request authorization contact customer service at (800) 627-8797.

ACUPUNCTURE/ACUPRESSURE ***(limited to 24 visits per Year for Participating and Non-Participating Providers combined)***	
(The Copayment for this benefit **will not** be applied toward the Member's maximum Copayment limit.)	
Participating Provider	You pay 30% of the Maximum Allowed Amount **plus** any charges in excess of our maximum payment of $30 per visit.

BENEFITS	YOUR PAYMENT RESPONSIBILITY
DENTAL INJURY ***(except for orthodontic services)***	
Participating Provider	You pay 30% of the Maximum Allowed Amount.
AMBULANCE	
Participating Provider	You pay 30% of the Maximum Allowed Amount.
MENTAL OR NERVOUS DISORDERS & SUBSTANCE ABUSE ***(Except for treatment of Severe Mental Illness and Serious Emotional Disturbances of a Child. Benefits for Covered Services and supplies provided for the treatment of specific Severe Mental Illness and Serious Emotional Disturbances of a Child are provided on the same basis, at the same Copayments, as any other medical condition.)***	
Note: The amount you pay for this benefit **will not** be applied toward your maximum Copayment limit.	
Facility Based Treatment	
Participating Provider	You pay 30% of the Maximum Allowed Amount (limited to 30 days per Year, Participating and Non-Participating Providers combined).
Professional Services (inpatient and outpatient Physician services) including psychological testing	
Participating Provider	You pay 30% of the Maximum Allowed Amount (limited to one visit per day and 20 visits per Year, Participating and Non-Participating Providers combined).
PREGNANCY AND MATERNITY CARE	
Hospital charges are paid as any other illness – see the "INPATIENT HOSPITAL" section of this Copayment list.	
Professional charges Participating Physician	You pay 30% of the Maximum Allowed Amount.
INFERTILITY SERVICES	
Participating Provider	You pay a $500 Copayment **plus** 30% of any balance of the Maximum Allowed Amount remaining after your $500 Copayment.
Note: The $500 Copayment for Infertility services **will not** be applied toward the Member's maximum Copayment limit or annual Deductible. **Infertility services are limited to our lifetime maximum payment of $2,000 per Member for Participating and Non-Participating Providers combined**.	

BENEFITS	YOUR PAYMENT RESPONSIBILITY
SKILLED NURSING FACILITY ***(limited to 100 days per Year for Participating and Non-Participating Providers combined)***	
Participating Skilled Nursing Facility	You pay 30% of the Maximum Allowed Amount.
HOME HEALTH CARE ***(limited to 100 visits per Year, up to 4 hours each visit, for Participating and Non-Participating Providers combined)***	
Participating Provider	You pay 30% of the Maximum Allowed Amount.
HOSPICE CARE	
Participating Provider	You pay no Copayment for all Covered Services.

Note: Hospice care is not subject to the annual Deductible.

INFUSION THERAPY	
Participating Provider	You pay 30% of the Maximum Allowed Amount.
MEDICAL SUPPLIES AND EQUIPMENT	
Participating Provider	You pay 50% of the Maximum Allowed Amount.
FOOTWEAR ***(Special Footwear, orthotic devices and services related to the preparation and dispensing of custom orthotics, including Special Footwear prescribed to treat conditions of diabetes, will be provided as Medically Necessary.)***	
Participating Provider	You pay 30% of the Maximum Allowed Amount.

PART IV NON-PARTICIPATING PROVIDER COMPREHENSIVE BENEFITS AND COPAYMENT LIST

YOUR PERSONAL FINANCIAL COSTS WHEN USING NON-PARTICIPATING PROVIDERS MAY BE CONSIDERABLY HIGHER THAN WHEN YOU USE PARTICIPATING PROVIDERS. EXCEPT FOR MEDICAL EMERGENCY CARE RENDERED BY NON-PARTICIPATING PROVIDERS WITHIN CALIFORNIA, YOU WILL HAVE TO PAY ANY PART OF A PROVIDER'S BILL WHICH IS OVER WHAT WE ALLOW IN BENEFITS FOR NON-PARTICIPATING PROVIDERS.

NO BENEFITS ARE PAYABLE FOR CARE FURNISHED IN NON-CONTRACTING HOSPITALS. (See the SPECIAL CIRCUMSTANCES sections of this Copayment list for possible exceptions.)

Benefits for Covered Services received in and outside California are subject to all of the terms, conditions, limitations and exclusions of this Combined Evidence of Coverage and Disclosure Form.

For a detailed description of what is covered, please see the Part entitled "WHAT IS COVERED."

The following require Preservice Review: All inpatient Hospital (except for the delivery of a Child or mastectomy surgery, including the length of Hospital stays associated with mastectomy), Facility Based Treatment for Mental or Nervous Disorders and Substance Abuse, Skilled Nursing Facility admissions, Infusion Therapy (in any setting) inclusive of Specialty Drugs through the specialty pharmacy program, and Home Health Care. You are responsible for an additional $250 Copayment per admission, treatment or course of therapy if Preservice Review is not obtained. This Copayment **will not** apply toward your annual Deductible and it will continue to be required even after the Anthem Blue Cross annual maximum payment limit has been reached (this Copayment is not required in Medical Emergencies). (**Important:** Please note there are other services, not listed above, that require Preservice Review. In addition, there are other Preservice Review requirements. Please see the Part entitled "UTILIZATION AND PRESERVICE REVIEW" for details.)

See the SPECIAL CIRCUMSTANCES sections of this Copayment list for situations that reduce your Copayment responsibility when utilizing a Non-Participating Provider.

BENEFITS	**YOUR PAYMENT RESPONSIBILITY**
INPATIENT HOSPITAL	
Non-Participating Hospital **(in or out of CA)**	You pay 50% of the Maximum Allowed Amount **plus** any charges in excess of our maximum payment of $650 per day unless Special Circumstances apply.

BENEFITS	YOUR PAYMENT RESPONSIBILITY
OUTPATIENT HOSPITAL, AMBULATORY SURGICAL CENTERS AND EMERGENCY ROOM	
Non-Participating Provider **(in or out of CA)**	You pay 50% of the Maximum Allowed Amount **plus** any charges in excess of our maximum payment of $380 per admit unless Special Circumstances apply.

Emergency room services are subject to an additional $150 Copayment per visit, which is waived if the visit results in an inpatient admission into a Hospital immediately following the emergency room services. The emergency room Copayment **will not** be applied toward the Member's annual Deductible.

OFFICE VISITS, ONLINE CLINIC VISITS AND RETAIL HEALTH CLINIC VISITS	
Non-Participating Provider	You pay 50% of the Maximum Allowed Amount **plus** any charges in excess of the Maximum Allowed Amount unless Special Circumstances apply.
OTHER PROFESSIONAL SERVICES ***(except Office Visits)***	
Non-Participating Provider	You pay 50% of the Maximum Allowed Amount **plus** any charges in excess of the Maximum Allowed Amount unless Special Circumstances apply.
URGENT CARE	
Non-Participating Provider **(in or out of CA)**	**Office Visits:** You pay 50% of the Maximum Allowed Amount **plus** any charges in excess of the Maximum Allowed Amount unless Special Circumstances apply. **Other Professional Services:** You pay 50% of the Maximum Allowed Amount **plus** any charges in excess of the Maximum Allowed Amount unless Special Circumstances apply. **Urgent Care Facility:** You pay 50% of the Maximum Allowed Amount **plus** any charges in excess of our maximum payment of $380 per admit unless Special Circumstances apply.

BENEFITS	YOUR PAYMENT RESPONSIBILITY
OUTPATIENT DIAGNOSTIC RADIOLOGY AND LABORATORY ***(includes advanced imaging procedures)***	
Outpatient diagnostic radiology and laboratory other than advanced imaging procedures	
Non-Participating Provider	You pay 50% of the Maximum Allowed Amount **plus** any charges in excess of the Maximum Allowed Amount unless Special Circumstances apply.
Advanced imaging procedures	
Non-Participating Provider	You pay 50% of the Maximum Allowed Amount **plus** any charges in excess of our maximum payment of $800 per procedure unless Special Circumstances apply. **Note:** If the procedure is received at an outpatient Hospital facility or Ambulatory Surgical Center, benefits are covered under the section in this Part entitled "OUTPATIENT HOSPITAL, AMBULATORY SURGICAL CENTERS AND EMERGENCY ROOM."
PREVENTIVE CARE ***(includes Physical Exam, Well Baby, Well Child and Adult Preventive Services)***	
Non-Participating Provider	You pay 50% of the Maximum Allowed Amount **plus** any charges in excess of the Maximum Allowed Amount unless Special Circumstances apply.
PHYSICAL and/or OCCUPATIONAL THERAPY/MEDICINE and CHIROPRACTIC CARE ***(provided for an aggregate of 24 visits per Year for Participating and Non-Participating Providers combined)***	
Non-Participating Provider	You pay 50% of the Maximum Allowed Amount **plus** any charges in excess of our maximum payment of $25 per visit.

Note: Additional visits will be covered as authorized by Anthem Blue Cross, but only if Anthem Blue Cross determines that additional treatment is Medically Necessary. Anthem Blue Cross will authorize a specific number of additional visits. To request authorization contact customer service at (800) 627-8797.

BENEFITS	YOUR PAYMENT RESPONSIBILITY
ACUPUNCTURE/ACUPRESSURE ***(limited to 24 visits per Year for Participating and Non-Participating Providers combined)***	
Non-Participating Provider	You pay 50% of the Maximum Allowed Amount **plus** any charges in excess of our maximum payment of $30 per visit.
AMBULANCE IN A MEDICAL EMERGENCY	
Non-Participating Provider (Within California)	You pay 30% of the Reasonable and Customary Value.
Non-Participating Provider (Outside California)	You pay 30% of the Reasonable and Customary Value **plus** any charges in excess of the Reasonable and Customary Value.
AMBULANCE OTHER THAN IN A MEDICAL EMERGENCY (WITH AN AUTHORIZED REFERRAL)	
Non-Participating Provider (In and Outside California)	You pay 30% of the Maximum Allowed Amount **plus** any charges in excess of the Maximum Allowed Amount.
AMBULANCE OTHER THAN IN A MEDICAL EMERGENCY (WITHOUT AN AUTHORIZED REFERRAL)	
Non-Participating Provider (In and Outside California)	You pay 50% of the Maximum Allowed Amount **plus** any charges in excess of the Maximum Allowed Amount.
PREGNANCY AND MATERNITY CARE	
Hospital charges are paid as any other illness – see the "INPATIENT HOSPITAL" section of this Copayment list.	
Professional charges Non-Participating Physician	You pay 50% of the Maximum Allowed Amount **plus** any charges in excess of the Maximum Allowed Amount unless Special Circumstances apply.
INFERTILITY SERVICES	
Non-Participating Provider	You pay a $500 Copayment **plus** 50% of any balance of the Maximum Allowed Amount remaining after your $500 Copayment **plus** any charges in excess of the Maximum Allowed Amount.

Note: The $500 Copayment for Infertility services **will not** be applied toward the Member's annual Deductible. **Infertility services are limited to our lifetime maximum payment of $2,000 per Member for Participating and Non-Participating Providers combined.**

BENEFITS	YOUR PAYMENT RESPONSIBILITY
MENTAL OR NERVOUS DISORDERS & SUBSTANCE ABUSE ***(Except for treatment of Severe Mental Illness and Serious Emotional Disturbances of a Child. Benefits for Covered Services and supplies provided for the treatment of specific Severe Mental Illness and Serious Emotional Disturbances of a Child are provided on the same basis, at the same Copayments, as any other medical condition.)***	
Facility Based Treatment	
Non-Participating Provider	You pay 50% of the Maximum Allowed Amount **plus** any charges in excess of our maximum payment of $175 per day (limited to 30 days per Year, Participating and Non-Participating Providers combined).
Professional Services (inpatient and outpatient Physician services) including psychological testing	
Non-Participating Provider	You pay 50% of the Maximum Allowed Amount **plus** any charges in excess of our maximum payment of $25 per visit (limited to one visit per day and 20 visits per Year, Participating and Non-Participating Providers combined).
INFUSION THERAPY ***(The combined maximum Anthem Blue Cross payment for all Infusion Therapy services (administrative, professional and Drugs) will not exceed $500 per day.)***	
Non-Participating Provider	You pay 50% of the Maximum Allowed Amount **plus** any charges in excess of our maximum payment of $50 per day for all Infusion Therapy expenses **except Drugs; plus** all charges in excess of the Average Wholesale Price (an accepted term in the pharmaceutical industry used as a benchmark for pricing) for all Infusion Therapy Drugs; and any charges in excess of the per day maximum payment indicated above.
SKILLED NURSING FACILITY ***(limited to 100 days per Year for Participating and Non-Participating Providers combined)***	
Non-Participating and Out-of-State Skilled Nursing Facility	You pay 50% of the Maximum Allowed Amount **plus** any charges in excess of our maximum payment of $150 per day.

BENEFITS	YOUR PAYMENT RESPONSIBILITY
HOME HEALTH CARE ***(limited to 100 visits per Year, up to 4 hours each visit, for Participating and Non-Participating Providers combined)***	
Non-Participating Provider	You pay 50% of the Maximum Allowed Amount **plus** any charges in excess of our maximum payment of $75 per visit.
HOSPICE CARE	
Non-Participating Provider	You pay 50% of the Maximum Allowed Amount **plus** any charges in excess of the Maximum Allowed Amount, unless Special Circumstances apply, **OR** you pay 50% of the Hospice rates set by Centers for Medicare and Medicaid Services (CMS – formerly HCFA) **plus** any excess charges unless Special Circumstances apply, whichever rate is less.
MEDICAL SUPPLIES AND EQUIPMENT	
Non-Participating Provider	You pay 50% of the Maximum Allowed Amount **plus** any charges in excess of the Maximum Allowed Amount unless Special Circumstances apply.
FOOTWEAR ***(Special Footwear, orthotic devices and services related to the preparation and dispensing of custom orthotics, including Special Footwear prescribed to treat conditions of diabetes, will be provided as Medically Necessary.)***	
Non-Participating Provider	You pay 50% of the Maximum Allowed Amount **plus** any charges in excess of the Maximum Allowed Amount unless Special Circumstances apply.
DENTAL INJURY ***(except for orthodontic services)***	
Non-Participating Provider	You pay 50% of the Maximum Allowed Amount **plus** any charges in excess of the Maximum Allowed Amount unless Special Circumstances apply.
FOREIGN COUNTRY PROVIDERS ***(for treatment of a Medical Emergency only)***	
All Providers	You pay 30% of eligible charges for Covered Services **plus** any ineligible charges.

Note: You are responsible at your expense for obtaining an English language translation of foreign country provider claims and any medical records that may be required.

BENEFITS	YOUR PAYMENT RESPONSIBILITY

OTHER ELIGIBLE PROVIDERS

The following class of providers does not enter into participating agreements with us and your payment responsibility for these providers is as indicated below: a blood bank, a dentist (D.D.S.), a dispensing optician, an audiologist, a respiratory therapist.

All providers listed above	You pay 30% of the Maximum Allowed Amount **plus** any charges in excess of the Maximum Allowed Amount.

Note: The providers listed above must be licensed according to state and local laws to provide covered medical services.

SPECIAL CIRCUMSTANCES ***(In and Outside California)***

Authorized Referral Care (Out-of-Network Referrals for Non-Participating Providers)

All Non-Participating Providers (Physician, Hospital (inpatient or outpatient), Ambulatory Surgical Center) except Hospice	You pay 30% of the Maximum Allowed Amount **plus** any charges in excess of the Maximum Allowed Amount.
Non-Participating Hospice	You pay any charges in excess of the Maximum Allowed Amount, not subject to the annual Deductible.

SPECIAL CIRCUMSTANCES ***(Within California)***

Medical Emergencies

Non-Participating Physician, Non-Participating Hospital, Non-Contracting Hospital or Non-Participating Ambulatory Surgical Center	You pay 30% of the Reasonable and Customary Value.

Note: Emergency room services are subject to an additional $150 Copayment per visit, which is waived if the visit results in an inpatient admission into a Hospital immediately following the emergency room services. The emergency room Copayment **will not** be applied toward the Member's annual Deductible.

BENEFITS	YOUR PAYMENT RESPONSIBILITY
SPECIAL CIRCUMSTANCES ***(Within California) (continued)***	
Designated Non-Contracting Hospitals	You pay 30% of the Designated Non-Contracting Hospital rate.

A Designated Non-Contracting Hospital will be considered as such for a limited time only. We will provide thirty (30) days advance notice, through our web site at **www.anthem.com/ca**, before the limited time will expire. After the expiration of the limited time frame, a Designated Non-Contracting Hospital will revert back to a Non-Contracting Hospital and be removed from our web site. Benefits are not payable for Non-Contracting Hospitals, except in the case of a Medical Emergency. A list of our Designated Non-Contracting Hospitals, along with the rates for Designated Non-Contracting Hospitals, may be found on our web site at **www.anthem.com/ca**. You may also call our customer service department toll free at (800) 627-8797 or write to us at Anthem Blue Cross, P.O. Box 60007, Los Angeles, CA 90060-0007 for a list of Designated Non-Contracting Hospitals.

SPECIAL CIRCUMSTANCES ***(Medical Emergencies Outside California – BlueCard Program)***

For information about the BlueCard Program, please see the "Out-of-Area Services" section under the Part entitled "GENERAL PROVISIONS."

Your payment responsibility for Covered Services received from non-participating providers, including Ambulance, will be at the BlueCard participating provider benefit level (30% of Covered Expense) for Medical Emergency services described below.

Emergency room services are subject to an additional $150 Copayment per visit, which is waived if the visit results in an inpatient admission into a Hospital immediately following the emergency room services.

Office Visit and Professional Services

BlueCard participating provider	**Office Visits:** You pay $30 per visit, not subject to the annual Deductible. **Professional Services:** You pay 30% of the BlueCard provider's Negotiated Price for all Covered Services other than the Office Visit.
BlueCard non-participating provider	**Office Visits and Professional Services:** You pay 30% of the Reasonable and Customary Value **plus** any charges in excess of the Reasonable and Customary Value.

BENEFITS	YOUR PAYMENT RESPONSIBILITY
SPECIAL CIRCUMSTANCES ***(Medical Emergencies Outside California – BlueCard Program) (continued)***	
Hospital or Ambulatory Surgical Center	
BlueCard participating provider	You pay 30% of the BlueCard provider's Negotiated Price.
BlueCard non-participating provider	You pay 30% of the Reasonable and Customary Value **plus** any charges in excess of the Reasonable and Customary Value.
ELECTIVE (NON-MEDICAL EMERGENCY) SERVICES ***(Outside California – BlueCard Program)***	
For information about the BlueCard Program, please see the "Out-of-Area Services" section under the Part entitled "GENERAL PROVISIONS."	
Office Visits and Professional Services	
BlueCard participating provider	**Office Visits:** You pay $30 per visit, not subject to the annual Deductible. **Professional Services:** You pay 30% of the BlueCard provider's Negotiated Price for all Covered Services other than the Office Visit.
BlueCard non-participating provider	**Office Visits and Professional Services:** You pay 50% of the BlueCard provider's Negotiated Price **plus** any charges in excess of the BlueCard provider's Negotiated Price.
Hospital or Ambulatory Surgical Center	
BlueCard participating provider	You pay 30% of the BlueCard provider's Negotiated Price.
BlueCard non-participating provider	**Hospital (Inpatient):** You pay all charges **except** $650 per day. **Outpatient Hospital and/or Ambulatory Surgical Center:** You pay all charges **except** $380 per admit.

PART V WHAT IS COVERED

All Covered Services are subject to the annual Deductible except as specifically stated in this Combined Evidence of Coverage and Disclosure Form.

Amounts that do not apply toward the annual Deductible are described in the section entitled ANNUAL DEDUCTIBLE in the Part entitled "ANNUAL DEDUCTIBLE, COPAYMENTS, MAXIMUM ALLOWED AMOUNT AND ANNUAL MAXIMUM PAYMENT LIMITS."

Described below are the types of services covered under this Combined Evidence of Coverage and Disclosure Form for the treatment of a covered illness, injury or condition. Before you review this list of Covered Services take a moment to review the definitions of "Maximum Allowed Amount" and "Reasonable and Customary Value," and also review the section of this Combined Evidence of Coverage and Disclosure Form called "Copayments" and the Parts entitled "PARTICIPATING PROVIDER COMPREHENSIVE BENEFITS AND COPAYMENT LIST" and "NON-PARTICIPATING PROVIDER COMPREHENSIVE BENEFITS AND COPAYMENT LIST." Knowing the meaning of these terms will greatly assist you in determining the benefits of this Combined Evidence of Coverage and Disclosure Form and your Copayment responsibility as well.

Another term you should become familiar with is "Preservice Review." Preservice Review begins when your Physician provides medical information to us prior to a specific service or procedure taking place so that we can determine if it's Medically Necessary and a Covered Service.

Remember, the following require Preservice Review: All inpatient Hospital (except for the delivery of a Child or mastectomy surgery, including the length of Hospital stays associated with mastectomy), Facility Based Treatment for Mental or Nervous Disorders and Substance Abuse, Skilled Nursing Facility admissions, Infusion Therapy (in any setting) inclusive of Specialty Drugs through the specialty pharmacy program, and Home Health Care, as well as some surgeries and certain diagnostic procedures. (**Important:** Please note there are other services, not listed above, that require Preservice Review. In addition, there are other Preservice Review requirements. Please see the Part entitled "UTILIZATION AND PRESERVICE REVIEW" for details.)

HOSPITAL SERVICES (requires Preservice Review, except for delivery of a Child or mastectomy surgery, including the length of Hospital stays associated with mastectomy)

- A Hospital room with two or more beds. If a private room is used, unless Medically Necessary, we will allow only up to the prevailing two-bed room rate.
- Care in Special Care Units.
- Operating, delivery and special treatment rooms.
- Supplies and services such as laboratory, cardiology, pathology and radiology rendered while in the facility.
- Drugs, medicines, and oxygen given to you during your stay.
- Blood, blood plasma, blood derivatives and blood factors. Blood transfusions, including blood processing and storage costs.
- Use of the emergency room.
- Outpatient services and supplies, including those in connection with outpatient surgery performed at an Ambulatory Surgical Center.

PROFESSIONAL SERVICES AND SUPPLIES (certain Professional Services and Supplies require Preservice Review)

- Services of a Physician (including surgeons and specialists).
- Services of an anesthesiologist or anesthetist.
- Online clinic visit services when available in your area. Covered Services include a medical consultation using the internet via webcam, chat or voice. Please see the Part entitled "WHAT IS NOT COVERED" for non-Covered Services.
- Services of a Retail Health Clinic.
- Outpatient speech therapy when following surgery, injury or otherwise as Medically Necessary (for an aggregate of 50 visits per Year). Additional visits will be covered when authorized by us, but only if we determine that additional treatment is Medically Necessary. We will authorize a specific number of additional visits. To request authorization contact customer service at (800) 627-8797.
- Outpatient diagnostic radiology and laboratory services. Please refer to the section in this Part entitled "Advanced Imaging Procedures" to see which procedures are covered under advanced imaging. **Note:** Preservice Review is required for specific outpatient diagnostic radiology and certain laboratory services.
- Screening for blood lead levels in children, when the screening is ordered by your Physician.
- Cancer screening tests approved by the federal Food and Drug Administration (FDA) and the Office Visit associated with performing those tests when ordered by your Physician. This includes screening for breast, cervical, ovarian and prostate cancer.
- Mammogram examinations when ordered by your Physician.
- Radiation therapy.
- Hemodialysis treatment.
- Surgical implants (except for cosmetic purposes).
- Artificial limbs or eyes.
- The first pair of contact lenses or eyeglasses when required as a result of a covered eye surgery.
- Blood transfusions, including blood processing and storage costs.
- Biological sera.
- FDA-approved medications that may be dispensed only by or under direct supervision of a Physician.
- Acupuncture/acupressure rendered by a Physician. **Note:** All supplies used in conjunction with the acupuncture/acupressure treatment will be included in the payment for the visit and will not be reimbursed in addition to the visit.
- Physical and/or occupational therapy and/or chiropractic care when rendered by a Physician. Members may receive these services in additional visits authorized by us but only if we determine that additional treatment is Medically Necessary. We will authorize a specific number of additional visits. To request authorization contact customer service at (800) 627-8797.
- Human immunodeficiency virus (HIV) testing.
- Venereal disease tests.
- Cytology examinations.
- Special Footwear, orthotic devices and services related to the preparation and dispensing of custom footwear that is Medically Necessary to treat an injury or illness as described under "Special Footwear" in the Part entitled "DEFINITIONS." The coverage for Special Footwear and orthotics shall include original and replacement devices when the device is Medically Necessary and is prescribed by a Physician or is ordered by a licensed health care provider acting within the scope of his or her license.

- Prosthetic devices and services related to the preparation and dispensing of custom prosthetics. Coverage for prosthetic devices shall include original and replacement devices when the device is Medically Necessary and is prescribed by a Physician or doctor of podiatric medicine acting within the scope of his or her license. Coverage includes but is not limited to:
  - prosthetic devices to achieve symmetry after mastectomy, and
  - prosthetic devices (except electronic voice producing machines) to restore a method of speaking for the Member after laryngectomy.
- Genetic testing and diagnostic procedures for Members when Medically Necessary to treat an inheritable disease.
- Injectable contraceptives and contraceptive devices when administered in a Physician's office or other institutional setting.
- Specialty Drugs provided by a Physician may be subject to the terms outlined under the section in this Part entitled "Specialty Pharmacy Program."
- Reconstructive Surgery.
- Ambulance service (base charge, mileage and non-reusable supplies) to transport you to the nearest Hospital or Skilled Nursing Facility or from a Hospital or Skilled Nursing Facility when Medically Necessary. Payment of benefits for ambulance services may be made directly to the provider of service unless proof of payment is received by us prior to the benefits being paid. If requested through a 911 call, ambulance charges are covered if it is reasonably believed that a Medical Emergency existed even if you are not transported to a Hospital. **Note:** Preservice Review is required for air ambulance in a non-Medical Emergency.

  IN SOME AREAS A 911 EMERGENCY RESPONSE SYSTEM HAS BEEN ESTABLISHED. THIS SYSTEM IS TO BE USED ONLY WHEN THERE IS AN EMERGENCY MEDICAL CONDITION THAT REQUIRES AN EMERGENCY RESPONSE.

  IF YOU REASONABLY BELIEVE THAT YOU ARE EXPERIENCING A MEDICAL EMERGENCY, YOU SHOULD CALL 911 OR GO DIRECTLY TO THE NEAREST HOSPITAL EMERGENCY ROOM.

URGENT CARE SERVICES

Often an urgent rather than an emergency medical problem exists. An urgent medical problem is an unexpected illness or injury requiring treatment that cannot reasonably be postponed for regularly scheduled care. It is not considered a Medical Emergency. Urgent medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). Treatment of an urgent medical problem is not life-threatening and does not require use of an emergency room at a Hospital.

Benefits for urgent care include evaluation and treatment such as:

- X-ray services;
- Stabilization for simple fractures;
- Tests including, but not limited to, those for: influenza, urinalysis, pregnancy test, rapid strep;
- Lab services;
- Simple laceration repairs; and
- Incision and drainage of an abscess.

ADVANCED IMAGING PROCEDURES (requires Preservice Review)

Advanced imaging procedures include but are not limited to:

- Computerized Tomography (CT)
- Computerized Tomography Angiography (CTA)
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Spectroscopy (MRS)
- Nuclear Cardiology
- Positron Emission Tomography (PET)
- PET and PET/CT Fusion
- QTC Bone Densitometry
- Diagnostic CT Colonography
- Echocardiogram

For a complete list of advanced imaging procedures or if you need more information, please call the customer service number shown on your ID card. You can also contact us on our website at **www.anthem.com/ca**. The list of advanced imaging procedures is subject to change as medical technologies evolve.

SECOND OPINIONS

If you have a question about your condition or about a plan of treatment which your Physician has recommended, you may receive a second medical opinion from another Physician. This second opinion visit would be provided according to the benefits, limitations and exclusions of this Combined Evidence of Coverage and Disclosure Form. If you wish to receive a second medical opinion, remember that greater benefits are provided when you choose a Participating Provider. You may also ask your Physician to refer you to a Participating Provider to receive a second opinion.

PREVENTIVE CARE

No Deductible is required for preventive care services (including Office Visits) received from Participating Providers; however, preventive care services (including Office Visits) received from Non-Participating Providers are subject to the Deductible.

Preventive care services are designed to detect and prevent medical conditions in advance and help you and your family stay well. Preventive care services are developed from national guidelines recommended by such agencies as the United States Preventive Services Task Force, the American Cancer Society, the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians.

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. Examples of these services are screenings for:
   - Breast cancer;
   - Cervical cancer;

- Colorectal cancer;
- High Blood Pressure;
- Type 2 Diabetes Mellitus;
- Cholesterol;
- Child and Adult Obesity.

2. Immunizations for children, adolescents, and adults 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 screenings for women provided for in the guidelines supported by the Health Resources and Services Administration.

You may call customer service at (800) 627-8797 for additional information about these services, or view the federal government's web sites, at:

- http://www.healthcare.gov/center/regulations/prevention.html;
- http://www.ahrq.gov/clinic/uspstfix.htm; or
- http://www.cdc.gov/vaccines/recs/acip/.

Recommended age, sex and/or frequency guidelines may apply in determining coverage. Please consult with your Physician for specific health guidelines.

Please note that the recommended frequency or nature of preventive care services may change over time due to new medical technology and developments.

Examples of preventive care Covered Services are provided below.

Well Baby and Well Child Preventive Care (Members through age 6)
- Office Visits.
- Routine physical exam including medically appropriate laboratory tests, procedures and radiology services in connection with the exam.
- Screenings including blood lead levels for children at risk for lead poisoning; vision (eye chart only); and hearing screening in connection with the routine physical exam.
- Immunizations including those recommended by the American Academy of Pediatrics and the Advisory Committee on Immunization Practices.

Well Child Preventive Care (Members ages 7 through 18)
- Hepatitis B and varicella zoster (chicken pox) injectable vaccines and other age appropriate injectable vaccinations as recommended by the American Academy of Pediatrics and the Office Visit associated with administering the injectable vaccination when ordered by your Physician.
- Screenings including blood lead levels for children at risk for lead poisoning; vision (eye chart only); human papillomavirus (HPV) test for cervical cancer; and hearing screening in connection with the routine physical exam.

Note: These services are provided at your Physician's office and not at HealthyCheck centers.

Adult Preventive Care
FDA-approved cancer screenings including an annual pap examination, breast exams, mammography testing, appropriate screening for breast cancer, ovarian, colorectal and cervical cancer screening tests, including the human papillomavirus (HPV) test for cervical cancer, prostate cancer screenings including digital rectal exam and prostate specific antigen (PSA) test, and the Office Visit related to these services. These services are provided at your Physician's office and not at HealthyCheck centers.

Physical Exam (for Members ages 7 to adult)
- Routine physical exams.
- Medically appropriate laboratory tests and procedures and radiology procedures in connection with the routine physical exam.
- Cholesterol, osteoporosis (periodic bone density screening for menopausal or post-menopausal women), vision (eye chart only), and hearing screenings in connection with the routine physical exam.
- Immunizations including those recommended by the Advisory Committee on Immunization Practices for Members age 19 and above.
- Preventive counseling and risk factor reduction intervention services in connection with tobacco use and tobacco use-related diseases.
- Limited to either the physical exam benefit per calendar Year ***or*** one (1) HealthyCheck center visit per calendar Year.

HealthyCheck Centers (for Members ages 7 to adult)
Anthem Blue Cross will offer clinically effective preventive care services at designated HealthyCheck centers on an annual basis. HealthyCheck centers are located in state licensed medical facilities. Call toll free (800) 274-WELL (9355) to make an appointment.

Preventive care services may be obtained at your Physician's office and at a HealthyCheck Center. Limited to either the physical exam benefit per calendar Year ***or*** one (1) HealthyCheck center visit per calendar Year.

PREGNANCY AND MATERNITY CARE (Please call toll free (800) 769-4896 within the first twelve (12) weeks of your pregnancy to notify us of your estimated date of delivery, your Physician's name, and the name of the Hospital you have chosen for delivery of your Child.)
- Doctor visits for prenatal and postnatal care and genetic testing.
- Routine nursery care for a newborn.
- Hospital services in connection with a pregnancy and inpatient Physician services for normal delivery, cesarean section and complications of pregnancy.
- Participation in the Expanded Alpha Feto Protein Program, a statewide prenatal testing program administered by California's State Department of Health Services.
- All other Covered Services or supplies.

Note: The mother and her newborn shall be entitled to inpatient Hospital coverage for a period of no less than 48 hours following a normal delivery and no less than 96 hours following a delivery by cesarean section. The decision to discharge the mother and newborn before the 48 or 96 hour time period can be made only by the treating Physician in consultation with the mother. If the mother is discharged early, then the mother and newborn will be covered for a postdischarge follow-up visit within 48 hours of the discharge when prescribed by the treating Physician.

INFERTILITY SERVICES

- Examinations.
- Diagnostic testing and work-ups.
- Medications administered in a Physician's office. If such medications are classified as Specialty Drugs, they may be subject to the terms outlined under the section in this Part entitled "Specialty Pharmacy Program."
- Reconstructive Surgery **except** for sterilization reversal.
- Artificial insemination.
- Supplies and appliances.
- In vitro fertilization.
- Gamete Intra Fallopian Transfer (GIFT).
- Zygote Intra Fallopian Transfer (ZIFT).

Note: For additional benefits for Drugs prescribed for the treatment of Infertility, see the Part entitled "YOUR PRESCRIPTION DRUG BENEFITS."

MENTAL OR NERVOUS DISORDERS AND SUBSTANCE ABUSE, INCLUDING TREATMENT FOR SEVERE MENTAL ILLNESS AND SERIOUS EMOTIONAL DISTURBANCES OF A CHILD (Preservice Review is required for Facility Based Treatment. Preservice Review is also required for outpatient professional services after the twelfth (12th) visit.)

Mental or Nervous Disorders and Substance Abuse: Covered Services must be for the treatment of Substance Abuse (such as drug or alcohol dependence) or a Mental or Nervous Disorder which can be improved by standard medical practice. Covered Services do not include programs to stop smoking, or to help with nicotine or tobacco abuse.

Severe Mental Illness and Serious Emotional Disturbances of a Child: Benefits for Covered Services and supplies provided for the treatment of specific Severe Mental Illness and Serious Emotional Disturbances of a Child are provided on the same basis, at the same Copayments, as any other medical condition.

These services are subject to all terms, conditions, limitations and exclusions of this Combined Evidence of Coverage and Disclosure Form.

Note: Severe Mental Illness, Serious Emotional Disturbances of a Child and any condition meeting the definition of "Mental or Nervous Disorders and Substance Abuse" is a Mental or Nervous Disorder no matter what the cause (please see the Part entitled "DEFINITIONS").

INFUSION THERAPY (requires Preservice Review)

A **Course of Therapy** is defined as Physician prescribed Infusion Therapy for a period of ninety (90) days or less.

Covered Services include:

- Drugs and other substances used in Infusion Therapy. If such medications are classified as Specialty Drugs, they may be subject to the terms outlined under the section in this Part entitled "Specialty Pharmacy Program."

- Professional services to order, prepare, dispense, deliver, administer, train or monitor (including clinical Pharmacy support) any Drugs or other substances used in a Course of Therapy.
- All necessary durable, reusable supplies and durable medical equipment including but not limited to: pump, pole, and electric monitor.
- Blood transfusions, including blood processing and the cost of unreplaced blood and blood products.
- Pharmacy compounding and dispensing services (including Pharmacy support) for intravenous solutions and medications when received from a Participating Provider.

Note: If services are performed in the home, those services must be billed by and performed by a provider licensed by state and local laws.

Infusion Therapy benefits will not be provided for:

- Compounding fees, such as charges for mixing or diluting Drugs, medicines or solutions, or incidental supplies, including disposable items such as cotton swabs, tubing, syringes and needles for Drugs, bandages, and intravenous starter kits when billed by a Non-Participating Provider. No separate benefit is provided for these services and supplies when billed by a Non-Participating Provider. When furnished by a Participating Provider, these services and supplies are covered, but the cost is included in the charges for the Drugs and durable medical equipment used.
- Drugs and medicines not requiring a Prescription.
- Drugs labeled "Caution, limited by federal law to Investigational use" or drugs prescribed for Experimental use, except as specifically stated under the section in this Part entitled "Cancer Clinical Trials."
- Drugs or other substances obtained outside the United States, unless related to a Medical Emergency.
- Non-Food and Drug Administration (FDA) approved homeopathic medications or other herbal medications.
- Charges by a Non-Participating Provider exceeding the Average Wholesale Price (AWP) of a Drug as determined by the manufacturer. The Average Wholesale Price includes the preparation of the finished product. The Average Wholesale Price is the average of the list prices that the manufacturers producing the Drug suggest that a wholesaler charge a Pharmacy for the Drug. The Member will be responsible for any charges in excess of the Average Wholesale Price of a Drug for Non-Participating Providers.

Note: Medical Supplies or Equipment used in Infusion Therapy **will not** be reimbursed under any other benefit of this Combined Evidence of Coverage and Disclosure Form.

SKILLED NURSING FACILITIES (requires Preservice Review)

The following services provided by a Skilled Nursing Facility, except private room charges over the prevailing two-bed room rate of the Skilled Nursing Facility, are limited to 100 days per Year. You must be under the active supervision of a Physician treating your illness or injury.

- A room with two or more beds.
- Special treatment rooms.
- Laboratory tests.
- Physical therapy, occupational therapy, and speech therapy. Oxygen and other respiratory therapy.
- Drugs and medicines given to you during your stay.

HOME HEALTH CARE (requires Preservice Review)

A Physician must order the Home Health Care and renew the order at least once every thirty (30) days. Providers in California must be a California licensed Home Health Agency or Visiting Nurse Association.

A visit is defined as four (4) hours or less of service provided by one of the following providers:

- A registered nurse or licensed vocational nurse;
- A licensed therapist for physical, occupational, speech or respiratory therapy;
- A medical social service worker;
- Services of a health aide employed by (or under arrangement with) a Home Health Agency or Visiting Nurse Association. A health aide is covered only if you are also receiving the services of a registered nurse, licensed vocational nurse or licensed therapist employed by the same organization, and the registered nurse, licensed vocational nurse or licensed therapist is supervising the services.
- Private duty nursing.

Medically Necessary Medical Supplies and Equipment provided by the Home Health Agency or Visiting Nurse Association are covered.

We will not cover Personal Comfort Items.

All Home Health Care services and supplies related to Infusion Therapy are included in the Infusion Therapy benefit and are not covered under this Home Health Care benefit.

HOSPICE CARE

We provide, for the terminally ill, Hospice care benefits that emphasize supportive services such as home care and pain control.

Members who have a terminal illness have the option of electing Hospice benefits, which include professional services of an attending Physician. An attending Physician is a Physician who is identified by the Member, at the time he or she elects Hospice coverage, as having the most significant role in the determination and delivery of their medical care. If the Member elects to receive Hospice care, he or she must file an election statement with the Hospice. The Member may revoke the election at any time. Election and revocation statements are available through the Hospice.

Hospice care is available for two 90-day periods, followed by an unlimited number of subsequent 60-day periods. Benefits will be considered only after the Member's attending Physician and the medical director of the Hospice each certifies in writing at the beginning of each period that the Member is terminally ill. We have the right to review any and all medical records or attending Physician's notes to verify that such certification is appropriate.

Covered Services include:

1. Interdisciplinary team care with the development and maintenance of an appropriate plan of care. An interdisciplinary team is a Hospice care team provided by the Hospice program providing care that includes the patient, the patient's family, a Physician (including surgeons), a registered nurse, and a social worker, and may include a volunteer and a spiritual care giver. A plan of care is a written plan that addresses the patient's needs and the needs of the family admitted to the Hospice program.

2. Short-term inpatient care arrangements.
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 your death. Bereavement services are available to surviving members of the immediate family for a period of one year after your death. Immediate family members are Spouses, Domestic Partners, children, stepchildren, parents, stepparents, siblings, stepsiblings, and legal guardians.
10. Palliative care (care which controls pain and relieves symptoms, but does not cure) which is appropriate for the illness.
11. Medical direction, with the medical director being also responsible for meeting the general medical needs of the Member to the extent that these needs are not met by the attending Physician.
12. Private duty nursing.

A period of crisis is a period in which a patient requires continuous care to achieve palliation or management of acute medical symptoms. During a period of crisis, we will:

- Make nursing care available on a continuous basis for as much as twenty-four (24) hours a day during periods of crisis as necessary to maintain the patient at home.
- Cover short-term inpatient care arrangements when the interdisciplinary team decides inpatient skilled nursing care is required that cannot be provided at home.
- Cover homemaker or home health aide services or both on a 24-hour continuous basis during periods of crisis, but the care provided during these periods must be predominantly nursing care.

We also will make respite care available. This means short-term inpatient care provided only when necessary to relieve the family members or other persons caring for the patient. We will make respite care available only on an occasional basis and for no more than five (5) consecutive days at a time.

Note: For services of a Non-Participating Hospice, unless Special Circumstances apply, the maximum Anthem Blue Cross allowed Covered Expense for Hospice benefits will be the applicable Hospice payment rate specified by Centers for Medicare and Medicaid Services (CMS – formerly HCFA) for the Medicare program. You may wish to consult the CMS web site **(http://cms.hhs.gov** or **http://cms.hhs.gov/manuals/pm_trans/2002/memos/comm_date_dsc.asp)** for information about Hospice payment rates under the Medicare program.

Note: Your Physician must consent to your care provided by the Hospice and must be consulted in the development of your treatment plan. The Hospice must submit a written treatment plan to us every thirty (30) days.

MEDICAL SUPPLIES AND EQUIPMENT (requires Preservice Review)

Rental up to purchase price or purchase of long-lasting medical equipment and supplies when Medically Necessary and ordered by your Physician. The equipment or supply must be for medical use to treat a health problem, and only for the use of the person for whom it was prescribed. Rental charges that exceed the reasonable purchase price of the equipment are not covered.

Covered under this benefit are inhaler spacers, nebulizers (including face masks and tubing), and peak flow meters when Medically Necessary for the management and treatment of asthma, including education to enable the Member to properly use the device(s).

Note: Coverage does not include benefits for: orthopedic shoes or shoe inserts, footwear (except as specifically stated), arch supports, disposable sheaths and supplies, correction appliances or support appliances and supplies such as stockings or personal comfort items as indicated in the Part entitled "WHAT IS NOT COVERED."

DENTAL

- Up to three (3) days of inpatient Hospital services when a Hospital stay is Medically Necessary due to an unrelated medical condition.
- Services of a Physician or dentist treating an accidental injury to your natural teeth when you receive treatment within one (1) year following the injury or within one (1) year following your Effective Date, whichever is later. Medical Emergency services to your natural teeth as a result of an accidental injury that occurs following your Effective Date. Treatment excludes orthodontia. Damage to your teeth due to chewing or biting is not an accidental injury.
- General anesthesia and associated facility charges for dental procedures in a Hospital or surgery center for enrolled Members if:
  - Under seven (7) years of age; or
  - Developmentally disabled regardless of age; or
  - The Member's health is compromised and general anesthesia is Medically Necessary, regardless of age.
- Medically Necessary dental or orthodontic services that are an integral part of Reconstructive Surgery for cleft palate procedures. Cleft palate is 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 Combined Evidence of Coverage and Disclosure Form, a Participating Provider who is a dentist may charge you his or her usual and customary rate for those services. Prior to providing you with dental services that are not a Covered Service, 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 Combined Evidence of Coverage and Disclosure Form, please call us at the customer service telephone number listed on your ID card. To fully understand your coverage under this plan, please carefully review this Combined Evidence of Coverage and Disclosure Form.

SMOKING CESSATION

Benefits for Covered Services will be provided at no Copayment for smoking cessation programs designed to end the dependence on nicotine. Smoking cessation drugs that may be purchased over the counter without a Prescription are not covered. We cover Medically Necessary Drugs for nicotine dependency that require a Prescription. See the Part entitled "YOUR PRESCRIPTION DRUG BENEFITS."

TREATMENT FOR DIABETES

Benefits for Covered Services and supplies for the treatment of diabetes are provided on the same basis, at the same Copayments, as any other medical condition. Benefits will be provided for Covered Expense for:

1. The following Diabetes Equipment and Supplies:

    a. Blood glucose monitors, including monitors designed to assist the visually impaired, and blood glucose testing strips.
    b. Insulin pumps and related necessary supplies.
    c. Pen delivery systems for Insulin administration.
    d. Podiatric devices, such as therapeutic shoes and shoe inserts, to prevent and treat diabetes-related complications. These devices are covered under your plan's benefits for Special Footwear and Orthotics (please see the section in this Part entitled "Professional Services and Supplies").
    e. Visual aids (but not eyeglasses) to help the visually impaired to properly dose Insulin.

    Except for podiatric devices, these equipment and supplies are covered under your plan's benefits for medical equipment (please see the section entitled "Medical Supplies and Equipment*"* under the Parts entitled "PARTICIPATING PROVIDER COMPREHENSIVE BENEFITS AND COPAYMENT LIST," "NON-PARTICIPATING PROVIDER COMPREHENSIVE BENEFITS AND COPAYMENT LIST," and "WHAT IS COVERED").

2. The Diabetes Outpatient Self-Management Training 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 the plan benefits for professional services by Physicians.

3. The following items are covered under your Prescription Drug benefits:

    a. Insulin, glucagon, and other Prescription Drugs for the treatment of diabetes.
    b. Insulin syringes.
    c. Urine testing strips, lancets and lancet puncture devices.

    These items must be obtained either from a retail Pharmacy or through the mail service prescription drug program. See the Part entitled "YOUR PRESCRIPTION DRUG BENEFITS."

PHENYLKETONURIA (PKU)

Benefits for the testing and treatment of phenylketonuria (PKU) are paid on the same basis as any other medical condition. Coverage for treatment of PKU shall include those formulas and special food products that are part of a diet prescribed by a licensed Physician and managed by a health care professional in consultation with a Physician who specializes in the treatment of metabolic disease and who participates in or is authorized by the plan. The diet must be deemed Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

The cost of the necessary formulas and special food products is covered only as it exceeds the cost of a normal diet. "Formula" means an enteral product or products for use at home. The formula must be prescribed by a Physician or nurse practitioner, or ordered by a registered dietician upon referral by a health care provider authorized to prescribe dietary treatments, and is Medically Necessary for the treatment of PKU. Formulas and special food products used in the treatment of PKU that are obtained from a Pharmacy are covered under your plan's Prescription Drug benefits. Refer to the Part entitled "YOUR PRESCRIPTION DRUG BENEFITS." Formulas and special food products that are not obtained from a Pharmacy are covered under this Part.

"Special food product" means a food product that is all of the following:

1. Prescribed by a Physician or nurse practitioner for the treatment of PKU, and
2. Consistent with the recommendations and best practices of qualified health professionals with expertise in the treatment and care of PKU, and
3. Used in place of normal food products, such as grocery store foods, used by the general population.

Note: It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving.

CENTERS OF MEDICAL EXCELLENCE (CME) FOR TRANSPLANTS AND BARIATRIC SURGERY

Anthem Blue Cross has established a network of Hospital facilities (called Centers of Medical Excellence or CME) to provide services for specified organ transplants (heart, liver, lung, heart/lung, pancreas, kidney, simultaneous pancreas/kidney, bone marrow harvest and transplant, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures) and bariatric surgical procedures.

Note: A Participating Provider in the Prudent Buyer Plan Network is not necessarily a CME facility. Information on CME facilities can be obtained by calling (800) 627-8797.

Bariatric Surgery (requires Preservice Review): Services and supplies will be provided in connection with Medically Necessary surgery for weight loss, only for morbid obesity and only when performed at a CME facility. You or your Physician must obtain Preservice Review for all bariatric surgical procedures. **Preservice Review can be obtained by calling toll free (800) 274-7767.**

Note: Charges for bariatric procedures and related services are covered only when the bariatric procedure and related services are performed at a CME facility. Preservice Review is required.

Members residing outside California are not required to use the CME network; however, Preservice Review is still required. Please also see "Bariatric Travel Expense" below.

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 Blue Cross in advance. Members who reside outside California are not required to use the CME network for bariatric surgical procedures and related services. However, these Members are eligible for the travel expense benefit if

they receive care at a bariatric CME facility that is fifty (50) miles or more from their residence. Our maximum payment will not exceed **$3,000** per surgery 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. Meals, tobacco, alcohol and drug expenses are excluded from coverage.

Customer service will confirm if the bariatric travel benefit is provided in connection with access to the selected bariatric CME. Details regarding reimbursement can be obtained by calling customer service toll free at (800) 627-8797. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

Organ and Tissue Transplants (requires Preservice Review): You or your Physician must obtain Preservice Review for all services related to specified organ transplants (heart, liver, lung, heart/lung, pancreas, kidney, simultaneous pancreas/kidney, bone marrow harvest and transplant, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures). **Preservice Review can be obtained by calling toll free (888) 613-1130.**

Note: Charges for these specified transplants and related services are covered only when Medically Necessary and only when the transplant and related services are performed at a CME. Preservice Review is required.

The following **services** are provided to you in connection with a covered organ or tissue transplant, if you are:

- The organ or tissue recipient, and the donor is also an enrolled Member.
- The organ or tissue donor, and the recipient is also an enrolled Member.
- The organ or tissue recipient, and the organ or tissue donor is not an enrolled Member. The donor is also eligible for services as described. Benefits are reduced by any amounts paid or payable by that donor's own coverage.
- The organ or tissue donor, and the organ or tissue recipient is not an enrolled Member. You are eligible for services as described. Benefits are reduced by any amounts paid or payable by the recipient's own coverage.
- An enrolled Member who needs to store cord blood and the storage is considered Medically Necessary according to the Anthem Blue Cross criteria for cord blood storage at an Anthem Blue Cross designated facility.

Organ and Tissue Transplant Donor Expense
Covered Expense for a donor, including donor testing and donor search, is limited to expense incurred for Medically Necessary Covered Services only. Benefits for Covered Services incident to obtaining the transplanted organs or tissue from a living donor or human organ transplant bank will be covered except as limited by this plan. Such benefits, including complications from the donor procedure for up to six weeks from the date of procurement, are covered.

We cover cell donor search performed at a nationally accredited bone marrow/stem cell organization only for an approved bone marrow or stem cell transplant, up to a maximum **$30,000** Anthem Blue Cross payment per transplant. Any Covered Expense incurred for these donor searches will not be applied to the annual maximum payment limits.

Organ and Tissue Transplant Travel Expense
Certain travel expenses incurred by the Member, up to a maximum **$10,000** Anthem Blue Cross payment per transplant, will be covered for the recipient or donor in connection with a covered organ or tissue transplant when performed at a CME that is qualified to provide services. All travel expenses are limited to the maximum set forth in the Internal Revenue Code at the time services are rendered and must be approved by Anthem Blue Cross in advance.

- Travel expenses include the following for the recipient (and one companion) or the donor:
  - Ground transportation to and from the CME facility when the CME is seventy-five (75) miles or more from the recipient's or donor's home. Air transportation by coach is available when the distance is three hundred (300) miles or more.
  - Lodging.

Note: When the recipient is under the age of eighteen (18), this benefit will apply to the recipient and two companions/caregivers.

When you request reimbursement of covered travel expenses, you must submit a completed travel reimbursement form and itemized, legible copies of all applicable receipts. Credit card slips are not acceptable. Covered travel expenses are not subject to the Deductible or Copayments. Please call customer service at (800) 627-8797 for further information and/or to obtain the travel reimbursement form.

Travel expenses that are not covered include, but are not limited to: meals, alcohol, tobacco, or any other non-food item; child care; mileage within the city where the CME is located, rental cars, buses, taxis or shuttle services, except as specifically approved by us; frequent flyer miles, coupons, vouchers or travel tickets; prepayments or deposits; services for a condition that is not directly related to, or a direct result of, the transplant; telephone calls; laundry; postage; entertainment; travel expenses for a donor companion/caregiver; or return visits for the donor for treatment of a condition found during the evaluation.

Each year thousands of people's lives are saved by organ transplants. The success rate of transplants is rising, but more donations are needed. This is a unique opportunity to give the Gift of Life. Anyone who is eighteen (18) years of age or older and of sound mind may become a donor when he or she dies. Minors may become donors with a parent or guardian's consent. Organ and tissue donation may be used for transplants and research. Today, it is possible to transplant about 25 different organs and tissues.

Your decision to become a donor could someday save or prolong the life of someone you know, even a close friend or family member. If you decide to become a donor, talk it over with your family. Let your Physician know your intentions as well. Obtain 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.

SPECIALTY PHARMACY PROGRAM (requires Preservice Review)
Specialty Drugs are high-cost, injectable, infused, oral or inhaled Drugs that generally require close supervision and monitoring of their effect on the patient by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail Pharmacies.

You can only have your Prescription for a Specialty Drug filled through the specialty pharmacy program, unless you qualify for an exception (please see the "Exceptions to the specialty pharmacy program" paragraph below). The specialty pharmacy fills only Specialty Drug Prescriptions. Specialty medication(s) are limited to a 30-day supply per order or the treatment needed during the Office Visit, whichever is less. The specialty pharmacy will deliver your Specialty Drug to you by mail or common carrier for self administration in your home or to your Physician's office. You cannot pick up your medication from them.

If your Physician orders the Specialty Drug to be administered in his/her office, only the medication needed for the visit will be delivered. Your Physician will be responsible for ordering the Specialty Drug for administration in his/her office.

Non-duplication of benefits applies to Specialty Drugs under this plan. This means when benefits are provided for Specialty Drugs under the plan's medical benefits, they will not be provided under the Part entitled "YOUR PRESCRIPTION DRUG BENEFITS." Conversely, if benefits are provided for Specialty Drugs under "YOUR PRESCRIPTION DRUG BENEFITS," they will not be provided under the plan's medical benefits.

To obtain a Specialty Drug for home use, you must have a Prescription for the Drug that states the Drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address, and be signed by a Physician.

You or your Physician may order your Specialty Drug from the specialty pharmacy program by calling (800) 274-7767. The first time you use the specialty pharmacy program, you will be asked to set up your account by completing an Intake Referral Form, which can be completed over the telephone. When you or your Physician calls the Specialty Pharmacy, a customer service representative will guide you or your Physician through the process, from placing your order to delivering your Specialty Drug to you or your Physician. You will be responsible to pay any applicable Deductible, Copayment or coinsurance. Once you have met your medical Deductible, you will only have to pay the cost of your Copayment or coinsurance, if any. If your Physician orders the Specialty Drug for administration in the office, you will also be responsible for any applicable Copayments or coinsurance. At the time of ordering and prior to shipping, the specialty pharmacy may require you to pay your applicable Deductible, Copayment or coinsurance, by credit card, debit card or other forms of payment.

You or your Physician may obtain a list of Specialty Drugs available through the specialty pharmacy program or order forms by contacting customer service at the address or telephone number shown below or by accessing our web site at **www.anthem.com/ca**.

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

Phone: (800) 274-7767
Fax: (866) 815-0839

Prior Authorization. Certain Specialty Drugs require written prior authorization in order for you to obtain benefits. Prior authorization criteria will be based on medical policies and clinical guidelines as established by our review committees. You may need to try a Drug other than the one originally prescribed if we determine that it should be clinically effective for you. However, if we determine through the prior authorization process that the Drug originally prescribed is Medically Necessary, you will be provided benefit coverage of that Drug through the specialty pharmacy program. If approved, Specialty Drugs requiring prior authorization will be provided to you after you make the required Copayment. (If, when you first become a Member, you are already being treated for a medical condition with a Drug that has been appropriately prescribed and is considered safe and effective for your medical condition and you underwent a prior authorization process under a prior plan which required you to take different Drugs, we will not require you to try a Drug other than the one you are currently taking.)

Your Physician must request prior authorization from us in order for you to obtain a Specialty Drug that requires prior authorization. The request may be made either by telephone or fax. At the time the request is initiated, specific clinical information will be requested from your Physician based on our medical policy or clinical guidelines and your specific diagnosis.

If the request is for urgently needed Drugs, after we get the request from your Physician:

- We will review it and decide if we will approve benefits within 72 hours, or if shorter, the time required by federal law. (As soon as we can, based on your medical condition, as Medically Necessary, we may take less than 72 hours to decide if we will approve benefits.) We will tell you and your Physician what we have decided by telephone, and in writing – by fax to your Physician and in writing by mail to you.

- If more clinical information is needed to make a decision, or we cannot make a decision for any reason, we will tell your Physician, within 24 hours after we get the request, what information is missing and why we cannot make a decision. If, for reasons beyond our control, we cannot tell your Physician what information is missing within 24 hours, we will tell your Physician that there is a problem as soon as we know that we cannot respond within 24 hours. In either event, we will tell you and your Physician that there is a problem in writing by fax, and when appropriate, by telephone to your Physician and in writing by mail to you.

- As soon as we can, based on your medical condition, as Medically Necessary, but not more than 48 hours after we have all the information we need to decide if we will approve benefits, we will tell you and your Physician what we have decided in writing – by fax to your Physician and by mail to you.

If the request is not for urgently needed Drugs, after we get the request from your Physician:

- Based on your medical condition, as Medically Necessary, we will review it and decide if we will approve benefits within 5-business days. We will tell you and your Physician what we have decided in writing – by fax to your Physician and by mail to you.

- If more clinical information is needed to make a decision, we will tell your Physician in writing within five (5) business days after we get the request-what information is missing and why we cannot make a decision. If, for reasons beyond our control, we cannot tell your Physician what information is missing within five (5) business days, we will tell your Physician that there is a

problem as soon as we know that we cannot respond within 5-business days. In any event, we will tell you and your Physician that there is a problem by telephone, and in writing – by fax to your Physician and by mail to you.

- As soon as we can, based on your medical condition, as Medically Necessary, within five (5) business days after we have all the information we need to decide if we will approve benefits, we will tell you and your Physician what we have decided in writing – by fax to your Physician and by mail to you.

While we are reviewing the request for a Specialty Drug, and the Drug is urgently needed, a 72-hour emergency supply of the medication or the smallest packaged quantity, whichever is greater, may be dispensed to you if your Physician determines that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment or coinsurance, if any.

If you have any questions regarding whether a Specialty Drug requires prior authorization, please call (800) 274-7767 or visit our website at **www.anthem.com/ca**.

If prior authorization of a Specialty Drug is not approved, you or your prescribing Physician may appeal our decision by calling us at (800) 627-8797. If you are not satisfied with the resolution based on your inquiry, you may file a grievance with us by following the procedures described in the Part entitled "GRIEVANCE PROCEDURES."

Exceptions to the specialty pharmacy program. This program does not apply to:

1. The first two months' supply of a Specialty Drug which is available through a Participating Pharmacy or home Infusion Therapy provider;
2. Drugs, which, due to medical necessity, are needed urgently and must be administered to the Member immediately.

How to obtain an exception to the specialty pharmacy program. If you believe that you should not be required to get your specialty medication through the specialty pharmacy program, for any of the reasons listed above, or others, you or your Physician must complete an "Exception to the Specialty Pharmacy Program" form to request an exception and send it to us. The form can be faxed or mailed to us. If you need a copy of the form, you may call us at (800) 627-8797 to request one. You can also get the form online at **www.anthem.com/ca**. If we give you an exception, it will be in writing for the approved amount of time as medically appropriate, not to exceed six (6) months. If you believe that you should still not be required to get your medication through the specialty pharmacy program when your prior exception approval expires, you must again request an exception. If we deny your request for an exception, it will be in writing and will tell you why we did not approve the exception.

Urgent or emergency need of a Specialty Drug subject to the specialty pharmacy program. If you are out of a Specialty Drug which must be obtained through the specialty pharmacy program, we will authorize an override of the specialty pharmacy program requirement for 72 hours, or until the next business day following a holiday or weekend, to allow you to get a 72-hour emergency supply of medication, or the smallest packaged quantity, whichever is greater, if your doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment or coinsurance, if any.

If you order your Specialty Drug through the specialty pharmacy program and it does not arrive, if your Physician decides that it is Medically Necessary for you to have the Drug immediately, we will authorize an override of the specialty pharmacy program requirement for a 30-day supply or less, to allow you to get an emergency supply of medication from a Participating Pharmacy or home Infusion Therapy provider near you. A customer service representative from the specialty pharmacy program will coordinate the exception and you will not be required to pay an additional Copayment.

Unless you qualify for an exception, if you don't get your Specialty Drug through the specialty pharmacy program, you will not receive any covered benefits for Specialty Drugs under this plan.

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

- Your coverage under this plan ends;
- The Agreement with the Group terminates;
- You reach a benefit maximum that applies to Specialty Drugs, if the plan includes such a maximum;

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

MASTECTOMY AND RELATED PROCEDURES

Benefits as described in this Combined Evidence of Coverage and Disclosure Form are payable for Hospital and professional services related to mastectomy, including the following services in connection with breast reconstruction and post-mastectomy care:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction on the other breast to produce a symmetrical appearance;
- Prosthesis; and
- Treatment for physical complications of all stages of mastectomy, including lymphedemas.

Coverage for reconstructive breast surgery may not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the coverage definition of "Medically Necessary."

Benefits are paid on the same basis as any other medical condition.

CANCER CLINICAL TRIALS

If a Member is diagnosed with cancer and accepted into a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer, Anthem Blue Cross will cover all routine patient care costs related to the clinical trial on the same basis as any other medical condition if the Member's treating Physician who is providing the health care services to the Member under this Combined Evidence of Coverage and Disclosure Form recommends participation in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the Member. The clinical trial must have a therapeutic intent and not just be to test toxicity. Benefits are paid on the same basis as any other medical condition and are subject to any applicable Copayments, coinsurance, and Deductibles.

Coverage for clinical trials is restricted to Participating Providers in California, unless the protocol for the clinical trial is not provided for at a California Hospital or by a California Physician. In the case of Covered Services for a clinical trial provided by a Non-Participating Provider, Anthem Blue Cross will pay based on the Maximum Allowed Amount subject to any applicable Copayments, coinsurance, and Deductibles. However, the Member will be responsible for charges in excess of the Maximum Allowed Amount.

The treatment provided in a clinical trial must either:

1. Involve a drug that is exempt under federal regulations from a new drug application, or
2. Be approved by one of the following:
   - One of the National Institutes of Health,
   - The federal Food and Drug Administration (FDA), in the form of an Investigational new drug application,
   - The United States Department of Defense, or
   - The United States Veterans Administration.

Covered Services include costs associated with the provision of health care services, including Drugs, items, devices and services which would otherwise be covered under this plan, including:

- Health care services typically provided absent a clinical trial.
- Health care services required solely for the provision of the Investigational drug, item, device or service.
- Health care services required for the clinically appropriate monitoring of the Investigational item or service.
- Health care services provided for the prevention of complications arising from the provision of the Investigational drug, item, device or service.
- Health care services needed for the reasonable and necessary care arising from the provision of the Investigational drug, item, device or service, including the diagnosis or treatment of the complications.

Covered Services will <u>not</u> include the following:

- Drugs or devices that have not been approved by the federal Food and Drug Administration (FDA) and that are associated with the clinical trial.
- Services other than health care services, such as travel, housing, companion expenses, and other non-clinical expenses, that a Member may require as a result of the treatment being provided for purposes of the clinical trial.
- Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.
- Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under the Agreement.
- Health care services customarily provided by the research sponsors free of charge to Members enrolled in the trial.

Note: You will be financially responsible for the costs associated with non-Covered Services.

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

PART VI WHAT IS NOT COVERED

We will not furnish benefits for:

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

Cosmetic Surgery: Cosmetic Surgery or other services that are performed to alter or reshape normal structures of the body in order to improve appearance.

Custodial Care: Custodial Care is care that does not require the services of trained medical or health professionals, such as, but not limited to: help in walking, getting in and out of bed, bathing or dressing; preparation of meals or special diets; feeding by utensil, tube or gastrostomy; suctioning; and supervision of medications which are ordinarily self-administered. Domiciliary or rest cures for which facilities and/or services of a general acute Hospital are not medically required, including residential treatment centers.

Dental Services: Dental treatment regardless of origin or cause, including, but not limited to:

- preventive care and fluoride treatments;
- dental implants;
- dental x-rays;
- dental supplies, appliances, and all associated expenses;
- diagnosis and treatment related to teeth, jawbones or gums;
- dentures, bridges, crowns, caps, clasps, habit appliances, partials, or other dental prostheses;
- extraction, restoration and replacement of teeth;
- services to improve dental clinical outcomes; and
- treatment for injuries that are a result of biting or chewing.

This exclusion does not apply to the following:

- services which we are required by law to cover;
- dental services to prepare the mouth for radiation therapy to treat head and/or neck cancer; and
- services specified as covered in this Combined Evidence of Coverage and Disclosure Form.

Diagnostic Admissions: Inpatient room and board charges in connection with a Hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis unless the inpatient stay is Medically Necessary.

Educational Treatment or Services that are educational, vocational, or training in nature, except as specifically provided or arranged by us.

End of Coverage: Services received after your coverage ends.

Excess Amounts: Any amounts in excess of the maximum amounts stated in the Comprehensive Benefits and Copayment List sections of the Combined Evidence of Coverage and Disclosure Form.

Expenses Before Your Coverage Begins: Services received before your Effective Date.

Experimental or Investigational: Services which are Experimental or Investigational in nature, except as specifically stated under "Cancer Clinical Trials" in the Part entitled "WHAT IS COVERED." If a Member has a life-threatening or seriously debilitating condition and Anthem Blue Cross determines that requested treatment is not a Covered Service because it is Experimental or Investigational, the Member may request an Independent Medical Review. Please see the Part entitled "GRIEVANCE PROCEDURES."

Food and/or Dietary Supplements: Nutritional and/or dietary supplements, except as provided in this Combined Evidence of Coverage and Disclosure Form 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.

Genetic Testing for non-medical reasons or when there is no medical indication or no family history of genetic abnormality.

Government Services: Any services you actually received that were provided by a local, state or federal government agency, or by a public school system or school district, except when payment under this Combined Evidence of Coverage and Disclosure Form is expressly required by federal or state law. We will not cover payment for these services that you have actually received if you are not required to pay for them or they are given to you for free. Veterans Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.

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.

Hearing Aids. Routine Hearing Tests except where provided for under the section entitled "Preventive Care" in the Part entitled "WHAT IS COVERED."

Immunizations solely for travel outside the United States.

Infertility Services: Sterilization reversal, costs associated with the storage of sperm, eggs, embryos and ovarian tissue, and any other services for Infertility except as specifically listed under the Part entitled "WHAT IS COVERED," "Infertility Services." Any amount in excess of our lifetime maximum payment for Infertility services.

Medical Supplies and Equipment: Medical supplies and equipment except as specifically stated under the benefit sections of this Combined Evidence of Coverage and Disclosure Form.

Mental or Nervous Disorders and Substance Abuse: Treatment of Mental or Nervous Disorders and Substance Abuse (including nicotine use) or psychological testing except as specifically stated under the benefit sections of this Combined Evidence of Coverage and Disclosure Form. **However, medical services provided to treat medical conditions that are caused by behavior of the Member that may be associated with mental or nervous conditions (for example, self-inflicted injuries) and treatment for Severe Mental Illness and Serious Emotional Disturbances of a Child are not subject to this limitation.**

Non-Contracting Hospital: No benefits are provided for care or treatment furnished in a Non-Contracting Hospital, except as indicated in the SPECIAL CIRCUMSTANCES sections under the Part entitled "NON-PARTICIPATING PROVIDER COMPREHENSIVE BENEFITS AND COPAYMENT LIST."

Non-Duplication of Medicare: If Medicare is a Member's primary health plan, we will not provide benefits that duplicate any benefits you would be entitled to receive under Medicare. This exclusion applies to all Parts of Medicare in which you can enroll without paying additional premium. However, if you have to pay an additional premium to enroll in Part A, B, C or D of Medicare this exclusion will apply to that particular Part of Medicare for which you must pay only if you have enrolled in that Part.

If you have Medicare, and Medicare is your primary health plan, your Medicare coverage will not affect the services covered under the Agreement, except as follows:

1. Your Medicare coverage will be applied first (primary) to any services covered by both Medicare and under the Agreement.
2. If you receive a service that is covered both by Medicare and under the Agreement, our coverage will apply only to the Medicare deductibles, coinsurance and other charges for Covered Services that you must pay over and above what is payable by your Medicare coverage.
3. For a particular claim, the combination of Medicare benefits and the benefits we will provide under the Agreement for that claim will not be more than the allowed Covered Expense you have incurred for the Covered Services you received.

We will apply toward your Deductible any expenses paid by Medicare for services covered under the Agreement except for expenses paid under Medicare Part D.

Non-Licensed Providers: Treatment or services provided by a non-licensed health care provider and treatment or services for which a health care provider license is not required. This includes treatment or services provided by a non-licensed provider under the supervision of a licensed Physician, except as specifically provided or arranged by us.

Not Medically Necessary: Any services or supplies that are: a) not Medically Necessary, b) not specifically described in this Combined Evidence of Coverage and Disclosure Form and part of a treatment plan for non-Covered Services, or c) provided as routine follow-up care for non-Covered Services (as recognized by the organized medical community in the state of California) (but we will provide benefits for Medically Necessary Covered Services directly related to non-Covered Services when complications exceed routine follow-up care such as life-threatening complications of Cosmetic Surgery). If Anthem Blue Cross determines that requested treatment is not a Covered Service because it is not Medically Necessary, a Member may request an Independent Medical Review. Refer to the Part entitled "GRIEVANCE PROCEDURES."

Nutritional Counseling.

Online Clinic Visits except as specifically stated under the benefit sections of this Combined Evidence of Coverage and Disclosure Form. This exclusion includes, but is not limited to, communications used for: reporting normal lab or other test results; office appointment requests; billing, insurance coverage or payment questions; requests for referrals to doctors outside the online care panel; obtaining Preservice Review; and Physician-to-Physician consultations.

Oral Contraceptive Drugs. (See the Part entitled "YOUR PRESCRIPTION DRUG BENEFITS.")

Orthodontic Services: Braces, other orthodontic appliances and orthodontic services, except for orthodontic services related to Reconstructive Surgery for cleft palate as specifically stated for dental-related benefits under the benefit sections of this Combined Evidence of Coverage and Disclosure Form.

Outdoor Treatment Programs.

Personal Comfort Items: Items which are furnished primarily for your personal comfort or convenience, including but not limited to, air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, shoes, elevators, hairpieces, diapers and supplies for comfort, hygiene or beautification.

Preexisting Conditions: No payment will be made for services or supplies for the treatment of a Preexisting Condition during a period of six (6) months following the date the Member's coverage under this Combined Evidence of Coverage and Disclosure Form is effective. However, this limitation does not apply to:

- a Member under age nineteen (19),
- a Child acquired through legal guardianship if the Child is added within thirty-one (31) days of final court decree or order,
- a Child born to or newly adopted by an enrolled Subscriber or Spouse, or
- conditions of pregnancy.

A **Preexisting Condition** means an illness, injury, disease or physical condition for which medical advice, diagnosis, care or treatment, including the use of Prescription Drugs, was recommended or received from a licensed health practitioner during the six (6) months immediately preceding the earlier of: the first day of the waiting period (applicable to newly hired employees) or the date the Member's coverage under this Combined Evidence of Coverage and Disclosure Form is effective. **Qualifying Prior Coverage** is any individual or group plan that provides medical, hospital and surgical coverage, including continuation or conversion coverage, or coverage under a publicly sponsored program such as CHAMPUS, Indian Health Service or tribal organization medical coverage, Peace Corps medical coverage, a state health benefits risk pool, Medicare or Medicaid. Qualifying Prior Coverage does not include accident only, credit, disability income, Medicare supplement, long-term care insurance, dental, vision, workers' compensation insurance, automobile insurance, no-fault insurance, or any medical coverage designed to supplement other private or governmental plans.

- We will reduce this six (6) month period, if you were covered under Qualifying Prior Coverage, and within not more than sixty-two (62) days of termination of that coverage you became eligible and applied for coverage under this Combined Evidence of Coverage and Disclosure Form, the time spent under the Qualifying Prior Coverage will be used to satisfy, or partially satisfy, the six (6) month period.

- We will also reduce this six (6) month period if a Member's employment has ended, the availability of health coverage offered through employment or sponsored by an Employer has terminated, or an Employer's contribution toward health coverage has terminated, provided the Subscriber becomes eligible for health coverage offered through employment or sponsored by an Employer within 180 days of termination of the Qualifying Prior Coverage and applies for coverage within thirty (30) days of becoming eligible for coverage under this Combined Evidence of Coverage and Disclosure Form.

- California law permits a Preexisting Condition exclusionary period of not more than six (6) months from the Member's Effective Date of coverage. Under federal law, the Preexisting Condition exclusionary period may not be more than twelve (12) months (or eighteen (18) months in the case of a late enrollee) from the beginning of the period of continuous employment the Employer requires to establish eligibility for coverage (sometimes referred to as the Employer's waiting period). For an Employer's Anthem Blue Cross coverage, the total Preexisting Condition exclusionary period will be the six (6) month period beginning with the Member's Effective Date of coverage.

Note: You have the right to obtain proof of Qualifying Prior Coverage from your prior plan. Please contact customer service at (800) 627-8797 if you have any questions regarding preexisting conditions.

Private Duty Nursing: Private duty nursing except as expressly provided under the sections entitled "Home Health Care" and "Hospice Care."

Replacement of prosthetics and durable medical equipment when lost or stolen.

Routine Physical Exams: Routine physical exams except as outlined under the benefit sections of this Combined Evidence of Coverage and Disclosure Form.

Services from Relatives: Professional services provided in the home by a person who lives in the Member's home or who is related to the Member by blood, marriage or adoption.

Services You Receive for Which You Have No Legal Obligation to Pay: Services you actually receive for which you have no legal obligation to pay or for which no charge would be made if you did not have health plan or insurance coverage, except services received at a non-governmental charitable research Hospital. Such a Hospital must meet the following guidelines: a) it must be internationally known as being devoted mainly to medical research, and b) at least ten percent of its yearly budget must be spent on research not directly related to patient care, and c) at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care, and d) it must accept patients who are unable to pay, and e) two-thirds of its patients must have conditions directly related to the Hospital's research.

Sex Changes: Procedures or treatments to change characteristics of the body to those of the opposite sex. This includes any medical, surgical or psychiatric treatment or study related to sex changes.

Specialty Drugs not obtained through the specialty pharmacy program (for which you will be required to pay the full cost) except as specifically stated under the "Specialty Pharmacy Program" section in the Part entitled "WHAT IS COVERED."

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

Telephone and Facsimile Machine Consultations: Consultations provided by telephone or facsimile machines.

Unlisted Services: Services not specifically listed in this Combined Evidence of Coverage and Disclosure Form as Covered Services.

Vein Treatment: Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.

Vision Care: Optometric services, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams and routine eye refractions, except as specifically stated under the benefit sections of this Combined Evidence of Coverage and Disclosure Form. **Certain Eye Surgeries:** Any eye surgery solely for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia), astigmatism and/or farsightedness (presbyopia).

Weight Reduction: Services primarily for weight reduction or treatment of obesity, or any care which involves weight reduction as a main method of treatment, except Medically Necessary treatment of morbid obesity (which requires Preservice Review), including bariatric surgery as stated under the Part entitled "WHAT IS COVERED," in the CENTERS OF MEDICAL EXCELLENCE (CME) FOR TRANSPLANTS AND BARIATRIC SURGERY section.

Workers' Compensation: Any condition for which benefits are recovered or can be recovered, either by any workers' compensation law or similar law, even if you do not claim those benefits. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to any workers' compensation law or similar law, we will provide the benefits of this plan for such conditions, subject to our right to a lien or other recovery under section 4903 of the California Labor Code, or other applicable law.

PART VII UTILIZATION AND PRESERVICE REVIEW

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

IMPORTANT: Utilization and Preservice Review does not guarantee that you have coverage or that benefits will be paid, nor does it guarantee the amount of benefits to which you are entitled. The payment of benefits is subject to all other terms, conditions, limitations and exclusions of this Combined Evidence of Coverage and Disclosure Form.

A. **Preservice Review.** We will determine **in advance** whether certain procedures and admissions are Medically Necessary and are the appropriate length of stay, if applicable. Services for which Preservice Review is required (i.e., services that need to be reviewed by us to determine whether they are Medically Necessary) include, but are not limited to, the following:

1. All inpatient Hospital admissions (except inpatient Hospital stays for the delivery of a Child or mastectomy surgery, including the length of Hospital stays associated with mastectomy);
2. Facility Based Treatment for Mental or Nervous Disorders and Substance Abuse (see the Part entitled "DEFINITIONS");
3. Skilled Nursing Facility stays;
4. Center of Medical Excellence (CME) procedures, including Organ and Tissue Transplants, Coronary Artery Bypass Surgeries, peripheral stem cell replacement and similar procedures;
5. All Infusion Therapy (in any setting) inclusive of Specialty Drugs through the specialty pharmacy program, and related services (for each Course of Therapy) in any setting, including but not limited to: Physician's office, infusion center, outpatient Hospital or clinic, or your home or other residential setting;
6. Home Health Care;
7. Specific outpatient services, including diagnostic treatment and other services;
8. Specific surgical procedures, wherever performed, as specified by us;
9. Specific diagnostic procedures, including advanced imaging procedures, such as:
   a) Computerized Tomography (CT)
   b) Computerized Tomography Angiography (CTA)
   c) Magnetic Resonance Imaging (MRI)
   d) Magnetic Resonance Angiography (MRA)
   e) Magnetic Resonance Spectroscopy (MRS)
   f) Nuclear Cardiology
   g) Positron Emission Tomography (PET)
   h) PET and PET/CT Fusion
   i) QTC Bone Densitometry
   j) Diagnostic CT Colonography
   k) Echocardiogram
10. Specific medical supplies and equipment;
11. Air ambulance in a non-Medical Emergency;
12. Outpatient professional services for Mental or Nervous Disorders and Substance Abuse including Severe Mental Illness and Serious Emotional Disturbances of a Child after twelve (12) visits;

13. Physical and Occupational Therapy after twenty-four (24) visits;
14. Speech Therapy after fifty (50) visits; and
15. Other services wherever they are rendered.

For a list of current procedures requiring Preservice Review, please call the toll-free number for customer service printed on your identification card.

To initiate Preservice Review, instruct your Physician to request Preservice Review at least five (5) working days before any non-urgent scheduled Hospital, Facility Based Treatment for Mental or Nervous Disorders and Substance Abuse, Skilled Nursing Facility admission, outpatient surgery, Infusion Therapy (in any setting) inclusive of Specialty Drugs in the specialty pharmacy program, Home Health Care or treatment, therapy, service and supply that requires Preservice Review by calling Anthem Blue Cross toll free at (800) 274-7767. But remember, you are responsible to see that it is done.

The review processes which may be undertaken are listed below in paragraphs D through G.

B. The Anthem Blue Cross Utilization Review Program evaluates only the medical need for Hospital, Facility Based Treatment for Mental or Nervous Disorders and Substance Abuse or Skilled Nursing Facility admissions, outpatient surgeries or other services received. This means that the Hospital admission or outpatient surgery performed at a Hospital or Ambulatory Surgical Center is Medically Necessary.

C. **You are always responsible for initiating Preservice Review. Remember, it is your responsibility to call the toll-free number printed on your identification card or visit www.anthem.com/ca to determine whether a particular service requires Preservice Review.** Whenever Preservice Review has not been performed for the following services received from a Non-Participating Provider, you will be required to pay an additional $250 Copayment for the admission, treatment, or therapy: an admission to a Hospital (except for the delivery of a Child or mastectomy surgery, including the length of Hospital stays associated with mastectomy), Facility Based Treatment for Mental or Nervous Disorders and Substance Abuse, Skilled Nursing Facility, Infusion Therapy (in any setting) or Home Health Care. **This Copayment is in addition to any other Copayment required by this Combined Evidence of Coverage and Disclosure Form. It will NOT apply toward satisfying your annual Deductible and it will continue to be required even after the Anthem Blue Cross annual maximum payment limit for Non-Participating Providers has been reached. This Copayment is not required in Medical Emergencies.**

D. **Admission Review**. We will determine at the time of admission if the Hospital, Facility Based Treatment for Mental or Nervous Disorders and Substance Abuse or Skilled Nursing Facility stay or surgery is Medically Necessary in the event Preservice Review is not conducted (except for inpatient Hospital stays related to the delivery of a Child or mastectomy surgery, including the length of Hospital stays associated with mastectomy).

E. **Continued Stay Review.** We will also determine if a continued Hospital, Facility Based Treatment for Mental or Nervous Disorders and Substance Abuse or Skilled Nursing Facility stay is Medically Necessary. The length of Hospital stays related to mastectomy will be determined by the treating Physician in consultation with the patient.

F. **Retrospective Review.** We will determine if a scheduled or Medical Emergency admission to a Hospital, Facility Based Treatment for Mental or Nervous Disorders and Substance Abuse or any surgery at a Hospital or an Ambulatory Surgical Center was Medically Necessary in the event that Preservice Review, admission review or continued stay review was not performed.

G. **Revoking or modifying a Preservice Review decision.** Anthem Blue Cross will determine **in advance** whether certain services (including procedures and admissions) are Medically Necessary and are the appropriate length of stay, if applicable. These review decisions may be revoked or modified prior to the service being rendered for reasons including but not limited to the following:

- Your coverage under this plan ends;
- The Agreement with the Group terminates;
- You reach a benefit maximum that applies to the service in question;
- Your benefits under the plan change so that the service is no longer covered or is covered in a different way.

For a copy of the Medical Necessity Review Process, please contact our customer service department toll free at (800) 627-8797.

PART VIII ALTERNATIVE BENEFITS

In order for a Member to obtain medically appropriate care in a more economical and cost-effective way when extensive long-term treatment is required, Anthem Blue Cross may recommend an alternative plan of treatment which includes services not covered under this Combined Evidence of Coverage and Disclosure Form.

Anthem Blue Cross makes treatment suggestions only; any decision regarding treatment belongs to the Member and the Member's Physician. When alternative treatments are to be provided, both the Member (or Member's guardian) and the Member's Physician must agree, in writing, with the terms and conditions of our recommended substitution of benefits. Alternative benefits paid are accumulated toward any lifetime maximums under this Combined Evidence of Coverage and Disclosure Form.

Benefits are provided for such alternative treatment plan only on a case-by-case basis. We have absolute discretion in deciding whether or not to offer to substitute benefits for any Member, which alternative benefits may be offered and the terms of the offer. Our substitution of benefits in a particular case in no way commits us to do so in another case or for another Member. Also, it does not prevent us from strictly applying the express benefits, limitations and exclusions of the Combined Evidence of Coverage and Disclosure Form at any other time or for any other Member.

PART IX YOUR PRESCRIPTION DRUG BENEFITS

Benefits are provided as follows for Prescription Drugs purchased from licensed retail Pharmacies by Members eligible to receive outpatient Prescription Drug benefits under this Combined Evidence of Coverage and Disclosure Form.

Our WellPoint National Pharmacy and Therapeutics Committee decides which outpatient Prescription Drugs are to be included on the list of preferred Drugs covered by the plan. The WellPoint National Pharmacy and Therapeutics Committee is comprised of independent doctors and pharmacists. This committee meets quarterly and decides on changes to make in the preferred Drug list based on our recommendations and a review of relevant information, including current medical literature.

The preferred list of Drugs, sometimes called a Formulary, helps your doctor make prescribing decisions. The presence of a Drug on the plan's Formulary does not guarantee that it will be prescribed. If you have a question regarding whether a Drug is on the Anthem Blue Cross preferred Drug list, please call the Pharmacy Benefits Manager (PBM) toll free at (800) 700-2533 or access information on our web site at **www.anthem.com/ca**.

Some medications may require prior authorization from Anthem Blue Cross. Please call the Pharmacy Benefits Manager toll free at (800) 700-2533 for a list of these Drugs. You may also wish to refer to the "Prior Authorization" section in this Part for more information.

Certain Drugs are dispensed in specific amounts based on our analysis of Prescription Drug dispensing trends and the Food and Drug Administration dosing recommendations. But, Medically Necessary Drugs will be provided based on our review consistent with professional practice and Food and Drug Administration guidelines.

Amounts allowed for Prescription Drugs obtained from Non-Participating Pharmacies are usually significantly lower than what those providers customarily charge, so you will almost always have a higher out-of-pocket expense for Drugs when you use a Non-Participating Pharmacy to fill your Prescription.

For an explanation of your Prescription Drug coverage when you are enrolled in Medicare Part D, see the Part entitled "BENEFITS FOR MEDICARE ELIGIBLE MEMBERS."

DEFINITIONS

- **Brand Name Prescription Drug (Brand Name)** is a Prescription Drug that has been patented.
- **Compound Medication** is a mixture of Prescription Drugs and other ingredients, of which at least one of the components is commercially available as a Prescription product. Compound Medications do not include:
  1. Duplicates of existing products and supplies that are mass-produced by a manufacturer for consumers; or
  2. Products lacking a National Drug Code (NDC) number.
- **Drugs** (Prescription Drugs) mean medications approved by the state of California Department of Health or the Food and Drug Administration (FDA) for general use by the public which requires a Prescription before the medication can be obtained. For purposes of this benefit, Insulin will be deemed a Prescription Drug.
- **Formulary** is a list of Drugs which Anthem Blue Cross has determined to be safe and cost-effective based on available medical literature.

- **Generic Prescription Drug (Generic)** is a pharmaceutical equivalent of one or more Brand Name Drugs and must be approved by the FDA as meeting the same standards of safety, purity, strength and effectiveness as the Brand Name Drug.
- **Maintenance Prescription Drugs** are Prescription Drugs which are taken for an extended period of time to treat a medical condition.
- **Multi-Source Brand Name Drugs** are Drugs with at least one Generic equivalent.
- **Non-Participating Pharmacy** is a Pharmacy which does not have a contract in effect with the Pharmacy Benefits Manager at the time services are rendered. In most instances, you will be responsible for a larger portion of your pharmaceutical bill when you go to a Non-Participating Pharmacy.
- **Participating Pharmacy** is a Pharmacy which has a contract in effect with the Pharmacy Benefits Manager at the time services are rendered. To identify a Participating Pharmacy, call your local Pharmacy directly or call the Pharmacy Benefits Manager toll free at (800) 700-2533.
- **Pharmacy** means a licensed retail Pharmacy.
- **Pharmacy Benefits Manager (PBM)** is the entity which administers Anthem Blue Cross' Prescription Drug benefits. The PBM is an independent contractor and not affiliated with Anthem Blue Cross.
- **Prescription** means a written order issued by a Physician.
- **Prescription Drug Maximum Allowed Amount** is the maximum amount we allow for Prescription Drugs. The amount is determined by Anthem Blue Cross using cost information provided to Anthem Blue Cross by the Pharmacy Benefits Manager. The Prescription Drug Maximum Allowed Amount is subject to change. You may determine the Prescription Drug Maximum Allowed Amount of a particular Prescription Drug by calling (800) 700-2533.
- **Prescription Drug Tiers** are used to classify Drugs for the purpose of setting Copayments. We will decide which Drugs should be in each tier based on clinical decisions made by the WellPoint National Pharmacy and Therapeutics Committee. You can get additional information by calling customer service at (800) 700-2533 or by accessing our web site at **www.anthem.com/ca.** You may also ask your pharmacist for assistance.

  We retain the right and discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example, by mouth, injection, topical or inhaled). We may cover one form of administration and may exclude or place other forms of administration in another tier. If it is Medically Necessary for you to use a Drug in an administrative form that is excluded, you will need to obtain written prior authorization (see the section entitled "Prior Authorization" in this Part) to receive that administrative form of the Drug. This is an explanation of what Drugs each tier includes:

  - **Tier 1 Drugs** are those that have the lowest Copayment. This tier includes low cost preferred Drugs that may be Generic, Single Source Brand Name Drugs or Multi-Source Brand Name Drugs.
  - **Tier 2 Drugs** are those that have Copayments higher than Tier 1 Drugs, but, lower than Tier 3 Drugs. This tier includes preferred Drugs that may be Generic, Single Source Brand Name Drugs or Multi-Source Brand Name Drugs.
  - **Tier 3 Drugs** are those that have Copayments higher than Tier 2 Drugs, but, lower than Tier 4 Drugs. This tier includes non-preferred Drugs that may be Generic, Single Source Brand Name Drugs, Multi-Source Brand Name Drugs or Compound Medications.
  - **Tier 4 Drugs** are those that have higher Copayments than Tier 3 Drugs. This tier includes non-preferred Drugs that may be Generic, Single Source Brand Name Drugs, or Multi-Source Brand Name Drugs.

- **Self-Administered Injectable Drugs** are Drugs which are self-administered by the patient (or family member), including Drugs with FDA labeling for self-administration.
- **Single Source Brand Name Drugs** are Drugs with no Generic equivalent.
- **Specialty Drugs** are high-cost, injectable, infused, oral or inhaled Drugs that generally require close supervision and monitoring of their effect on the patient by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail Pharmacies.

DRUG UTILIZATION REVIEW

Your Prescription Drug benefits include utilization review of Prescription Drug usage for your health and safety. Certain Drugs may require prior authorization. If there are patterns of over-utilization or misuse of Drugs, we will notify your personal Physician and your pharmacist. We reserve the right to limit benefits to prevent over-utilization of Drugs.

PRIOR AUTHORIZATION

Certain Drugs require written prior authorization for you to obtain benefits even if the prescribing doctor writes "do not substitute" or "dispense as written" on the Prescription. Prior authorization criteria will be based on medical policy, clinical guidelines and established Pharmacy and therapeutic guidelines.

You may need to try a Drug other than the one originally prescribed if we determine that it should be clinically effective for you. However, if we determine through the prior authorization process that the Drug originally prescribed is Medically Necessary, you will be provided the Drug originally requested at the applicable Copayment. If approved, Drugs requiring prior authorization will be provided to you after you make the required Copayment. (If, when you first become a Member, you are already being treated for a medical condition with a Drug that has been appropriately prescribed and is considered safe and effective for your medical condition and you underwent a prior authorization process under a prior plan which required you to take different Drugs, we will not require you to try a Drug other than the one you are currently taking.)

In order for you to obtain a Drug that requires prior authorization, your Physician must make a written request to us using a Drug Prior Authorization form. The form can be faxed or mailed to us. If your Physician needs a copy of the form, he or she may call us at (888) 831-2242 to request one. The form is also available online at **www.anthem.com/ca**.

If the request is for urgently needed Drugs, after we get the Drug Prior Authorization form:

- We will review it and decide if we will approve benefits within 72 hours, or if shorter, the time required by federal law. (As soon as we can, based on your medical condition, as Medically Necessary, we may take less than 72 hours to decide if we will approve benefits.) We will tell you and your Physician what we have decided in writing – by fax to your Physician and by mail to you.

- If more information is needed to make a decision, or we cannot make a decision for any reason, we will tell your Physician, within 24 hours after we get the form, what information is missing and why we cannot make a decision. If, for reasons beyond our control, we cannot tell your Physician what information is missing within 24 hours, we will tell your Physician that there is a problem as soon as we know that we cannot respond within 24 hours. In either event, we will tell you and your Physician that there is a problem in writing by fax, and, when appropriate, by telephone to your Physician, and in writing by mail to you.

- As soon as we can, based on your medical condition, as Medically Necessary, but not more than 48 hours after we have all the information we need to decide if we will approve benefits, we will tell you and your Physician what we have decided in writing – by fax to the Physician and by mail to you.

If the request is not for urgently needed Drugs, after we get the Drug Prior Authorization form:

- Based on your medical condition, as Medically Necessary, we will review it and decide if we will approve benefits within five (5) business days. We will tell you and your Physician what we have decided in writing – by fax to your doctor and by mail to you.

- If more information is needed to make a decision, we will tell your Physician in writing within five (5) business days after we get the request what information is missing and why we cannot make a decision. If, for reasons beyond our control, we cannot tell your Physician what information is missing within five (5) business days, we will tell your Physician that there is a problem as soon as we know that we cannot respond within five (5) business days. In any event, we will tell you and your Physician that there is a problem in writing by fax, and when appropriate, by telephone to your Physician, and in writing to you by mail.

- As soon as we can, based on your medical condition, as Medically Necessary, within five (5) business days after we have all the information we need to decide if we will approve benefits, we will tell you and your Physician what we have decided in writing – by fax to your Physician and by mail to you.

While we are reviewing the Drug Prior Authorization form, a 72-hour emergency supply of medication or the smallest packaged quantity, whichever is greater, may be dispensed to you if your Physician or pharmacist determines that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment or coinsurance shown in this Part for the 72-hour supply of your Drug. If we approve the request for the Drug after you have received a 72-hour supply, you will receive the remainder of the 30-day supply of the Drug. If you have paid the applicable Copayment for the 72-hour supply, you will have no additional Copayment. If not, you will be responsible to pay the applicable Copayment for the remainder of the 30-day supply.

If you have any questions whether a Drug is on our preferred Drug list or requires prior authorization, please call (800) 700-2533.

If prior authorization of a Drug is not approved, you or your prescribing Physician may appeal our decision by calling us at (800) 700-2533. If you are not satisfied with the resolution based on your inquiry, you may file a grievance with us by following the procedures described in the Part entitled "GRIEVANCE PROCEDURES."

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

- Your coverage under this plan ends;
- The Agreement with the Group terminates;

- You reach a benefit maximum that applies to Prescription Drugs, if the plan includes such a maximum;
- Your Prescription Drug benefits under the plan change so that Prescription Drugs are no longer covered or are covered in a different way.

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

PRESCRIPTION DRUG DEDUCTIBLE

Each Member must meet a Prescription Drug Deductible amount of $150 each Year. Before we pay for Tier 2, Tier 3 or Tier 4 Drugs, you must satisfy the $150 Prescription Drug Deductible per Member per Year. The Prescription Drug Deductible is waived for Tier 1 Drugs, and Copayments for Tier 1 Drugs do not apply to the Prescription Drug Deductible. Amounts you pay for Tier 2, Tier 3 and Tier 4 Drugs apply toward the Prescription Drug Deductible whether the Drugs are purchased through the mail service prescription drug program or at Participating or Non-Participating Pharmacies. However, for any amounts you pay for a Brand Name Drug that you request or your Physician specifies as "dispense as written" or "do not substitute" when a Generic Drug equivalent exists, the Prescription Drug Maximum Allowed Amount for that Brand Name Drug **will not** be applied toward the Prescription Drug Deductible. Amounts **will** be applied to the Prescription Drug Deductible in specific instances where the Member requests and receives prior authorization to purchase a Brand Name Drug that has a Generic equivalent when Medically Necessary.

Note: The Prescription Drug Deductible is separate from the annual Deductible for medical benefits and **does not** accumulate toward satisfying your medical annual maximum Copayment limit for Participating Providers or the Tier 4 Prescription Drug out-of-pocket maximum. In addition, the Prescription Drug Deductible does not apply to the Anthem Blue Cross medical annual maximum payment limit for Non-Participating Providers.

TIER 4 PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM

Your Prescription Copayments for Tier 4 Drugs will accrue toward a Prescription Drug out-of-pocket maximum for Tier 4 Drugs (also referred to as the Tier 4 Prescription Drug out-of-pocket maximum) of $3,500 per Member per Year for Participating and Non-Participating Pharmacies combined.

Participating Pharmacy (includes Participating Retail Pharmacies, the Mail Service Prescription Drug Program and the Specialty Pharmacy Program): After you pay $3,500 for Tier 4 Prescription Drugs in a Year, no further Copayments will be required for the remainder of the Year for Tier 4 Prescription Drugs.

Non-Participating Pharmacy: After you pay $3,500 for Tier 4 Prescription Drugs in a Year, we will reimburse you 100% of the Prescription Drug Maximum Allowed Amount for Tier 4 Prescription Drugs for the remainder of the Year. At the time of purchase, you will be responsible to pay all charges for these Drugs and submit a claim to us requesting reimbursement. See the section entitled "When You Go to a Non-Participating Pharmacy" in this Part for more information.

WHAT IS COVERED

- Outpatient Drugs and medications which federal and/or state of California law restrict to sale by Prescription only.
- Insulin. Diabetic supplies such as syringes prescribed and dispensed for use with Insulin, and lancets and test strips for use in monitoring diabetes.
- Non-infused Compound Medications, which may be limited to distribution at designated Participating Pharmacies.
- Oral contraceptive Drugs prescribed for birth control. If your Physician determines that oral contraceptive Drugs are not medically appropriate, coverage for another FDA approved Prescription contraceptive method will be provided.
- Drugs and medications prescribed for the treatment of Infertility are limited to our lifetime maximum payment of $1,500 per Member. If such medications are classified as Specialty Drugs, they may be subject to the terms outlined under the section in this Part entitled "Specialty Pharmacy Program."
- Drugs and medications prescribed for the treatment of impotence and/or sexual dysfunction must be authorized in advance by Anthem Blue Cross and are limited to eight (8) tablets/units per 30-day period. **(Not covered under the mail service prescription drug program.)**
- Phenylketonuria (PKU) formulas and special food products to treat PKU that are listed on the Formulary and obtained from a Pharmacy. You must also satisfy the Prescription Drug Deductible when obtaining PKU formulas and special food products, except when the Tier 1 Copayment applies.
- Influenza immunization (flu vaccine), including administration by injection or inhalation, and the pneumonia vaccine.

CONDITIONS OF SERVICE

- The Drug or medicine must:
  - Be prescribed in writing by a Physician, and be dispensed by a licensed retail pharmacist, by mail through the mail service prescription drug program, or, if a Specialty Drug, through the specialty pharmacy program, within one (1) year of being prescribed, subject to federal or state laws.
  - Be approved for use by the Food and Drug Administration (FDA).
  - Be for the direct care and treatment of the Member's illness, injury or condition. Dietary supplements, health aids or drugs prescribed for cosmetic purposes are not included, except as specifically stated under the section entitled "What is Covered" in this Part.
  - Be purchased from a licensed retail Pharmacy, ordered by mail through the mail service prescription drug program, or, for a Specialty Drug, ordered through the specialty pharmacy program.
  - Not be used while the Member is an inpatient in any facility.
  - Be dispensed by a Participating Pharmacy if it is an approved Compound Medication. You may call (800) 700-2533 or go to our web site at **www.anthem.com/ca** to find out where to fill your Prescription for an approved Compound Medication. All claims for reimbursement for Compound Medications must be submitted electronically (by the Pharmacy) and will be paid at the Prescription Drug Maximum Allowed Amount.
  - Be dispensed by the specialty pharmacy program if it is a Specialty Drug. Please see the "Specialty Pharmacy Program" section in this Part for information on how to obtain Specialty Drugs through the specialty pharmacy program.
- The Prescription must not exceed a 30-day supply (unless ordered by mail through the mail service prescription drug program, in which case the limit is a 90-day supply). Specialty Drugs in the specialty pharmacy program, even ordered through the mail, are limited to a 30-day supply per fill.

WHEN YOU GO TO A PARTICIPATING PHARMACY

Prescription Drugs are subject to a $150 Prescription Drug Deductible per Member per Year, except this Deductible is waived for Tier 1 Drugs. Please refer to the "Prescription Drug Deductible" section in this Part for further information.

When you present your identification card at a Participating Pharmacy, you will have to pay the applicable Copayment listed below for each covered Prescription and/or refill up to a 30-day supply. If the retail price for a covered Prescription and/or refill is less than the applicable Copayment amount, you will not be required to pay more than the retail price.

- **Tier 1 Drugs:**
  $10 Copayment*

- **Tier 2 Drugs:**
  $30 Copayment*

- **Tier 3 Drugs:**
  $50 Copayment*

- **Tier4 Drugs:**
  30% of the Prescription Drug Maximum Allowed Amount up to a maximum $150 Copayment.

- **Flu and Pneumonia Vaccines:**
  No Copayment and the Prescription Drug Deductible is waived.

- **Diabetic Supplies:**
  $30 Copayment

***Note:** If a Generic Drug equivalent is available and you purchase a Brand Name Drug, your payment responsibility can be significantly higher. Please refer to the "Preferred Generic Program" section in this Part for additional information.

Note: Unless an exception is made, after the first two months' supply of a Specialty Drug has been obtained through a retail Pharmacy, the Drug will then be available only through the specialty pharmacy program. Please see the "Specialty Pharmacy Program" section in this Part for further information.

WHEN YOU GO TO A NON-PARTICIPATING PHARMACY

Prescription Drugs are subject to the $150 Prescription Drug Deductible per Member per Year, except this Deductible is waived for Tier 1 Drugs. Please refer to the "Prescription Drug Deductible" section in this Part for further information.

If you purchase a Prescription Drug from a Non-Participating Pharmacy, you will have to pay for the full cost of the Drug and submit a claim to Pharmacy Benefits Manager, Attn: Prescription Drug Program, P.O. Box 66583, St. Louis, MO 63166-6583.

Claim forms and customer service are available by calling toll free (800) 700-2533. Mail the claim form with the appropriate portion completed and signed by the pharmacist to the Pharmacy Benefits Manager no later than fifteen (15) months after the date of dispensing.

The Rate of Reimbursement is as Follows:

- **When your Prescription is filled at a Non-Participating Pharmacy <u>within</u> the state of California:** The reimbursement will be 50% of the Prescription Drug Maximum Allowed Amount.
- **When your Prescription is filled at a Non-Participating Pharmacy <u>outside</u> the state of California**: The reimbursement will be the Prescription Drug Maximum Allowed Amount, less the Copayment as stated for Participating Pharmacies.

Note: Please refer to the "Definitions" section in this Part for the definition of "Prescription Drug Maximum Allowed Amount."

Note: There is no reimbursement for Compound Medications or Specialty Drugs obtained from Non-Participating Pharmacies; therefore, you are responsible for paying the full cost of any Compound Medications or Specialty Drugs you receive from Non-Participating Pharmacies.

WHEN YOU ORDER BY MAIL

Prescription Drugs are subject to a $150 Prescription Drug Deductible per Member per Year, except this Deductible is waived for Tier 1 Drugs. Please refer to the "Prescription Drug Deductible" section in this Part for further information.

Your mail service prescription drug program is administered by the Pharmacy Benefits Manager. Your mail service Prescription is filled by an independent, licensed Pharmacy. Anthem Blue Cross does not dispense Drugs or fill Prescriptions.

Maintenance Drugs (an ongoing Prescription) can be purchased by mail, requiring the applicable Copayment listed below to be submitted for each covered Prescription and/or refill up to a 90-day supply.

- **Tier 1 Drugs:**
  $10 Copayment*
- **Tier 2 Drugs:**
  $60 Copayment*
- **Tier 3 Drugs:**
  $100 Copayment*
- **Diabetic Supplies:**
  $60 Copayment

***Note:** If a Generic Drug equivalent is available and you purchase a Brand Name Drug, your payment responsibility can be significantly higher. Please refer to the "Preferred Generic Program" section in this Part for additional information.

Note: The first mail service Prescription must include a completed Patient Profile form. This form may be obtained by calling toll free (800) 700-2533. You need to enclose only the Prescription and Copayment for any subsequent mail service Prescription.

Note: Some Prescription Drugs and/or medicines may not be available or are not covered for purchase through the mail service prescription drug program, including, but not limited to: antibiotics; Specialty Drugs; Drugs and medications for the treatment of Infertility, impotence and/or sexual dysfunction; and injectables, including Self-Administered Injectables except Insulin. Please call customer service toll free at (866) 274-6825 to check availability of the Drug or medicine.

SPECIALTY PHARMACY PROGRAM

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

Specialty Drugs are subject to a $150 Prescription Drug Deductible per Member per Year. Please refer to the "Prescription Drug Deductible" section in this Part for further information.

Specialty Drug Prescriptions:
You will have the following Copayment for each covered Specialty Drug Prescription and/or refill obtained through the specialty pharmacy program:

- **Tier 4 Drugs:**
  30% of the Prescription Drug Maximum Allowed Amount up to a maximum $150 Copayment.

Non-duplication of benefits applies to Specialty Drugs under this plan. This means when benefits are provided for Specialty Drugs under the plan's Pharmacy benefits, they will not be provided under the Part entitled "WHAT IS COVERED." Conversely, if benefits are provided for Specialty Drugs under "WHAT IS COVERED," they will not be provided under the plan's Pharmacy benefits.

Certain Specialty Drugs require written prior authorization. (Please see the "Prior Authorization" section in this Part for more information).

When you order your Prescription through the specialty pharmacy program.
You can only have your Prescription for a Specialty Drug filled through the specialty pharmacy program, unless you qualify for an exception (please see the "Exceptions to the specialty pharmacy program" paragraph below). Specialty Drugs are limited to a 30-day supply per fill. The specialty pharmacy will deliver your Specialty Drugs to you by mail or common carrier for self administration in your home. You cannot pick up your medication from them.

The Prescription for the Specialty Drug must state the Drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address and be signed by a Physician. You or your Physician may order your Specialty Drug from the specialty pharmacy program by calling (800) 870-6419. The first time you use the specialty pharmacy program, you will be asked to set up your account by completing an Intake Referral Form, which can be completed over the telephone. When you or your Physician calls the Specialty Pharmacy, a customer service representative will guide you or your Physician through the process from placing your order to delivering your Specialty Drug to you. You will be responsible to pay any applicable Prescription Drug Deductible, Copayment or coinsurance. Once you have met your Prescription Drug Deductible, you will only have to pay the cost of your Copayment or coinsurance. At the time of ordering and prior to shipping, the specialty pharmacy may require you to pay your applicable Prescription Drug Deductible, Copayment and coinsurance by credit card, debit card or other forms of payment.

You or your Physician may obtain a list of Specialty Drugs available through the specialty pharmacy program or order forms by contacting customer service at the address or telephone number shown below or by accessing our web site at **www.anthem.com/ca**.

Pharmacy Benefits Manager
Attn: Specialty Pharmacy Program
Standard Accounts
P.O. Box 66583
St. Louis, MO 63166-6583

Phone: (800) 870-6419
Fax: (800) 824-2642

Unless you qualify for an exception, if Specialty Drugs are not obtained through the specialty pharmacy program, you will not receive any benefits for them under this plan. You will have to pay the full cost of any Specialty Drugs you get from a retail Pharmacy that should have been obtained from the specialty pharmacy program. Please note that Specialty Drugs are not covered though the mail service prescription drug program; however, if you do order a Specialty Drug through the mail service prescription drug program, the order will be forwarded to the specialty pharmacy program for processing and will be processed according to the specialty pharmacy program rules.

Exceptions to the specialty pharmacy program.

This requirement does not apply to:

1. The first two months' supply of a Specialty Drug which is available through a retail Participating Pharmacy;
2. Drugs, which, due to medical necessity, are needed urgently and must be administered to the Member immediately.

How to obtain an exception to the specialty pharmacy program.

If you believe that you should not be required to get your Specialty Drug through the specialty pharmacy program, for any reasons listed above or others, you or your Physician must complete an "Exception to the Specialty Pharmacy Program" form to request an exception and send it to the Pharmacy Benefits Manager. The form can be faxed or mailed to the PBM. If you need a copy of the form, you may call customer service at (800) 700-2533 to request one. You can also get the form online at **www.anthem.com/ca**. If the Pharmacy Benefits Manager has given you an exception, it will be in writing for the approved amount of time as medically appropriate, not to exceed six (6) months. If you believe that you should still not be required to get your medication through the specialty pharmacy program when your prior exception approval expires, you must again request an exception. If the Pharmacy Benefits Manager denies your request for an exception, it will be in writing and will tell you why the exception was not approved.

Urgent or emergency need of a Specialty Drug subject to the specialty pharmacy program.

If you are out of a Specialty Drug which must be obtained through the specialty pharmacy program, the Pharmacy Benefits Manager will authorize an override of the specialty pharmacy program requirement for 72 hours, or until the next business day following a holiday or weekend, to allow you to get a 72-hour emergency supply of medication, or the smallest packaged quantity, whichever is greater, if your doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment or coinsurance, if any.

If you order your Specialty Drug through the specialty pharmacy program and it does not arrive, if your Physician decides that it is Medically Necessary for you to have the Drug immediately, the Pharmacy Benefits Manager will authorize an override of the specialty pharmacy program requirement for a 30-day supply or less to allow you to get an emergency supply of medication from a Participating Pharmacy near you. A customer service representative from the specialty pharmacy program will coordinate the exception and you will not be required to pay an additional Copayment.

PREFERRED GENERIC PROGRAM

Prescription Drugs will be dispensed by a pharmacist as prescribed by your Physician. Generic Drugs will be dispensed by Participating Pharmacies when a Generic Drug equivalent exists unless you request a Brand Name Drug or your Physician specifies a Brand Name Drug and states "dispense as written" or "do not substitute." If you purchase a Brand Name Drug in this circumstance, and it is not determined that the Brand Name Drug is Medically Necessary (see the section entitled "Prior Authorization" in this Part), you will pay the Tier 1 Copayment plus the difference in cost between the Prescription Drug Maximum Allowed Amount for the Brand Name Drug and the Generic equivalent.

SPECIAL PROGRAMS

Special Programs

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

Half-Tablet Program

The Half-Tablet Program allows you to pay a reduced Copayment on selected "once daily dosage" medications. The Half-Tablet Program allows you to obtain a 30-day supply (15 tablets) of a higher strength version of your medication when the Prescription is written by the Physician to take "1/2 tablet daily" of those medications on a list approved by us. The WellPoint National Pharmacy and Therapeutics Committee will determine additions and deletions to the approved list. The Half-Tablet Program is strictly voluntary and your decision to participate should follow consultation with and the concurrence of your Physician. To obtain a list of the products available on this program call (866) 614-0147 or visit our internet website at **www.anthem.com/ca.**

WHAT IS NOT COVERED

IN ADDITION TO ANY LIFETIME MAXIMUMS FOR SPECIFIED SERVICES OR LIMITATIONS ON PREEXISTING CONDITIONS, PRESCRIPTION DRUGS AND REIMBURSEMENT WILL NOT BE FURNISHED FOR:

- Any expense incurred in excess of the Prescription Drug Maximum Allowed Amount.
- Drugs and medications which may be obtained without a Physician's Prescription, except Insulin and Niacin for cholesterol lowering.
- Prescription Drugs which have non-Prescription chemical and dosage equivalents. If a Drug is prescribed because the non-Prescription equivalent was tried and did not work, this exclusion does not apply.
- Non-medicinal substances or items.

- Over-the-counter smoking cessation drugs. This does not apply to Medically Necessary Drugs that you can only get with a Prescription under state and federal law.
- Contraceptive devices prescribed for birth control except as specifically stated under the section entitled "What is Covered" in this Part. Also, under the Part entitled "WHAT IS COVERED," contraceptive implants and associated professional services are specified as covered under the section describing benefits for "Professional Services and Supplies," subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- Drugs and medications used to induce non-spontaneous abortions. While not covered under this Prescription Drug benefit, FDA approved medications that may be dispensed only by or under direct supervision of a Physician, such as Drugs and medications used to induce non-spontaneous abortions, are specified as covered under the section of the Part entitled "WHAT IS COVERED" describing benefits for "Professional Services and Supplies," subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- Dietary supplements, herbs, vitamins, cosmetics, health or beauty aids, or similar products which are not FDA approved to diagnose, treat, cure or prevent a medical condition. However, formulas that are prescribed by a Physician for the treatment of phenylketonuria, listed on our Formulary, and obtained from a Pharmacy are covered as specified under Prescription Drug services and supplies that are covered. You will also want to know the following:
  - Under the Part entitled "WHAT IS COVERED," special food products and formulas for the treatment of phenylketonuria that are prescribed by a Physician, but are not available from a Pharmacy, are specified as covered under the section describing benefits for treatment of "Phenylketonuria," subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
  - Under the Part entitled "WHAT IS COVERED," health aids that are Medically Necessary and satisfy the description of medical supplies and equipment will be covered under the section describing benefits for "Medical Supplies and Equipment," subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- Drugs furnished by a Hospital, Skilled Nursing Facility, rest home, sanitarium, convalescent hospital or similar facility. While not covered under this Prescription Drug benefit, if you need Prescription Drugs while in a Hospital, Skilled Nursing Facility, rest home, sanitarium, convalescent hospital or similar facility, you will want to know the following:
  - Under the Part entitled "WHAT IS COVERED," Drugs and medicines furnished to you by a Hospital while you are a patient at a Hospital are specified as covered under the section describing benefits for "Hospital Services," subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
  - Under the Part entitled "WHAT IS COVERED," Drugs and medicines furnished to you by a Skilled Nursing Facility while you are a patient at a Skilled Nursing Facility are specified as covered under the section describing benefits for "Skilled Nursing Facilities," subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
  - In a rest home, sanitarium, convalescent hospital or similar facility, Drugs supplied and administered by the Member's Physician are specified as covered under the Part entitled "WHAT IS COVERED," under the section describing benefits for "Professional Services and Supplies," subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits. Other Drugs that may be prescribed by a Physician for a Member in a rest home, sanitarium, convalescent hospital or similar facility can be purchased at a Pharmacy by the Member, or a friend, relative or care giver on behalf of the Member, and in such case, benefits will be provided under this Prescription Drug benefit.

- Any Drug labeled "Caution, limited by federal law to Investigational use," non-FDA approved Investigational drugs or any drug or medication prescribed for Experimental indications. If Anthem Blue Cross determines that the requested drug is not covered because it is Investigational or prescribed for Experimental indications, the Member may request an Independent Medical Review. Refer to the Part entitled "GRIEVANCE PROCEDURES."
- Syringes and/or needles, except those dispensed for use with Insulin. While not covered under this Prescription Drug benefit, under the Part entitled "WHAT IS COVERED," these items are covered under the sections describing benefits for "Home Health Care," "Infusion Therapy," and/or "Medical Supplies and Equipment," subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- Durable medical equipment, devices, appliances, and supplies, except lancets and test strips for use in the monitoring of diabetes. While not covered under this Prescription Drug benefit, if you need those items, you will want to know the following:
  - Under the Part entitled "WHAT IS COVERED," durable medical equipment, devices, appliances, and supplies are specified as covered under the section describing benefits for "Medical Supplies and Equipment," subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
  - Under the Part entitled "WHAT IS COVERED," Diabetes Equipment and Supplies provided for the treatment of diabetes are specified as covered under the section describing benefits for "Treatment for Diabetes," subject to all the terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- Immunizing agents (except as specifically stated as covered in this Part), biological sera, blood, blood products, blood plasma and oxygen. While not covered under this Prescription Drug benefit, if you need those items, you will want to know the following:
  - Under the Part entitled "WHAT IS COVERED," these services are covered under the sections describing benefits for "Hospital Services," "Professional Services and Supplies," "Infusion Therapy," "Skilled Nursing Facilities," "Hospice Care" or "Medical Supplies and Equipment," subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- Professional charges in connection with administering, injecting or dispensing Drugs. While not covered under this Prescription Drug benefit, under the Part entitled "WHAT IS COVERED," these services are specified as covered under the sections describing benefits for "Professional Services and Supplies" and "Infusion Therapy," subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- Drugs and medications dispensed or administered in an outpatient setting, including, but not limited to, outpatient Hospital facilities and doctors' offices. While not covered under this Prescription Drug benefit, if you need such Drugs in an outpatient setting, you will want to know the following:
  - Under the Part entitled "WHAT IS COVERED," these Drugs are specified as covered under the sections describing benefits for "Hospital Services," "Professional Services and Supplies" and "Infusion Therapy," subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- Drugs prescribed for cosmetic purposes.

- Drugs prescribed for the treatment of Infertility in excess of our lifetime maximum payment of $1,500 per Member.
- Drugs used for weight loss, except for the Medically Necessary treatment of morbid obesity.
- Drugs obtained outside the United States unless related to a Medical Emergency.
- Allergy desensitization products, allergy serum. While not covered under this Prescription Drug benefit, if you need such Drugs, you will want to know the following:
  - Under the Part entitled "WHAT IS COVERED," Drugs (which reference would include allergy desensitization products, allergy serum) are covered under the sections describing benefits for "Hospital Services," "Professional Services and Supplies" and "Skilled Nursing Facilities," subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- All Infusion Therapy and medications except self-administered injectables and aerosols. While not covered under this Prescription Drug benefit, if you need Infusion Therapy and medications, you will want to know the following:
  - Under the Part entitled "WHAT IS COVERED," Infusion Therapy is specified as covered under the sections describing benefits for "Professional Services and Supplies" and "Infusion Therapy," subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- Treatment of impotence and/or sexual dysfunction must be Medically Necessary, and documentation of a confirmed diagnosis of erectile dysfunction must be submitted to us for review. Drugs and medications for the treatment of impotence and/or sexual dysfunction are limited to eight (8) tablets/units per 30-day period. **Not covered under the mail service prescription drug program.**
- Hepatitis B and varicella zoster (chicken pox) vaccines for Members age 7 through 18 and childhood immunizations. While not covered under this Prescription Drug benefit, under the Part entitled "WHAT IS COVERED," these immunizing agents are specified as covered under the section describing benefits for "Preventive Care," subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- A Prescription dispensed in excess of a 30-day supply (unless ordered by mail through the mail service prescription drug program, in which case the limit is a 90-day supply).
- Replacement of Drugs and medications when lost, stolen or damaged.
- Compound Medications obtained from other than a Participating Pharmacy. **You will have to pay the full cost of Compound Medications you get from a Non-Participating Pharmacy.**
- Specialty Drugs that must be obtained from the specialty pharmacy program but which are instead obtained from a retail Pharmacy. You will have to pay the full cost of the Specialty Drugs you get from a Pharmacy that should have been obtained from the specialty pharmacy program. If you order a Specialty Drug through the mail service prescription drug program, it will be forwarded to the specialty pharmacy program for processing and will be processed according to specialty pharmacy program rules.

CLAIMS AND CUSTOMER SERVICE

For retail Pharmacy information, please write to:

Pharmacy Benefits Manager
Standard Accounts
Attn: Prescription Drug Program
P.O. Box 66583
St. Louis, MO 63166-6583

or call toll free (800) 700-2533

For mail service prescription drug program information, please write to:

Pharmacy Benefits Manager
Standard Accounts
Mail Service Prescription Drug Program
P.O. Box 66558
St. Louis, MO 63166-6558

or call toll free (866) 274-6825

For specialty pharmacy program information, please write to:

Pharmacy Benefits Manager
Attn: Specialty Pharmacy Program
Standard Accounts
P.O. Box 66583
St. Louis, MO 63166-6583

or call toll free: (800) 870-6419
or contact by fax: (800) 824-2642

You may also access our web site at **www.anthem.com/ca** for information about retail, mail service or specialty pharmacy programs.

PART X BENEFITS FOR MEDICARE ELIGIBLE MEMBERS

This health plan is **not** a supplement to Medicare. This plan provides benefits according to a **Non-Duplication of Medicare clause**. When a Member becomes eligible for Medicare benefits, Anthem Blue Cross automatically becomes the secondary health plan for Members meeting any of the following criteria:

- Members who are age sixty-five (65) or older and enrolled in this plan through an Employer Group of less than twenty (20) employees.
- Members who are eligible for Medicare due to a disability and are under age sixty-five (65).
- Members any age with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant, sometimes called ESRD) following a thirty (30) month coordination period with Medicare. The coordination period begins when the following occurs:
  - Three (3) months of kidney dialysis treatments for end-stage renal disease have ended, or
  - Members have received a kidney transplant within the first three (3) months after starting a course of kidney dialysis treatments for end-stage renal disease, or
  - Members have enrolled in a self-dialysis training program, and received training for home dialysis for treatment of end-stage renal disease.

Note: Anthem Blue Cross remains the primary health plan for Medicare beneficiaries not meeting any of the above listed criteria.

NON-DUPLICATION OF MEDICARE BENEFITS

Medicare Part A provides benefits for Hospital services while Medicare Part B provides benefits for professional services including doctor's office, laboratory and other outpatient services. **If Medicare is a Member's primary health plan, it is important that the Member enroll in both Parts A and B of Medicare**.

If Medicare is a Member's primary health plan, we will not provide benefits that duplicate any benefits you would be entitled to receive under Medicare. This exclusion applies to all Parts of Medicare in which you can enroll without paying additional premium. However, if you have to pay an additional premium to enroll in Part A, B, C or D of Medicare this exclusion will apply to that particular Part of Medicare for which you must pay only if you have enrolled in that Part.

If you have Medicare, and Medicare is your primary health plan, your Medicare coverage will not affect the services covered under the Agreement, except as follows:

1. Your Medicare coverage will be applied first (primary) to any services covered by both Medicare and under the Agreement.
2. If you receive a service that is covered both by Medicare and under the Agreement, our coverage will apply only to the Medicare deductibles, coinsurance and other charges for Covered Services that you must pay over and above what is payable by your Medicare coverage.
3. For a particular claim, the combination of Medicare benefits and the benefits we will provide under the Agreement for that claim will not be more than the allowed Covered Expense you have incurred for the Covered Services you received.

We will apply toward your Deductible any expenses paid by Medicare for services covered under the Agreement except for expenses paid under Medicare Part D.

PART XI GENERAL PROVISIONS

Form or Content of Combined Evidence of Coverage and Disclosure Form: NO AGENT OR EMPLOYEE OF OURS IS AUTHORIZED TO CHANGE THE TERMS, CONDITIONS OR BENEFITS OF THIS COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM. Any changes can be made only through an endorsement signed and authorized by one of our officers.

Benefits Not Transferable: You and your eligible Family Members are the only persons entitled to receive benefits under this Combined Evidence of Coverage and Disclosure Form. The right to benefits cannot be transferred. FRAUDULENT USE OF SUCH BENEFITS WILL RESULT IN CANCELLATION OF THIS COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM AND APPROPRIATE LEGAL ACTION WILL BE TAKEN.

Relationship of Parties: We are not responsible for any claim for damages or injuries suffered by the Member while receiving care in any Hospital, Skilled Nursing Facility, Physician's office, or Home Health Agency. Such facilities act as independent contractors.

Workers' Compensation Insurance: This Combined Evidence of Coverage and Disclosure Form does not take the place of or affect any requirement for, or coverage by, workers' compensation insurance.

Governing Law: Anthem Blue Cross is subject to the requirements of the Knox-Keene Health Care Service Act of 1975, as amended, as set forth at Chapter 2.2 of Division 2 of the California Health and Safety Code and at Subchapter 5.5 of Chapter 3 of Title 10 of the California Code of Regulations, and any provision required to be stated herein by either of the above shall bind Anthem Blue Cross whether or not provided in this Combined Evidence of Coverage and Disclosure Form. This Combined Evidence of Coverage and Disclosure Form shall be construed and enforced in accordance with the laws of the state of California.

Submission of Claims: Either the Subscriber or provider of service must claim benefits by sending us properly completed claim forms itemizing the services or supplies received and the charges. These claim forms must be received by us within fifteen (15) months from the date the services or supplies are received. We will not be liable for benefits if we do not receive completed claim forms within this time period. Claim forms must be used; canceled checks or receipts are not acceptable. Claim forms are available by accessing our web site at **www.anthem.com/ca**, by calling toll free (800) 627-8797, or by writing to us at the address in the next sentence. Claims should be submitted to Anthem Blue Cross, P.O. Box 60007, Los Angeles, CA 90060-0007.

Right of Recovery: Whenever payment has been made in error, we 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 we recover from the provider a payment made in error, except in cases of fraud or misrepresentation on the part of the provider, we will only recover such payment from the provider within 365 days of the date we made the payment on a claim submitted by the provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

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

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

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

Receipt of Information: We are entitled to receive from any provider of service information about you which is necessary to administer claims on your behalf. By submitting an application for coverage, you have authorized every provider who has furnished or is furnishing care to disclose all facts, opinion or other information pertaining to your care, treatment, and physical conditions, upon our request. You agree to assist in obtaining this information if needed. Failure to assist us in obtaining the necessary information when requested may result in the delay or rejection of your claims until the necessary information is received.

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES REGARDING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. PLEASE CONTACT OUR CUSTOMER SERVICE DEPARTMENT AT (800) 627-8797 TO OBTAIN A COPY.

Terms of Coverage:

- In order for you to be entitled to benefits under this Combined Evidence of Coverage and Disclosure Form, both the Agreement (Group) and your coverage under the Agreement must be in effect on the date the expense giving rise to a claim for benefits is incurred.
- 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 a charge is made.
- The Agreement and this Combined Evidence of Coverage and Disclosure Form are subject to amendment, modification or termination according to the provisions of the Agreement without your consent or concurrence. Your entitlement to any increase in benefits as a result of any amendment or modification of the Agreement or this Combined Evidence of Coverage and Disclosure Form is subject to the provisions found under the Part entitled "WHO IS COVERED AND WHEN."
- Under the Agreement, the Employer must pay us the subscription charges, sometimes called premiums, for your coverage. For information regarding the amount of the subscription charges or any sums to be withheld from your salary or to be paid by you to your Employer, please contact your Employer.

Payment to Providers and Provider Reimbursement: Physicians and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. Hospitals or other health care facilities may be paid either a fixed fee or on a discounted fee-for-service basis. We may pay the benefits of this Combined Evidence of Coverage and Disclosure Form directly to Contracting Hospitals, Participating Providers, CMEs and medical transportation providers. We may pay Hospitals, Physicians and other providers of service or the person or persons having paid for your Hospital or medical services directly when you assign benefits in writing no later than the time of filing proof of loss (claim). These payments fulfill our obligation to you for those services. If you or one of your Family Members receives services other than Medical Emergency care from a Non-Participating Provider, payment may be made directly to the Subscriber and you will be responsible for payment to that provider. An assignment of benefits, even if assignment includes the provider's right to receive payment, is void unless an Authorized Referral has been approved by us. We will pay Non-Contracting Hospitals and other providers of service directly when Medical Emergency services and care are provided to you or one of your Family Members. We will continue such direct payment until the Medical Emergency care results in stabilization. If the Medical Emergency care is rendered within California by a Non-Participating Provider or at a Non-Contracting Hospital, you will not be responsible for any amount in excess of the Reasonable and Customary Value.

Termination of Providers: We will provide you with a notice of termination of a general acute Hospital from which you are receiving a course of treatment at least sixty (60) days in advance of the effective date of termination. To locate another Hospital in your area, call our customer service department at (800) 627-8797.

Transition Assistance for New Members: Transition Assistance is a process that allows for continuity of care for new Members receiving services from a Non-Participating Provider. If you are a new Member, you may request Transition Assistance if any one of the following conditions applies:

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services shall be provided for the duration of the acute condition.
2. A serious chronic condition. A serious chronic condition is a medical condition due to 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 us in consultation with the Member and the Non-Participating Provider and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the time the Member enrolls with us.
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 Member enrolls with us.
6. Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the time the Member enrolls with Anthem Blue Cross.

Please contact customer service toll free at (800) 627-8797 to request Transition Assistance or to obtain a copy of the written policy. Eligibility is based on the Member's clinical condition; it is not determined by diagnostic classifications. Transition Assistance does not provide coverage for services not otherwise covered under the Agreement.

We will notify you by telephone, and the provider by telephone and fax, as to whether or not your request for Transition Assistance is approved. If approved, the Member will be financially responsible only for applicable Deductibles, coinsurance and/or Copayments under this plan. Financial arrangements with Non-Participating Providers are negotiated on a case-by-case basis. We will request that the Non-Participating Provider agree to negotiate reimbursement and/or contractual requirements that apply to Participating Providers, including payment terms. If the Non-Participating Provider does not agree to negotiate said reimbursement and/or contractual requirements, we are not required to continue that provider's services. If the Member does not meet the criteria for Transition Assistance, the Member is afforded due process including having a Physician review the request.

Continuation of Care after Termination of Provider: Subject to the terms and conditions set forth below, we will pay benefits to a Member at the Participating Provider level for Covered Services (subject to applicable Copayments, coinsurance, Deductibles and other terms) rendered by a provider whose participation in Anthem Blue Cross' provider network has terminated.

1. The Member must be under the care of the Participating Provider at the time of our termination of the provider's participation. The terminated provider must agree in writing to provide services to the Member in accordance with the terms and conditions of his/her agreement with Anthem Blue Cross prior to termination. The provider must also agree in writing to accept the terms and reimbursement rates under his/her agreement with Anthem Blue Cross prior to the termination. If the provider does not agree with these contractual terms and conditions, we are not required to continue the provider's services beyond the contract termination date.

2. We will furnish such benefits for the continuation of services by a terminated provider only for any of the following conditions:

    a. 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.
    b. A serious chronic condition. A serious chronic condition is a medical condition due to 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 Blue Cross in consultation with the Member and the terminated provider and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the provider's contract termination date.
    c. 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.
    d. 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.

e. 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 provider's contract termination date.
f. 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 provider's contract termination date.

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

4. Please contact customer service toll free at (800) 627-8797 to request continuation of care or to obtain a copy of the written policy. Eligibility is based on the Member's clinical condition; it is not determined by diagnostic classifications. Continuation of care does not provide coverage for services not otherwise covered under the Agreement.

We will notify you by telephone, and the provider by telephone and fax, as to whether or not your request for continuation of care is approved. If approved, the Member will be financially responsible only for applicable Deductibles, coinsurance and/or Copayments under this plan. Financial arrangements with terminated providers are negotiated on a case-by-case basis. We will request that the terminated provider agree to negotiate reimbursement and/or contractual requirements that apply to Participating Providers, including payment terms. If the terminated provider does not agree to negotiate said reimbursement and/or contractual requirements, we are not required to continue that provider's services. If you disagree with our determination regarding continuation of care, please refer to the Part entitled "GRIEVANCE PROCEDURES."

Responsibility to Pay Providers: In accordance with Anthem Blue Cross' Participating Provider agreements, Members will not be required to pay any Participating Provider for amounts owed to that provider by us (not including Copayments, Deductibles and services or supplies that are not a benefit of this Combined Evidence of Coverage and Disclosure Form), even in the unlikely event that Anthem Blue Cross fails to pay the provider. Members are liable, however, to pay Non-Participating Providers for any amounts not paid to those providers by Anthem Blue Cross. Note: For Medical Emergency care rendered within California by a Non-Participating Provider or at a Non-Contracting Hospital, you will not be responsible for any amount in excess of the Reasonable and Customary Value.

Availability of Care: If there is an epidemic or public disaster we will use our best efforts to ensure health care services are provided to Members. In the unfortunate event of an epidemic or public disaster, Hospitals and other Participating Providers will do their best to provide the services you may need. If you or your eligible Family Members cannot obtain care from one of these Participating Providers, you may need to seek services from any available emergency facility. You will have the same amount of time to submit any claims as stated in this Part, under the section entitled "Submission of Claims."

Expense in Excess of Benefits: We are not liable for any expense you incur in excess of the benefits of this Combined Evidence of Coverage and Disclosure Form.

Protection of Coverage: We do not have the right to cancel the coverage of any Member under the Agreement while:

- The Agreement is still in effect, and
- The Member is still eligible, and
- The Member's subscription charges are paid according to the terms of the Agreement.

Note: These are subject to the conditions listed in the section entitled "When Your Coverage Ends/Termination of Benefits" under the Part entitled "WHO IS COVERED AND WHEN."

Providing of Care: We are not responsible for providing any type of Hospital, medical or similar care.

Non-Regulation of Providers: Benefits provided under this Combined Evidence of Coverage and Disclosure Form do not regulate the amounts charged by providers of medical care or attempt to evaluate those services.

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

OUT-OF-AREA SERVICES

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

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

BlueCard® Program

Under the BlueCard® Program, when you access Covered Services within the geographic area served by a Host Blue, Anthem Blue Cross will remain responsible for fulfilling Anthem Blue Cross' contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

Whenever you access Covered Services outside Anthem Blue Cross' service area and the claim is processed through the BlueCard Program, the amount you pay for Covered 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 Blue Cross.

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 Blue Cross uses for your claim because they will not be applied retroactively to claims already paid.

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

CARE OUTSIDE THE UNITED STATES – BLUECARD WORLDWIDE

Prior to travel outside the United States, check with your Employer/Group or call the customer service number on your ID card to find out if your plan has BlueCard Worldwide benefits. Your coverage outside the United States may be different and we recommend:

- Before you leave home, call the customer service number on your ID card for coverage details. **You have coverage only for Medical Emergency services when traveling outside the United States.**
- Always carry your current Anthem Blue Cross ID card.
- In an emergency, go directly to the nearest hospital.
- **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 (804) 673-1177.** An assistance coordinator, along with a medical professional, will arrange a physician appointment or hospitalization, if needed.

Call the Service Center in these non-emergent situations:

- **You need to find a doctor or hospital or need medical assistance services.** An assistance coordinator, along with a medical professional, will arrange a physician appointment or hospitalization, if needed.

- **You need to be hospitalized or need inpatient care.** After calling the Service Center, you must also call Anthem Blue Cross for Preservice Review, at the phone number on your ID card. Note: this number is different than the phone numbers listed above for BlueCard Worldwide.

Payment Information

- **Participating BlueCard Worldwide hospitals.** In most cases, when you make arrangements for hospitalization through BlueCard Worldwide, you should not need to pay up front for inpatient care at participating BlueCard Worldwide hospitals except for the out-of-pocket costs (non-Covered Services, Deductible, Copayments and coinsurance) you normally pay. The hospital should submit your claim on your behalf.

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

Claim Filing

- **The hospital will file your claim** if the BlueCard Worldwide Service Center arranged your hospitalization. You will need to pay the hospital for the out-of-pocket costs you normally pay.

- **You must file the claim** for outpatient and doctor care, or inpatient care not arranged through the BlueCard Worldwide Service Center. You will need to pay the health care provider and subsequently send an international claim form with the original bills to Anthem Blue Cross.

Claim Forms

International claim forms are available from Anthem Blue Cross, the BlueCard Worldwide Service Center, or online at **www.bcbs.com/bluecardworldwide**. The address for submitting claims is on the form.

PUBLIC POLICY PARTICIPATION

We have established a public policy committee (that we call our Consumer Relations Committee) to advise our Board of Directors. This Committee advises the Board about how to assure the comfort, dignity and convenience of the people we cover. The Committee consists of Members covered by our health plan, Participating Providers and a member of our Board of Directors. The Committee may review our financial information, and information about the nature, volume and resolution of the complaints we receive. The Consumer Relations Committee reports directly to our Board.

If you would like to be considered for membership on the Consumer Relations Committee, please write to:

Anthem Blue Cross
Attention: Director, Product Services and Promotion
P.O. Box 9086
Oxnard, CA 93031-9086

PART XII EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

Under the federal Employee Retirement Income Security Act of 1974 (ERISA), Employer sponsored plans other than church or government groups are subject to certain claim procedure rules. These rules, detailed in this Part, govern any claim or request for benefits, including Preservice Review for medical services. Preservice Review, when required by the plan, is considered to be part of a claim and is subject to ERISA procedure rules.

Any dispute regarding an adverse benefit decision may be submitted to voluntary binding arbitration only after the Member has followed the ERISA appeal procedures. For a Member enrolled in a plan subject to ERISA, any dispute which does not involve an adverse benefit decision is subject to binding arbitration (please see the Part entitled "BINDING ARBITRATION").

This Combined Evidence of Coverage and Disclosure Form contains information on reporting claims, including the time limitations for submitting a claim. Claim forms may be obtained from the plan administrator or from Anthem Blue Cross. If your Employer provides any plan that is subject to ERISA, ERISA applies some additional claim procedure rules, which are set forth below. To the extent that ERISA claim procedure rules are more beneficial to you, they will apply in place of any similar claim procedure rules included in this Combined Evidence of Coverage and Disclosure Form.

A Participating Pharmacy's failure to fill a Prescription for you is not considered a claim under your plan. However, in the event that a Participating Pharmacy fails to fill a Prescription for you, or if you request a Prescription from a Non-Participating Pharmacy, you may submit a claim for the Prescription to us. For information on submitting a Pharmacy claim, please refer to the Part entitled "YOUR PRESCRIPTION DRUG BENEFITS."

Note: To determine if your plan is subject to ERISA, check your Anthem Blue Cross identification card, or contact customer service at (800) 627-8797. If your identification card indicates "ERISA: Y" your plan is subject to ERISA.

These ERISA rules apply only to adverse benefit decisions. If you are enrolled in a plan provided by your Employer that is subject to ERISA, the rules outlined below will apply to adverse benefit decisions, but not to any other type of dispute you may have with us.

If you are enrolled in a plan provided by your Employer that is **not** subject to ERISA, the rules outlined below will **not** apply to you. For any grievance or dispute, please see the Parts entitled "GRIEVANCE PROCEDURES" and "BINDING ARBITRATION."

URGENT CARE (when care has not yet been received)

Under ERISA, a claim involving urgent care is defined as any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Member. A preservice claim is any request for medical benefits that requires Preservice Review.

Note: All hours/days referred to are defined as calendar hours/days.

When you submit a request for benefits:

- We must notify you within seventy-two (72) hours of receipt of your request for benefits as to what we determine your benefits to be.
- If your request for benefits does not contain all the necessary information, we must notify you within twenty-four (24) hours of receipt of your request as to what information is needed to make a determination on your request.
- Any notice to you by us will be by telephone or in writing by facsimile or other rapid means.
- You have forty-eight (48) hours from receipt of this notice to provide to us the information needed to make a determination on your request for benefits. You may submit this information either by telephone or in writing by facsimile or other rapid means.

If your request for benefits is denied in whole or in part:

- We must provide written notice of the adverse benefit determination to you within seventy-two (72) hours after receiving all the information needed to make a determination on your request for benefits. The notice will explain the reason for the adverse benefit decision and the plan provisions upon which the adverse benefit determination was made.
- You have one hundred eighty (180) days from receipt of our adverse benefit decision on your request for benefits to appeal our decision. You may submit an appeal of the adverse benefit decision either by telephone or in writing by facsimile or other rapid means.
- Within seventy-two (72) hours of receipt of your appeal, we must notify you, either by telephone or in writing by facsimile or other rapid means, of our decision on your appeal.
- If your appeal does not result in a reversal of the adverse benefit decision, you may pursue additional voluntary appeals, including those outlined under the Parts entitled "GRIEVANCE PROCEDURES" and "BINDING ARBITRATION."

NON-URGENT CARE – PRESERVICE (when care has not yet been received)

Note: Any claim that does not meet the above-stated criteria for urgent care is considered to be a non-urgent care claim. A preservice claim is any request for medical benefits that requires Preservice Review.

Note: All days referred to are defined as calendar days.

When you submit a request for benefits:

- We must notify you within fifteen (15) days of receipt of your request for benefits as to what we determine your benefits to be. This period may be extended one time for up to fifteen (15) days provided we determine that an extension is necessary due to matters beyond our control, and notify you prior to the expiration of the initial fifteen (15) day period of the circumstances requiring the extension of time and the date by which we expect to render a decision.
- In no case may we take more than thirty (30) days to make a determination on your request for benefits.
- If your request for benefits does not contain all the necessary information, we must notify you in writing within five (5) days of receipt of your request as to what information is needed to make a determination on your request.
- You have forty-five (45) days from receipt of this notice to provide to us the information needed to make a determination on your request for benefits.

If your request for benefits is denied in whole or in part:

- We must provide written notice of the adverse benefit decision to you within fifteen (15) days after receiving all the information needed to make a determination on your request for benefits. The notice will explain the reason for the adverse benefit decision and the plan provisions upon which the denial is based. This period may be extended one time for up to fifteen (15) days provided we determine that an extension is necessary due to matters beyond our control, and notify you prior to the expiration of the initial 15-day period as to the circumstances requiring the extension of time and the date by which we expect to render a decision.
- You have one hundred eighty (180) days from receipt of our adverse benefit decision on your request for benefits to appeal our decision. You must submit your appeal in writing.
- Within thirty (30) days of receipt of your written appeal, we must notify you in writing of our decision on your appeal.

Note: Once you have completed this mandatory appeal process, you or your plan may have other voluntary alternative dispute resolution options, such as voluntary binding arbitration.

CONCURRENT CARE DECISIONS

If, after approving a request for benefits in connection with your illness, injury, disease or other condition, Anthem Blue Cross decides to reduce or end these benefits, in whole or in part:

- We must notify you sufficiently in advance of the reduction in, or end of, benefits to allow you the opportunity to appeal our decision before the reduction in, or end of, benefits occurs. This notice will explain the reason for reducing or ending your benefits and the plan provisions upon which the decision was made.
- To keep the benefits previously approved, you must successfully appeal our decision to reduce or end those benefits. You must make your appeal to us at least twenty-four (24) hours prior to the reduction in, or end of, benefits.
- If you appeal the decision to reduce or end your benefits less than twenty-four (24) hours prior to the reduction in, or end of, benefits, your appeal will be treated as if you were appealing an urgent care adverse benefit decision (see the section entitled “URGENT CARE,” above).
- If we receive your appeal for benefits at least twenty-four (24) hours prior to the reduction in, or end of, benefits, we must notify you of our decision regarding your appeal within twenty-four (24) hours of receipt of the appeal. If we deny your appeal of the decision to reduce or end your benefits, in whole or in part, we must explain the reason for the adverse benefit decision and the plan provisions upon which the decision was based.
- You may further appeal the adverse benefit decision according to the rules for appeal of an urgent care adverse benefit decision (see the section entitled “URGENT CARE,” above).

NON-URGENT CARE – POST SERVICE (after care has been received)

Note: Under ERISA rules, a post-service claim is not considered to be an urgent care claim.

Note: All days referred to are defined as calendar days.

When you submit a claim:

- We must notify you in writing within thirty (30) days of receipt of your claim as to what we determine your benefits to be. This period may be extended one time for up to fifteen (15) days provided we determine that an extension is necessary due to matters beyond our control, and notify you prior to the expiration of the initial thirty (30) day period as to the circumstances requiring the extension of time and the date by which we expect to render a decision.
- In no case may we take more than forty-five (45) days to make a determination on your claim.
- If your claim does not contain all the necessary information, we must notify you in writing within thirty (30) days of receipt of your claim as to what information is needed to make a determination on your claim.
- You have forty-five (45) days from receipt of this notice to provide to us the information needed to make a determination on your claim.

If your claim is denied in whole or in part:

- We must provide written notice of the adverse benefit decision to you within thirty (30) days after receiving all the information needed to make a determination on your claim. The notice will explain the reason for the adverse benefit decision and the plan provisions upon which the denial decision is based.
- You have one hundred eighty (180) days from receipt of our adverse benefit decision on your claim to appeal our decision. You must submit your appeal in writing to us.
- Within thirty (30) days of receipt of your written appeal, we must notify you in writing of our decision on your appeal.

Note: Once you have completed this mandatory appeal process, you or your plan may have other voluntary alternative dispute resolution options, such as voluntary binding arbitration.

Note: You, your beneficiary, or a duly authorized representative may appeal any adverse benefit decision on a claim for benefits with us and request a review of the adverse benefit decision. In connection with such a request, documents pertinent to the administration of the plan may be reviewed free of charge, and issues outlining the basis of the appeal may be submitted. You may have representation throughout the appeal and review procedure.

PART XIII GRIEVANCE PROCEDURES

If you have a question about your eligibility, your benefits under this Combined Evidence of Coverage and Disclosure Form, or concerning a claim, please call our customer service department toll free at (800) 627-8797, or you may write to us (please address your correspondence to Anthem Blue Cross, P.O. Box 9086, Oxnard, CA 93031-9086, marked to the attention of the customer service department). Our customer service staff will answer your questions or assist you in resolving your issue.

If you are dissatisfied and wish to file a grievance, you may request a copy of the grievance form to complete and return to us, or ask the customer service representative to complete the form for you over the telephone. You may also submit a grievance form online in the "Members" section at **www.anthem.com/ca**. You must submit your grievance to us no later than 180 days following the date you receive a denial notice from us or any other incident or action with which you are dissatisfied. You must include all pertinent information from your identification card and the details and circumstances of your concern or problem. Upon receipt of your grievance, your issue will become part of our formal grievance process and will be resolved accordingly.

All grievances received by us will be acknowledged in writing. After we have reviewed your grievance, we will send you a written statement on its resolution or pending status. If your case involves an imminent and serious threat to your health, including, but not limited to, severe pain or the potential loss of life, limb, or major bodily function, review of your grievance will be expedited, and we will provide you with a written statement on the disposition or pending status of the grievance no later than three (3) days from the receipt of the grievance.

If you are dissatisfied with the resolution of your grievance, or if your grievance has not been resolved after at least thirty (30) days, you may submit your grievance to the Department of Managed Health Care (DMHC) for review prior to binding arbitration (see the section entitled "DEPARTMENT OF MANAGED HEALTH CARE"). If your case involves an imminent and serious threat to your health, as described above, or a cancellation or non-renewal of coverage under this EOC, you are not required to complete our grievance process, but may immediately submit your grievance to the Department of Managed Health Care for review.

You may at any time pursue your ultimate remedy, which is binding arbitration (see the Part entitled "BINDING ARBITRATION").

INDEPENDENT MEDICAL REVIEW BASED UPON THE DENIAL OF EXPERIMENTAL OR INVESTIGATIONAL TREATMENT

If a Member has had coverage denied because proposed treatment is determined by us to be Experimental or Investigational, that Member may ask for review of that denial by an Independent Medical Review ("IMR") organization contracting with the Department of Managed Health Care. A request for review may be submitted to the Department of Managed Health Care in accordance with the procedures described under "INDEPENDENT MEDICAL REVIEW OF GRIEVANCES INVOLVING A DISPUTED HEALTH CARE SERVICE." To qualify for IMR, all of the following conditions must be satisfied:

- The Member has a life-threatening or seriously debilitating condition.
    - A life-threatening condition is a condition or disease where the likelihood of death is high unless the course of the condition or disease is interrupted and/or a condition or disease with a potentially fatal outcome where the end-point of clinical intervention is survival.
    - A seriously debilitating condition is a disease or condition that causes major, irreversible morbidity.
- The proposed treatment must be recommended by a Participating Physician, or a board certified or board eligible Physician qualified to treat the Member, who has certified in writing that it is more likely to be beneficial than standard treatment, and who has provided the supporting evidence.
- If an IMR is requested by the Member or by a qualified Non-Participating Physician, as described above, the requester must supply two items of acceptable medical and scientific evidence (as defined below).

Within three (3) business days of our receipt from the Department of Managed Health Care of a request by a qualified Member for an IMR, we will provide the IMR organization designated by the Department with a copy of all relevant medical records and documents for review, and any information submitted by the Member or the Member's Physician. Any subsequent information received will be forwarded to the IMR organization within three (3) business days. Additionally, any newly developed or discovered relevant medical records identified by us or our Participating Providers after the initial documents are provided will be forwarded immediately to the IMR organization. The IMR organization will render its determination within thirty (30) days of the request (or seven (7) days in the case of an expedited review), except the reviewer may ask for three (3) more days if there was any delay in receiving the necessary records.

"Acceptable medical and scientific evidence" means the following sources:

- Peer reviewed scientific studies published in or accepted for publication by medical journals that meet national recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
- Medical journals recognized by the Secretary of Health and Human Services under Section 1861 (t) (2) of the Social Security Act;
- Either of the following reference compendia: The American Hospital Formulary Service's-Drug Information or the American Dental Association Accepted Dental Therapeutics;
- Any of the following reference compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen:
  - The Elsevier Gold Standard's Clinical Pharmacology.
  - The National Comprehensive Cancer Network Drug and Biologics Compendium.
  - The Thomson Micromedex DrugDex.
- Medical literature meeting the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline, MEDLARS database Health Services Technology Assessment Research;
- Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes; and
- Peer reviewed abstracts accepted for presentation at major medical association meetings.

INDEPENDENT MEDICAL REVIEW OF GRIEVANCES INVOLVING A DISPUTED HEALTH CARE SERVICE

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

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

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

1. a. Your provider has recommended a health care service as Medically Necessary,
   b. You have received urgent care or Medical Emergency services that a provider determined was Medically Necessary, or
   c. You have been seen by a Participating Provider for the diagnosis or treatment of the medical condition for which you seek independent review;

2. The disputed health care service has been denied, modified, or delayed by us based in whole or in part on a decision that the health care service is not Medically Necessary; and

3. You have filed a grievance with us and the disputed decision is upheld or the grievance remains unresolved after thirty (30) days. If your grievance requires expedited review you may bring it immediately to the DMHC's attention. The DMHC may waive the requirement that you follow our grievance process in extraordinary and compelling cases.

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

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

For more information regarding the IMR process, or to request an application form, please call our customer service department toll free at (800) 627-8797.

DEPARTMENT OF MANAGED HEALTH CARE

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(800) 627-8797** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **(http://www.hmohelp.ca.gov)** has complaint forms, IMR application forms and instructions on-line.

QUESTIONS ABOUT YOUR PRESCRIPTION DRUG COVERAGE

If you have outpatient Prescription Drug coverage and you have questions or concerns, you may call the Pharmacy customer service toll free number at (800) 700-2533. If you are dissatisfied with the resolution of your inquiry and want to file a grievance, you may write to us at Anthem Blue Cross, Grievance and Appeal Management, P.O. Box 4310, Woodland Hills, CA 91367, or ask the Pharmacy customer service representative to help you and follow the formal grievance process.

PART XIV BINDING ARBITRATION

Note: If your coverage is provided pursuant to an employer-sponsored benefit plan that is exempt from ERISA or if you have a dispute that is not governed by ERISA you will be subject to the following binding arbitration provision:

This Binding Arbitration provision does not apply to class actions.

ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration." YOU AND ANTHEM BLUE CROSS AGREE TO BE BOUND BY THIS ARBITRATION PROVISION AND ACKNOWLEDGE THAT THE RIGHT TO A JURY TRIAL IS WAIVED FOR BOTH DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN AND MEDICAL MALPRACTICE CLAIMS.

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

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

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

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

information on how to obtain an application from the neutral arbitration entity, for relief of all or a portion of their share of the fees and expenses of the neutral arbitration entity. Approval or denial of an application in the case of extreme financial hardship will be determined by the neutral arbitration entity.

Please send all binding arbitration demands in writing to:

Anthem Blue Cross
P.O. Box 9086
Oxnard, CA 93031-9086

COMPLAINTS

If you have a complaint about services from Anthem Blue Cross or your health care provider, please call Anthem Blue Cross first. Our toll free customer service telephone number is (800) 627-8797, or you may write to us at Anthem Blue Cross, P.O. Box 60007, Los Angeles, CA, 90060-0007.

If you have any questions regarding your eligibility or membership, please feel free to contact our customer service department toll free at (800) 627-8797 or you may write to us at Anthem Blue Cross, P.O. Box 9062, Oxnard, CA 93031-9062.

PART XV THIRD PARTY LIABILITY

Under some circumstances, a third party may be liable or legally responsible by reason of negligence, an intentional act, or the breach of a legal obligation of such third party for an injury, disease, or other condition for which a Member receives Covered Services. In that event, any benefits we pay under this Combined Evidence of Coverage and Disclosure Form for such Covered Services will be subject to the following:

- We will automatically have a lien upon any amount you receive from the third party or the third party's insurer or guarantor by judgment, award, settlement or otherwise. Our lien will be in the amount of the benefits we pay under this Combined Evidence of Coverage and Disclosure Form for treatment of the illness, injury, disease, or condition for which the third party is liable. Our lien will not exceed the amount we actually paid for those services if we paid the provider other than on a capitated basis. If we paid the provider on a capitated basis, our lien will not exceed 80% of the usual and customary charges for those services in the geographic area in which they were rendered. In addition, if you engaged an attorney to gain your recovery from the third party, our lien shall not be for a sum in excess of one-third of the monies due you under any final judgment, compromise, or settlement agreement. If you did not engage an attorney, our lien shall not be for a sum in excess of one-half of the monies due you under any final judgment, compromise, or settlement agreement. Where a final judgment includes a special finding by a judge, jury or arbitrator that you were partially at fault, our lien shall be reduced by the same comparative fault percentage by which your recovery was reduced. Our lien is subject to a pro rata reduction commensurate with your reasonable attorney's fees and costs in accordance with the common fund doctrine.

- You agree to advise us in writing of your claim against a third party within sixty (60) days of making such claim, and that you will take such action, furnish such information and assistance, and execute such papers as we may require to facilitate enforcement of our lien rights. You agree not to take any action that may prejudice our rights or interests under the Agreement. You agree also that failing to give us such notice, or failing to cooperate with us, or taking action that prejudices our rights will be a material breach of the Agreement. In the event of such material breach, you will be personally responsible and liable for reimbursing to us the amount of benefits we paid.

- We will be entitled to collect on our lien even if the amount recovered by or for the Member (or his or her 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 suffered by the Member.

PART XVI COORDINATION OF BENEFITS

If you are covered by more than one group health plan or dental plan, your benefits under This Plan will be coordinated with the benefits of those Other Plans so that the benefits and services you receive from all group coverages do not exceed 100% of the Covered Expense. 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 appears in these provisions, the first letter of each word will be capitalized. When you see these capitalized words, you should refer to this "Definitions" provision.

Allowable Expense is any necessary, reasonable and customary item of expense which is at least partially covered by at least one Other Plan. For the purposes of determining our payment, the total value of Allowable Expense as provided under This Plan and all Other Plans will not exceed the greater of: (1) the amount which we would determine to be eligible expense, if you were covered under This Plan only; or (2) the amount any Other Plan would determine to be eligible expenses in the absence of other coverage.

Other Plan is any of the following:

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

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

Principal Plan is the 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

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

ORDER OF BENEFITS DETERMINATION

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

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

2. A plan which covers you as a Subscriber pays before a plan which covers you as a dependent. But, if you are a Medicare beneficiary and also a dependent of an employee with current employment status under another plan, this rule might change. If, according to Medicare's rules, Medicare pays after that plan which covers you as a dependent, then the plan which covers you as a dependent pays before a plan which covers you as a Subscriber.

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

3. For a dependent Child covered under plans of two parents, the plan of the parent whose birthday falls earlier in the calendar Year 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 last. If the order of benefit determination provisions of the Other Plan does not agree under these circumstances with the order of benefit determination provisions of This Plan, this rule will not apply.

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

OUR RIGHTS UNDER THIS PROVISION

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

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

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

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

PART XVII EXTENSION OF BENEFITS

A. If a Member is Totally Disabled when coverage ends and is under the treatment of a Physician, the benefits of this Combined Evidence of Coverage and Disclosure Form will continue to be provided for services treating the totally disabling illness or injury. No benefits are provided for services treating any other illness, injury or condition.

B. A Member confined as an inpatient in a Hospital or Skilled Nursing Facility is considered Totally Disabled as long as the inpatient stay is Medically Necessary, and no written certification of the total disability is required. Benefits of this Combined Evidence of Coverage and Disclosure Form will continue until a Member is discharged or transferred to a lesser level of care facility.

C. A Member who was not confined as an inpatient, is no longer confined as an inpatient, or is transferred to a lower level of care as stated in paragraph B above, and who wishes to apply for total disability benefits must submit written certification by the Physician of the total disability and we may require the submission of medical records and/or a statement from Social Security. We must receive this certification within ninety (90) days of the date coverage ends under this Combined Evidence of Coverage and Disclosure Form. At least once every ninety (90) days while benefits are extended, we must receive proof that the Member's total disability is continuing.

D. Benefits are provided until one of the following occurs:

1. The Member is no longer Totally Disabled, or
2. The maximum benefits of the Combined Evidence of Coverage and Disclosure Form are paid, or
3. The Member becomes covered under another group health plan that provides coverage without limitation for the disabling illness or injury, or
4. A period of twelve (12) consecutive months has passed since the date coverage has ended.
5. If the Member or any representative for the Member fails to notify Anthem Blue Cross of the continuing disability at the end of any of the ninety (90) day intervals, the extension will automatically terminate. Notification is the responsibility of the Member or a representative who may be appointed by the Member.

PART XVIII CONVERSION

When your coverage under the Agreement ends, you may apply to Anthem Blue Cross within sixty-three (63) days for a Conversion Benefit Agreement. THE TERMS, BENEFITS AND SUBSCRIPTION CHARGES OF THE CONVERSION PLAN ARE DIFFERENT THAN THOSE OF THE AGREEMENT. Application for conversion membership does not require a health statement. Conversion membership is not available if:

- The Agreement terminated or the Employer's participation terminated and the Agreement is replaced by similar coverage under another group contract within fifteen (15) days of the date of termination of the Agreement or the Member's participation, or
- The Member's coverage under the Agreement ends because of failure to pay subscription charges, or
- The Member is eligible for Group health coverage when coverage under the Agreement ends, or
- The Member is eligible for Medicare coverage when coverage under the Agreement ends, whether or not the Member has actually enrolled in Medicare, or
- The Member is covered under any individual health plan when coverage under the Agreement ends, or
- The Member is terminated by us for good cause, or
- The Member knowingly furnished incorrect information or otherwise improperly obtained the benefits of the plan, or
- The Member has not been continuously covered during the three-month period immediately preceding their termination of coverage.

PART XIX CONTINUATION OF COVERAGE CAL-COBRA

If the Group is an Employer with two (2) to nineteen (19) full-time, permanent, active employees on a typical business day, you may be entitled, in accordance with the provisions of this Part, to continue for a limited period of time coverage that would otherwise end. In order to continue coverage, you must qualify as described below, and you and the Group must also satisfy the requirements set out below.

DEFINITIONS

The meanings of key terms used in this section are shown below. Whenever any of the key terms shown below appears 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 Cal-COBRA Continuation" provisions that follow.

Qualified Beneficiary means: (a) a person enrolled for this Cal-COBRA continuation coverage who, on the day before the Qualifying Event, was covered under the Agreement as either a Subscriber or Family Member, (b) a Child who is born to or placed for adoption with the Subscriber during the Cal-COBRA continuation period, or (c) a Child for whom the Subscriber or Spouse has been appointed permanent legal guardian by final court decree or order during the Cal-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 Cal-COBRA continuation period, with the exception of newborns, adoptees, and children of permanent legal guardians as specified above.

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

A. **For Subscriber and Family Members:**

1. The Subscriber's termination of employment, for any reason other than gross misconduct; or
2. A reduction in the Subscriber's work hours.

B. **For Family Members:**

1. The death of the Subscriber;
2. The Spouse's divorce or legal separation from the Subscriber;
3. The end of a Child's status as a dependent Child, as defined by the Agreement;
4. The Subscriber's entitlement to Medicare; or
5. The loss of eligible status by an enrolled Family Member.

ELIGIBILITY FOR CAL-COBRA CONTINUATION

A Subscriber or Family Member may choose to continue coverage under the Agreement if his or her coverage would otherwise end due to a Qualifying Event.

Exception: A Member is not entitled to continue coverage if, at any time of the Qualifying Event: (1) the Member is entitled to Medicare; (2) the Member is covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a Preexisting Condition of the Member; (3) we fail to receive timely notice of the Qualifying Event or election, as set out below, of a Cal-COBRA continuation; (4) the Member fails to submit the required subscription charge as set out below; (5) the Member is covered, becomes covered, or is eligible for federal COBRA; or (6) the Member is covered, becomes covered, or is eligible for coverage pursuant to Chapter 6A of the Public Health Service Act, 29 U.S.C. Section 1161 et seq. If one Member is unable to continue coverage for these reasons, other entitled Members may still choose to continue their coverage.

TERMS OF CAL-COBRA CONTINUATION

1. For Qualifying Event A., above, the Group must notify the Subscriber and us within thirty (30) days of the Qualifying Event of the right to continue coverage. We in turn must within fourteen (14) days give you official notice of the Cal-COBRA continuation right.

2. You must inform us within sixty (60) days of Qualifying Event B., above, if you wish to continue coverage. We in turn must within fourteen (14) days give you official notice of the Cal-COBRA continuation right.

If you choose to continue coverage, you must notify us within sixty (60) days of the later of: (i) the date your coverage under the Agreement terminates by reason of a Qualifying Event, or (ii) the date you were sent notice of your Cal-COBRA continuation right. The Cal-COBRA continuation coverage may be chosen for all Members within a covered family, or only for selected Members.

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.

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

The initial subscription charges must be delivered to us within forty-five (45) days after you elect Cal-COBRA continuation coverage.

An election of continuation coverage must be in writing and delivered to us by first class mail or other reliable means of delivery, including personal delivery, express mail or private courier company. The initial subscription charges must be delivered to us at Anthem Blue Cross, P.O. Box 9062, Oxnard, CA 93031-9062 by first class mail, certified mail or other reliable means of delivery, including personal delivery, express mail or private courier company, and must be in an amount sufficient to pay all subscription charges due. **A failure to properly give notice of an election of continuation coverage or a failure to properly and timely pay subscription charges due will disqualify you from continuing coverage under this Part.**

If you have Cal-COBRA continuation coverage under a prior plan that terminates because the agreement between the employer and the prior plan terminates, you may elect continuation coverage under the Agreement, which will continue for the balance of the period under which you would have remained covered under the prior plan. To do so, you must make the election and pay all subscription charges on

the terms described above and below. Such continuation coverage will terminate if you fail to comply with the requirements for enrolling in and paying premiums to us within thirty (30) days of receiving notice of the termination of the prior plan.

Additional Family Members. A Child acquired during the Cal-COBRA continuation period is eligible to be enrolled as a Family Member and has separate rights as a Qualified Beneficiary. The standard enrollment provisions of the Agreement apply to enrollees during the Cal-COBRA continuation period. A Family Member acquired and enrolled after the effective date of continuation coverage resulting from the original Qualifying Event is not eligible for a separate continuation if a subsequent Qualifying Event results in the person's loss of coverage.

Cost of Coverage. You must pay us the premium required under the Agreement for your Cal-COBRA continuation coverage, and the notice of your Cal-COBRA continuation right, which you will receive from us, will include the amount of the required premium payment. This premium, also sometimes called the "subscription charge," must be remitted to us by the first of each month during the Cal-COBRA continuation period and shall be 110% of the rate applicable to a Member for whom a Qualifying Event has not occurred. The first payment of the subscription charge is due within forty-five (45) days after you elect Cal-COBRA. **We must receive subsequent payments of the subscription charge from you by the first of each month in order to maintain the coverage in force.**

Besides applying to the Subscriber, the Subscriber's rate also applies to:

1. A Spouse whose Cal-COBRA continuation began due to divorce, separation or death of the Subscriber;
2. A Child if neither the Subscriber nor the Spouse has enrolled for this Cal-COBRA continuation coverage (if more than one Child is so enrolled, the subscription charge will be based on the two-party or three-party rate depending on the number of children enrolled); and
3. A Child whose Cal-COBRA continuation began due to the person no longer meeting the dependent Child definition.

Subsequent Qualifying Events. Once covered under the Cal-COBRA continuation, it is possible for a second Qualifying Event to occur. If that happens, a Member who is a Qualified Beneficiary may be entitled to an extended Cal-COBRA continuation period. This period will in no event continue beyond thirty-six (36) months from the date of the first Qualifying Event.

For example, a Child may have been originally eligible for Cal-COBRA continuation due to termination of the Subscriber employment, and enrolled for this Cal-COBRA continuation as a Qualified Beneficiary. If, during the Cal-COBRA continuation period, the Child reaches the upper age limit of the plan, the Child is eligible to remain covered for the balance of the continuation period, which would end no later than thirty-six (36) months from the date of the original Qualifying Event (the termination of employment).

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

For Family Members properly enrolled during the Cal-COBRA continuation, coverage begins according to the enrollment provisions of the Agreement.

When Cal-COBRA Continuation Ends.

For Members beginning Cal-COBRA continuation coverage effective on or after January 1, 2003, this continuation will end on the earliest of:

1. The end of thirty-six (36) months from the Qualifying Event;*
2. The date the Agreement terminates;
3. The end of the period for which subscription charges are last paid;
4. The date the Member becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a Preexisting Condition of the Member, in which case this Cal-COBRA continuation will end at the end of the period for which the Preexisting Condition exclusion or limitation applied;
5. In the case of (a) a Subscriber who is eligible for continuation coverage because of the termination of employment or reduction in hours of the Subscriber's employment (except for gross misconduct) and determined, under Title II or Title XVI of the Social Security Act, to be disabled at any time during the first sixty (60) days of continuation coverage and (b) his or her Spouse or dependent Child who has elected Cal-COBRA coverage, the end of thirty-six (36) months from the Qualifying Event. If the Subscriber is no longer disabled under Title II or Title XVI, benefits shall terminate on the later of thirty-six (36) months from the Qualifying Event or the month that begins more than thirty-one (31) days after the date of the final determination under Title II or Title XVI that the Subscriber is no longer disabled;
6. The date the Member becomes entitled to Medicare;
7. The date the Employer, or any successor employer or purchaser of the Employer, ceases to provide any group benefit plan to his or her employees; or
8. The date the Member moves out of the plan's service area or commits fraud or deception in the use of services.

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

If your Cal-COBRA continuation under this plan ends in accordance with items 1. or 2. above, you are eligible for medical conversion coverage. We must provide notice of this conversion right within 180 days prior to such termination date.

If your Cal-COBRA continuation coverage under this plan ends because the Group replaces our coverage with coverage from another company, the Group must notify you at least thirty (30) days in advance and let you know what you have to do to enroll for coverage under the new plan for the balance of your Cal-COBRA continuation period.

For Members beginning Cal-COBRA continuation coverage effective prior to January 1, 2003, this continuation will end on the earliest of:

1. The end of eighteen (18) months from the Qualifying Event, if the Qualifying Event was termination of employment or reduction in work hours;*
   Note: The eighteen (18) months may be extended for up to twenty-nine (29) months for total disability as determined by the Social Security Administration.
2. The end of thirty-six (36) months from the Qualifying Event, if the Qualifying Event was the death of the Subscriber, divorce or legal separation, or the end of Family Member status;*

3. For a Family Member, the end of thirty-six (36) months from the date the Subscriber became entitled to Medicare, if the Qualifying Event was the Subscriber's entitlement to Medicare;
4. The date the Agreement terminates;
5. The end of the period for which premiums are last paid;
6. The date the Member becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a Preexisting Condition of the Member, in which case this Cal-COBRA continuation will end at the end of the period for which the Preexisting Condition exclusion or limitation applied;
7. In the case of (a) a Subscriber who is eligible for continuation coverage because of the termination of employment or reduction in hours of the Subscriber's employment (except for gross misconduct) and determined, under Title II or Title XVI of the Social Security Act, to be disabled at any time during the first sixty (60) days of continuation coverage, and (b) his or her Spouse or dependent Child who has elected Cal-COBRA coverage, the end of eighteen (18) months from the Qualifying Event. If the Subscriber is no longer disabled under Title II or Title XVI, benefits shall terminate on the later of eighteen (18) months from the Qualifying Event or the month that begins more than thirty-one (31) days after the date of the final determination under Title II or Title XVI that the Subscriber is no longer disabled;
8. The date the Member becomes entitled to Medicare;
9. The date the Employer, or any successor employer or purchaser of the Employer, ceases to provide any group benefit plan to his or her employees; or
10. The date the Member moves out of the plan's service area or commits fraud or deception in the use of services.

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

If your Cal-COBRA continuation under this plan ends in accordance with items 1., 2., 3. or 4. above, you are eligible for medical conversion coverage. We must provide notice of this conversion right within 180 days prior to such termination date.

If your Cal-COBRA continuation coverage under this plan ends because the Group replaces our coverage with coverage from another company, the Group must notify you at least thirty (30) days in advance and let you know what you have to do to enroll for coverage under the new plan for the balance of your Cal-COBRA continuation period.

EXTENSION OF CONTINUATION DURING TOTAL DISABILITY

Note: This section (EXTENSION OF CONTINUATION DURING TOTAL DISABILITY) applies ONLY to Members who began Cal-COBRA continuation coverage effective prior to January 1, 2003.

If, at the time of termination of employment or reduction in hours or at any time during the first sixty (60) days of a Cal-COBRA continuation, a Qualified Beneficiary is determined to be disabled for Social Security purposes, all covered Members may be entitled to up to twenty-nine (29) months of continuation coverage after the original Qualifying Event, as provided below. The Member must furnish us with written notice within thirty (30) days of the Social Security Administration's decision that the Member is no longer Totally Disabled.

Eligibility for Extension. To continue coverage for up to twenty-nine (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 us with proof of the Social Security Administration's determination of disability during the first eighteen (18) months of the Cal-COBRA continuation period and no later than sixty (60) days after the date of the Social Security Administration's determination of such disability.

Cost of Coverage. For the nineteenth (19^{th}) through the twenty-ninth (29^{th}) months that the total disability continues, you must remit to us the cost for extended continuation coverage. This cost (called the "subscription charge") shall be subject to the following conditions:

1. This charge shall be 150% of the applicable rate, depending upon the number of persons covered, and must be remitted to us by you by the first of each month during the period of extended continuation coverage.
2. We must receive the subscription charge from you by the first of each month in order to maintain the extended continuation coverage in force.

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

1. The end of the month following a period of thirty (30) days after the Social Security Administration's final determination that you are no longer Totally Disabled;
2. The end of a period of twenty-nine (29) months from the Qualifying Event;
3. The date the Agreement terminates;
4. The end of the period for which subscription charges are last paid;
5. The date the Member becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a Preexisting Condition of the Member, in which case this Cal-COBRA extension will end at the end of the period for which the Preexisting Condition exclusion or limitation applied;
6. In the case of (a) a Subscriber who is eligible for continuation coverage because of the termination of employment or reduction in hours of the Subscriber's employment (except for gross misconduct) and determined, under Title II or Title XVI of the Social Security Act, to be disabled at any time during the first sixty (60) days of continuation coverage and (b) his or her Spouse or dependent Child who has elected Cal-COBRA coverage, the end of thirty-six (36) months from the Qualifying Event. If the Subscriber is no longer disabled under Title II or Title XVI, benefits shall terminate on the later of thirty-six (36) months from the Qualifying Event or the month that begins more than thirty-one (31) days after the date of the final determination under Title II or Title XVI that the Subscriber is no longer disabled;
7. The date the Member becomes entitled to Medicare;
8. The date the Employer, or any successor employer or purchaser of the Employer, ceases to provide any group benefit plan to his or her employees; or
9. The date the Member moves out of the plan's service area or commits fraud or deception in the use of services.

You must inform us within thirty (30) days of a final determination by the Social Security Administration that you are no longer Totally Disabled.

POST CAL-COBRA CONTINUATION OF COVERAGE FOR QUALIFYING EVENTS OCCURRING FOR AGES 60 AND OVER

Note: This section (POST CAL-COBRA CONTINUATION OF COVERAGE FOR QUALIFYING EVENTS OCCURRING FOR AGES 60 AND OVER) applies ONLY when Subscribers turn sixty (60) years of age prior to January 1, 2005.

Subject to payment of subscription charges stated in the Agreement, coverage under this plan may be continued for the Subscriber, the Subscriber's Spouse and the Subscriber's former Spouse (if any) under Section 1373.621 of the Health and Safety Code, in accordance with the following provisions. This continuation may be elected following the CAL-COBRA CONTINUATION OF COVERAGE shown above.

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

Requirements: The Subscriber, Spouse and former Spouse may continue coverage under this plan if:

1. The Subscriber, or the Subscriber on behalf of himself or herself and the Spouse, was entitled to, and had elected to continue coverage under, Cal-COBRA as described in the preceding section;
2. The Subscriber or Spouse has not elected to continue coverage under any other available continuation;
3. The Subscriber has worked for the Employer for at least five (5) years prior to termination of employment; and
4. The Subscriber is at least sixty (60) years old on the date employment with the Group ended.

The former Spouse may continue coverage under this plan in accordance with this section if he or she was covered as a Qualified Beneficiary under Cal-COBRA.

TERMS OF CAL-COBRA EXTENSION OF CONTINUATION OF COVERAGE

Note: This section (TERMS OF CAL-COBRA EXTENSION OF CONTINUATION OF COVERAGE) applies ONLY when Subscribers turn sixty (60) years of age prior to January 1, 2005.

Notice and Election. We will notify you and your Spouse or former Spouse of the right to an extension in your continuation of coverage at least ninety (90) days prior to the date continuation of coverage under Cal-COBRA is scheduled to end.

If you choose to continue coverage, you must notify us in writing within thirty (30) days prior to the end of your Cal-COBRA continuation period.

If you fail to elect the extended Cal-COBRA continuation during the Post Cal-COBRA election period, you may not elect the Cal-COBRA continuation at a later date.

Cost of Coverage. You must pay us the premium required under the Agreement for your Cal-COBRA extended coverage, and the notice of your Cal-COBRA extended coverage right, which you will receive from us, will include the amount of the required premium payment. This premium, also sometimes called the "subscription charge," must be remitted to us by the first of each month during the Cal-COBRA extended continuation period and shall be 110% of the rate applicable to a Member for whom a Qualifying Event has not occurred. **We must receive payment of the subscription charge from you by the first of each month in order to maintain the coverage in force.**

Besides applying to the Subscriber, the Subscriber's rate also applies to a Spouse or former Spouse whose Cal-COBRA continuation began due to divorce, separation or death of the Subscriber.

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

1. The date the Agreement terminates;
2. The end of the period for which subscription charges are last paid;
3. The date the Member becomes covered under any other group health plan;
4. The date the Member becomes entitled to Medicare;
5. For a Spouse or former Spouse of the Subscriber, five (5) years from the date on which continuation coverage under Cal-COBRA was scheduled to end for the Subscriber;
6. In the case of (a) a Subscriber who is eligible for continuation coverage because of the termination of employment or reduction in hours of the Subscriber's employment (except for gross misconduct) and determined, under Title II or Title XVI of the Social Security Act, to be disabled at any time during the first sixty (60) days of continuation coverage and (b) his or her Spouse or dependent Child who has elected Cal-COBRA coverage, the end of thirty-six (36) months from the Qualifying Event. If the Subscriber is no longer disabled under Title II or Title XVI, benefits shall terminate on the later of thirty-six (36) months from the Qualifying Event or the month that begins more than thirty-one (31) days after the date of the final determination under Title II or Title XVI that the Subscriber is no longer disabled;
7. The date on which the Employer or former employer terminates its Group Benefit Agreement with the health care services plan and no longer provides coverage for any active employees through the plan;
8. The date the Member reaches age 65;
9. The date the Employer, or any successor employer or purchaser of the Employer, ceases to provide any group benefit plan to his or her employees; or
10. The date the Member moves out of the plan's service area or commits fraud or deception in the use of services.

If your Cal-COBRA continuation under this plan ends in accordance with items 1. or 5. above, you may be eligible for medical conversion coverage. We must provide notice of this conversion right within 180 days prior to such termination date.

If your Cal-COBRA continuation coverage under this plan ends because the Group replaces our coverage with coverage from another company, the Group must notify you at least thirty (30) days in advance and let you know what you have to do to enroll for coverage under the new plan for the balance of your Cal-COBRA continuation period.

PART XX CONTINUATION OF COVERAGE COBRA

Most employers who employ twenty (20) or more people on a typical business day are subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If the Employer who provides coverage under the Agreement is subject to the federal law which governs this provision (Title X of P.L. 99-272), you may be entitled to 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 appears 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" section.

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 the Agreement as either a Subscriber or Family Member, (b) a Child who is born to or placed for adoption with the Subscriber during the COBRA continuation period, or (c) a Child for whom the Subscriber or Spouse has been appointed permanent legal guardian by final court decree or order 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, adoptees, and children of permanent legal guardians as specified above.

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

A. **For Subscriber and Family Members:**

1. The Subscriber's termination of employment, for any reason other than gross misconduct; or
2. A reduction in the Subscriber's work hours.

B. **For Retired Employees and their Family Members.** Cancellation or a substantial reduction of retiree benefits under the plan due to the Group's filing for Chapter 11 bankruptcy, provided that:

1. The Agreement expressly includes coverage for retirees; and
2. Such cancellation or reduction of benefits occurs within one year before or after the Group's filing for bankruptcy.

C. **For Family Members:**

1. The death of the Subscriber;
2. The Spouse's divorce or legal separation from the Subscriber;
3. The end of a Child's status as a dependent Child, as defined by the Agreement; or
4. The Subscriber's entitlement to Medicare.

ELIGIBILITY FOR COBRA CONTINUATION

A Subscriber or Family Member may choose to continue coverage under the Agreement if his or her coverage would otherwise end for a Qualifying Event.

Exception: A Member is not entitled to continue coverage if, at any time of the Qualifying Event, that Member is: 1) entitled to Medicare*; or 2) covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a Preexisting Condition of the Member. If one Member is unable to continue coverage for these reasons, other entitled Members may still choose to continue their coverage.

*Entitlement to Medicare will not preclude a person from continuing coverage for which the person became eligible due to Qualifying Event B.

TERMS OF COBRA CONTINUATION

Notice. The Group or its administrator (we are not the administrator) will notify either the Subscriber or Family Member of the right to continue coverage under COBRA, as provided below:

1. For Qualifying Events A. or B. above, the Group or its administrator will notify the Subscriber of the right to continue coverage.
2. For Qualifying Events C (1) or C (4) above, a Family Member will be notified of the COBRA continuation right.
3. You must inform the Group within sixty (60) days of Qualifying Events C (2) or C (3) above if you wish to continue coverage. The Group in turn will promptly give you official notice of the COBRA continuation right.

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

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

Notice of continued coverage, along with the initial subscription charge, must be delivered to us by the Group within forty-five (45) days after you elect COBRA continuation coverage.

Additional Family Members. A Spouse or Child acquired during the COBRA continuation period is eligible to be enrolled as a Family Member. The standard enrollment provisions of the Agreement apply to enrollees during the COBRA continuation period.

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

Besides applying to the Subscriber, the Subscriber's rate also applies to:

1. A Spouse whose COBRA continuation began due to divorce, separation or death of the Subscriber;
2. A Child if neither the Subscriber nor the Spouse has enrolled for this COBRA continuation coverage (if more than one Child is so enrolled, the subscription charge will be the two-party or three-party rate depending on the number of children enrolled); and
3. A Child whose COBRA continuation began due to the person no longer meeting the dependent Child definition.

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

For example, a Child may have been originally eligible for COBRA continuation due to termination of the Subscriber 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 to remain covered for the balance of the continuation period which would end no later than thirty-six (36) months from the date of the original Qualifying Event (the termination of employment).

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

For Family Members properly enrolled during the COBRA continuation, coverage begins according to the enrollment provisions of the Agreement.

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

1. The end of eighteen (18) months from the Qualifying Event, if the Qualifying Event was termination of employment or reduction in work hours;*
   Note: (For Members beginning COBRA continuation coverage effective January 1, 2003 or later ONLY.) At the end of eighteen (18) months, you have the option to continue coverage under Cal-COBRA for the balance of thirty-six (36) months (COBRA and Cal-COBRA combined). All COBRA eligibility must be exhausted before the Member is eligible to continue coverage under Cal-COBRA.
2. The end of thirty-six (36) months from the Qualifying Event, if the Qualifying Event was the death of the Subscriber, divorce or legal separation, or the end of dependent Child status;*
3. The end of thirty-six (36) months from the date the Subscriber became entitled to Medicare, if the Qualifying Event was the Subscriber's entitlement to Medicare;
4. The date the Agreement terminates;
5. The end of the period for which subscription charges are last paid;
6. The date the Member becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a Preexisting Condition of the Member, in which case this COBRA continuation will end at the end of the period for which the Preexisting Condition exclusion or limitation applied; or
7. The date the Member becomes eligible for Medicare.

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

Subject to the Agreement remaining in effect, a retired Subscriber whose COBRA continuation coverage began due to Qualifying Event B. may be covered for the remainder of his or her life; that person's covered Family Members may continue coverage for thirty-six (36) months after the Subscriber's death. But, coverage could terminate prior to such time for either the Subscriber or Family Member in accordance with items 4., 5. or 6. above.

If your COBRA continuation under this plan ends in accordance with items 1. or 2., you are eligible for medical conversion coverage. The Group will provide notice of this conversion right within 180 days prior to such termination date.

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 sixty (60) days of COBRA, the Qualified Beneficiary is determined to be disabled for Social Security purposes, all covered Members may be entitled to up to twenty-nine (29) months of continuation coverage after the original Qualifying Event.

Eligibility for Extension. To continue coverage for up to twenty-nine (29) months from the date of the original Qualifying Event, the disabled Member must:

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

Notice. The Member must furnish the Group with proof of the Social Security Administration's determination of disability during the first eighteen (18) months of the COBRA continuation period and no later than sixty (60) days after the date of the Social Security Administration's determination of such disability.

Cost of Coverage. For the nineteenth (19^{th}) through the twenty-ninth (29^{th}) months that the total disability continues, the Group must remit to us the cost for extended continuation coverage. This cost (called the "subscription charge") shall be subject to the following conditions:

1. This charge shall be 150% of the applicable rate, depending upon the number of persons covered, and must be remitted to us by the Group by the first of each month during the period of extended continuation coverage.
2. The Group may require that you pay the entire cost of the extended continuation coverage.
3. We must receive timely payment of the subscription charge from the Group by the first of each month in order to maintain the extended continuation coverage in force.

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

1. The end of the month following a period of thirty (30) days after the Social Security Administration's final determination that you are no longer Totally Disabled;
2. The end of twenty-nine (29) months from the Qualifying Event;
   Note: (For Members beginning COBRA continuation coverage effective January 1, 2003 or later ONLY.) At the end of twenty-nine (29) months, you have the option to continue coverage under Cal-COBRA for the balance of thirty-six (36) months (COBRA and Cal-COBRA combined). All COBRA eligibility must be exhausted before the Member is eligible to continue coverage under Cal-COBRA.
3. The date the Agreement terminates;
4. The end of the period for which subscription charges are last paid;
5. The date the Member becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a Preexisting Condition of the Member, in which case this COBRA extension will end at the end of the period for which the Preexisting Condition exclusion or limitation applied; or
6. The date the Member becomes entitled to Medicare.

You must inform the Group within thirty (30) days of a final determination by the Social Security Administration that you are no longer Totally Disabled.

POST-COBRA CONTINUATION FOR QUALIFYING MEMBERS

Note: This section (POST COBRA CONTINUATION FOR QUALIFYING MEMBERS) applies ONLY when Subscribers turn sixty (60) years of age prior to January 1, 2005.

Subject to payment of subscription charges as stated in the Agreement, coverage under this plan may be continued for the Subscriber, the Subscriber's Spouse and the Subscriber's former Spouse (if any) under Section 1373.621 of the Health and Safety Code and Section 2800.2 of the Labor Code, in accordance with the following provisions. This continuation may be elected following the CONTINUATION OF COVERAGE shown above (the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), or Title X of P.L. 99-272).

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

Requirements. The Subscriber and Spouse may continue coverage under this plan if:

A. The Subscriber, or the Subscriber on behalf of himself or herself and the Spouse, was entitled to, and had elected to continue coverage under, COBRA as described in the preceding section;
B. The Subscriber or Spouse has not elected to continue coverage under any other available continuation;
C. The Subscriber has worked for the Employer for at least the prior five (5) years; and
D. The Subscriber is at least sixty (60) years old on the date employment with the Group ended.

The former Spouse may continue coverage under this plan in accordance with this section if he or she was covered as a Qualified Beneficiary under COBRA, as described in the preceding section.

Notice and Election. The Group or its administrator (we are not the administrator) will notify the Subscriber or Spouse and former Spouse of the right to continue coverage at least ninety (90) days prior to the date continuation of coverage under COBRA is scheduled to end.

For the Subscriber and Spouse, this continuation may be chosen for both, the Subscriber only, or for the Spouse only. The former Spouse may elect this continuation for himself or herself only.

To elect this continuation, you must notify the Employer in writing within thirty (30) days prior to the date continuation coverage under COBRA is scheduled to end. If you fail to elect this continuation when first eligible, you may not elect this continuation at a later date. Notice of continued coverage, along with the initial subscription charge, must be delivered to us by the Group within forty-five (45) days after you elect this continuation.

Cost of Coverage. This continuation is subject to payment of subscription charges to the Employer at the time the Group subscription charge is due. The Group may require that you pay the entire cost of your continuation coverage. The Group is responsible to us for the timely payment of subscription charges due for the continuation of your coverage under this Combined Evidence of Coverage and Disclosure Form.

The rates for continuation coverage under this section are as follows:

- For the Subscriber and Spouse, the rate shall be 102% of the applicable Group rate. For the purpose of determining subscription charges payable, the Spouse continuing coverage alone will be considered to be a Subscriber.

- For a former Spouse, the rate shall be 102% of the applicable Group rate.

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

- The end of the period for which subscription charges are last paid;
- The date the Agreement terminates;
- The date the Subscriber, Spouse or former Spouse becomes covered under any group health plan not maintained by the Employer;
- The date the Subscriber, Spouse or former Spouse becomes entitled to Medicare;
- The date the Subscriber, Spouse or former Spouse reaches age sixty-five (65); or
- For the Spouse or former Spouse, five (5) years from the date the Spouse's or former Spouse's COBRA continuation coverage ended.

If your continuation under this plan ends in accordance with item 6., you are eligible for medical conversion coverage.

CONTINUATION FOR QUALIFYING FAMILY MEMBERS

Subject to payment of subscription charges as stated in the Agreement, coverage under this plan may be continued for enrolled Family Members of a Subscriber in accordance with the following provisions. You may elect this continuation instead of, or following, the CONTINUATION OF COVERAGE shown above (the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), or Title X of P.L. 99-272). **However, for an eligible Spouse, this continuation may not be elected if the POST-COBRA CONTINUATION FOR QUALIFYING MEMBERS described in the previous section was elected.**

A. QUALIFYING EVENTS FOR CONTINUATION COVERAGE

Coverage may be continued by an eligible Family Member if that coverage would otherwise end because of:

1. The death of the Subscriber,
2. Notice of the final decree of divorce, annulment or dissolution of marriage between the Subscriber and the enrolled Spouse, or
3. The Subscriber's entitlement to Medicare.

Eligible Family Members. The following Family Members may continue coverage:

1. Surviving Spouse,
2. Divorced Spouse of the Subscriber, and
3. Dependent Child (except a Child of a divorced Spouse of the Subscriber who remains enrolled as a Family Member of that Subscriber).

Note: Eligibility for coverage as Family Members is determined according to the eligibility requirements described under the Part entitled "WHO IS COVERED AND WHEN."

B. TO ELECT THIS CONTINUATION

To elect this continuation, the Family Member (or guardian for a Child under age 18) must properly file an application within thirty-one (31) days from the Qualifying Event. An application is considered properly filed only if all requested information is supplied and the application is personally signed, dated, and given to the Group within thirty-one (31) days of the Qualifying Event. We must receive this application from the Group within ninety (90) days.

This continuation coverage may be chosen for all eligible Family Members, or only for selected Members. However, if the Member fails to elect the continuation when first eligible, that Member may not elect the continuation at a later date.

C. **WHEN CONTINUATION ENDS**

This continuation will end on the earliest of:

1. The end of the period for which subscription charges were last paid;
2. The date the Agreement terminates;
3. The end of ninety (90) days from the date the Family Member's continuation coverage began;
4. The date the Family Member moves outside California*;
5. The date the surviving or divorced Spouse remarries*;
6. The date the Family Member becomes eligible for any comparable state, federal or private group medical plan*;
7. The date the Family Member becomes eligible for coverage under an employer group health plan*;
8. The date a dependent Child is no longer eligible due to age*;
9. The date the Family Member knowingly furnishes incorrect information or otherwise improperly obtains benefits of the plan;
10. The date the Subscriber or Spouse is no longer the permanent legal guardian.*

*This continuation coverage will not end for the other eligible Family Members if item 4., 6., 7., 8., or 10. above applies to a dependent Child.

D. **PAYMENT OF SUBSCRIPTION CHARGES**

The Group is responsible to Anthem Blue Cross for the timely payment of subscription charges due for the continuation of any Member's coverage under this plan. For purposes of determining subscription charges payable, the surviving or divorced Spouse will be considered to be a Subscriber.

PART XXI GUARANTEED ACCESS TO COVERAGE FOR FEDERALLY ELIGIBLE DEFINED INDIVIDUALS

A health care service plan or insurance company that offers hospital, medical or surgical benefits under an individual health care service plan contract or insurance policy may not decline to offer coverage to, or deny enrollment of, a federally eligible defined individual or impose any Preexisting Condition with respect to the coverage. A federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides that if you lose group health coverage and meet the criteria below, you are entitled to purchase individual health coverage from any health care service plan or insurance company that sells individual coverage for hospital, medical or surgical benefits. A health plan cannot reject your application if you are an eligible person under HIPAA, you agree to pay the required premiums, and you live or work within the plan's service area.

A federally eligible individual is an individual who, as of the date on which the individual seeks coverage under this provision, meets all of the following conditions:

1. Has had eighteen (18) or more months of creditable coverage without a break of sixty-three (63) days or more between any of the periods of creditable coverage or since the most recent coverage was terminated, and whose most recent creditable coverage was under a group health plan (including Cal-COBRA or COBRA), a federal government plan maintained for federal employees, or a governmental plan or church plan as defined in the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1002), and
2. Is not eligible for coverage under a group health plan, Medicare, or Medi-Cal, and does not have any other health coverage, and
3. Was not terminated from his or her most recent creditable coverage due to nonpayment of premiums or fraud, and
4. If offered continuation coverage under COBRA or Cal-COBRA, has elected and exhausted that coverage.

Creditable coverage means:

1. Any individual or group policy, contract, or program that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other plans. The term includes continuation or conversion coverage but does not include accident only, credit, coverage for on-site medical clinics, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.
2. The federal Medicare program pursuant to Title XVIII of the Social Security Act.
3. The Medicaid program pursuant to Title XIX of the Social Security Act.
4. Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.
5. 10 U.S.C.A. Chapter 55 (commencing with Section 1071) (CHAMPUS).

6. A medical care program of the Indian Health Service or of a tribal organization.
7. A state health benefits risk pool.
8. A health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901) (FEHBP).
9. A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the Public Health Service Act, as amended by Public Law Section 104-191, the Health Insurance Portability and Accountability Act of 1996.
10. A health benefit plan under 22 U.S.C.A. 2504(e) of the Peace Corps Act.
11. Any other creditable coverage as defined by subdivision (c) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg (c)).

PART XXII DEFINITIONS

Here are the meanings of some of the words or terms used in this booklet. While reading this booklet, if you see a term that is capitalized you should refer to these definitions.

Agreement is the Group Benefit Agreement issued by Anthem Blue Cross to the Employer (Group) as a means of providing certain benefits to the employees and the eligible dependents of the employees.

Agreement Date is the date the Agreement between Anthem Blue Cross and the Employer comes into effect.

Ambulatory Surgical Center is a freestanding outpatient surgical facility. It must be licensed 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 Healthcare Organizations or the Accreditation Association of Ambulatory Health Care.

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

Authorized Referral (out-of-network referral) occurs when a Member, because of his or her medical needs requires the services of a specialist who is a Non-Participating Physician or requires special services or facilities not available at a Participating Hospital, but only when:

- There is no Participating Physician who practices in the appropriate specialty or there is no Participating Hospital, Participating Ambulatory Surgical Center, or Participating Hospice which provides the required services or has the necessary facilities within a thirty (30) mile radius of the principal residential address as reflected on our files or within the county in which the principal residence is located, whichever is less, and
- The referral has been authorized by us ***before*** services are rendered.

Child is the Subscriber's, Spouse's, or Domestic Partner's natural Child, stepchild, legally adopted Child, Child placed in the physical custody of the parent for legal adoption, or Child for whom the Subscriber, Spouse or Domestic Partner has been appointed permanent legal guardian by final court decree or order.

Contracting Hospital is a Hospital that has a contract with us to provide care to our Members; however, this does not necessarily make it a Participating Hospital.

Copayment is the amount of Covered Expense you are responsible for paying. Copayment does not include charges for services that are not Covered Services or charges in excess of Covered Expense.

Cosmetic Surgery is surgery that is performed to alter or reshape normal structures of the body in order to improve appearance. **Reconstructive Surgery** is surgery that is Medically Necessary and appropriate and is performed to correct or repair abnormal structure of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to do either of the following: (1) to improve function or (2) recreate a normal appearance, to the extent possible. **Note:** Cosmetic Surgery does not become Reconstructive Surgery because of psychological or psychiatric reasons.

Covered Expense is the expense you incur for Covered Services, but for some services the amount of Covered Expense will be limited to a maximum amount that is described in the benefit sections of this Combined Evidence of Coverage and Disclosure Form.

Covered Services are Medically Necessary services or supplies which are listed in the benefit sections of this Combined Evidence of Coverage and Disclosure Form and for which you are entitled to receive benefits.

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; administration of medicine which is usually self-administered; or any other care which does not require continuing services of a medical professional.

Day Treatment Program Center is an outpatient Hospital based program that is licensed according to state and local laws to provide outpatient care and treatment of Mental or Nervous Disorders and Substance Abuse under the supervision of psychiatrists.

Deductible means the amount of Covered Expense you must pay for Covered Services before certain benefits are available to you under this Combined Evidence of Coverage and Disclosure Form. Your annual Deductible is stated in the Part entitled "ANNUAL DEDUCTIBLE, COPAYMENTS, MAXIMUM ALLOWED AMOUNT AND ANNUAL MAXIMUM PAYMENT LIMITS." Your Prescription Drug Deductible is stated in the Part entitled "YOUR PRESCRIPTION DRUG BENEFITS."

Designated Non-Contracting Hospital is a Non-Contracting Hospital for which Anthem Blue Cross has established a temporary arrangement and rate to charge our Members for Covered Services provided under this Combined Evidence of Coverage and Disclosure Form. This arrangement will apply only to Covered Services received during the specified time frame. No benefits are available for services received outside of that time frame, except for Medical Emergencies. A list of Designated Non-Contracting Hospitals may be obtained by accessing our web site at **www.anthem.com/ca**, by calling our customer service department toll free at (800) 627-8797, or by writing to us at Anthem Blue Cross, P.O. Box 60007, Los Angeles, CA, 90060-0007.

Diabetes Equipment and Supplies means the following items for the treatment of Insulin-using diabetes or non-Insulin-using diabetes and gestational diabetes as Medically Necessary or medically appropriate:

- blood glucose monitors
- blood glucose testing strips
- blood glucose monitors designed to assist the visually impaired
- Insulin pumps and related necessary supplies
- ketone urine testing strips
- lancets and lancet puncture devices
- pen delivery systems for the administration of Insulin
- podiatric devices to prevent or treat diabetes-related complications
- Insulin syringes
- visual aids, excluding eyewear, to assist the visually impaired with proper dosing of Insulin

Diabetes Outpatient Self-Management Training Program includes training provided to a qualified Member after the initial diagnosis of diabetes in the care and management of that condition, including nutritional counseling and proper use of Diabetes Equipment and Supplies; additional training authorized on the diagnosis of a Physician or other health care practitioner of a significant change in the qualified Member's symptoms or condition that requires changes in the qualified Member's self-management regime; and periodic or episodic continuing education training when prescribed by an appropriate health care practitioner as warranted by the development of new techniques and treatments for diabetes. Diabetes Outpatient Self-Management Training must be provided by a health care practitioner or provider who is licensed, registered or certified in California to provide appropriate health care services.

Domestic Partners are two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring. Further, they must have either filed a Declaration of Domestic Partnership with the Secretary of State of the state of California in accordance with Section 298.5 of the Family Code, or have been issued an equivalent document by a local agency of California, another state, or a local agency of another state under which the partnership was created. A Domestic Partner must meet the plan's eligibility requirements for Domestic Partners outlined under the Part entitled "WHO IS COVERED AND WHEN."

Effective Date is the date the Member's coverage under this Combined Evidence of Coverage and Disclosure Form begins. It appears on the Subscriber's identification card.

Employer (Group) is the person, company, corporation, partnership or other entity (depending on the legal form of organization) which has entered into a contract with Anthem Blue Cross to provide the benefits of this Combined Evidence of Coverage and Disclosure Form.

Employer Effective Date is the date this Combined Evidence of Coverage and Disclosure Form became effective under the terms of the Agreement.

Experimental Procedures (Experimental) are those that are mainly limited to laboratory and/or animal research, but which are not generally accepted as proven and effective procedures within the organized medical community. Anthem Blue Cross has discretion to make this determination. However, if a Member has a life-threatening or seriously debilitating condition and Anthem Blue Cross determines that requested treatment is not a Covered Service because it is Experimental, the Member may request an Independent Medical Review. Please refer to the Part entitled "GRIEVANCE PROCEDURES."

Facility Based Treatment for Mental or Nervous Disorders and Substance Abuse (Facility Based Treatment) is treatment rendered in, including, but not limited to, an acute psychiatric facility, Hospital, psychiatric health facility, residential treatment center or Day Treatment Program Center.

Family Members are members of the Subscriber's family who are eligible and accepted under this Combined Evidence of Coverage and Disclosure Form.

Guaranteed Association means a nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or employer meeting its membership criteria, and that (1) includes one or more small employers as defined in state law, (2) does not condition membership directly or indirectly on the health or claims history of any person, (3) uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered to the association, (4) is organized and maintained in good faith for purposes unrelated to insurance, (5) has been in active existence on January 1, 1992, and for at least five years prior to that date, (6) has included health insurance as a membership benefit for at least five years prior to January 1, 1992, (7) has a constitution and bylaws, or other analogous governing documents that provide for election of the governing board of the association by its members, (8) offers any plan contract that is purchased to all individual members and employer members in this state, (9) includes any member choosing to enroll in the plan contracts offered to the association provided that the member has agreed to make the required premium payments, and (10) covers at least 1,000 persons with the health care service plan with which it contracts. The requirement of 1,000 persons may be met if component chapters of a statewide association contracting separately with the same carrier cover at least 1,000 persons in the aggregate.

Home Health Agencies and Visiting Nurse Associations which are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in your home, and they must be approved as a home health care provider under Medicare and the Joint Commission on Accreditation of Healthcare 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 Participating 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 Healthcare Organizations.

For the purposes of Severe Mental Illness and Serious Emotional Disturbances of a Child, a Hospital will be a residential treatment center, and an acute psychiatric facility which is a Hospital specializing in psychiatric treatment or a designated psychiatric unit of a Hospital licensed by the state to provide 24-hour acute inpatient care for persons with psychiatric disorders. For the purposes of this plan, the term acute psychiatric facility also includes psychiatric health facilities which are acute 24-hour facilities as defined in California Health and Safety Code 1250.2. They must be:

- licensed by the California Department of Health Services;
- qualified to provide short-term inpatient treatment according to state law;
- accredited by the Joint Commission on Accreditation of Healthcare Organizations;

- staffed by an organized medical or professional staff which includes a Physician as medical director; and
- actually providing an acute level of care.

Host Blue is an independent licensee of the Blue Cross and Blue Shield Association that participates in the Association's BlueCard Program, which allows our Members to have the reciprocal use of participating providers that contract with other Blue Cross and/or Blue Shield Plans. If you are outside California and require medical care or treatment, you may use a local Blue Cross and/or Blue Shield Provider that has an agreement with the Host Blue. If you use one of these providers, your out-of-pocket expenses may be lower than those incurred when using a provider that does not participate with a local Blue Cross and/or Blue Shield Plan. (Please also see the definition of "Negotiated Price.")

Infertility is the inability to:

- conceive after sexual relations without contraceptives for the period of one year; or
- maintain a pregnancy until fetal viability.

Infusion Therapy is the administration of Drugs (Prescription substances) by the intravenous (into a vein), intramuscular (into a muscle), subcutaneous (under the skin), and intrathecal (into the spinal canal) routes. For the purpose of this Combined Evidence of Coverage and Disclosure Form, it shall also include Drugs administered by aerosol (into the lungs) and by a feeding tube.

Investigational Procedures (Investigational) are those:

- that have progressed to limited use on humans, but which are not generally accepted as proven and effective procedures within the organized medical community; or
- that do not have final approval from the appropriate governmental regulatory body; or
- that are not supported by scientific evidence which permits conclusions concerning the effect of the service, Drug or device on health outcomes; or
- that do not improve the health outcome of the patient treated; or
- that are not as beneficial as any established alternative; or
- whose results outside the Investigational setting cannot be demonstrated or duplicated; or
- that are not generally approved or used by Physicians in the medical community.

Anthem Blue Cross has discretion to make this determination. However, if a Member has a life-threatening or seriously debilitating condition and Anthem Blue Cross determines that requested treatment is not a Covered Service because it is Investigational, the Member may request an Independent Medical Review. Please refer to the Part entitled "GRIEVANCE PROCEDURES."

Maximum Allowed Amount for this plan is the maximum amount of reimbursement we will allow for Covered Services and supplies. See the section entitled "Maximum Allowed Amount" in the Part entitled "ANNUAL DEDUCTIBLE, COPAYMENTS, MAXIMUM ALLOWED AMOUNT AND ANNUAL MAXIMUM PAYMENT LIMITS."

Medical Emergency, as determined by us, means a sudden onset of a medical or Psychiatric Emergency Medical Condition manifesting itself by acute symptoms of sufficient severity including, without limitation, sudden and unexpected severe pain that the absence of immediate medical or psychiatric attention could reasonably result in:

- permanently placing the Member's health in jeopardy, or
- causing other serious medical or psychiatric consequences, or
- causing serious impairment to bodily functions, or
- causing serious dysfunction of any bodily organ or part.

Medical Emergency includes being in active labor when there is inadequate time for a safe transfer to another Hospital prior to delivery, or when such a transfer would pose a threat to the health and safety of the Member or unborn Child.

Medically Necessary shall mean health care services that a Physician, exercising professional clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice,
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease, and
- Not primarily for the convenience of the patient, Physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician specialty society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Member shall mean both the Subscriber and all other Family Members who are enrolled for coverage under this Combined Evidence of Coverage and Disclosure Form.

Mental or Nervous Disorders and Substance Abuse are conditions that affect thinking and the ability to figure things out, perception, mood and behavior. A Mental or Nervous Disorder is recognized primarily by symptoms or signs that appear as distortions of normal thinking, distortions of the way things are perceived (for example, seeing or hearing things that are not there), moodiness, sudden and/or extreme changes in mood, depression, and/or unusual behavior such as depressed behavior or highly agitated or manic behavior. Some Mental or Nervous Disorders are: schizophrenia; manic depressive and other conditions usually classified in the medical community as psychosis; drug, alcohol or other substance addiction or abuse; depressive phobic, manic and anxiety conditions (including panic disorders); bipolar affective disorders including mania and depression; obsessive compulsive disorders; hypochondria; personality disorders (including paranoid, schizoid, dependent, antisocial and borderline); dementia and delirious states; post traumatic stress disorder; hyperkinetic syndromes (including attention deficit disorders); adjustment reactions; reactions to stress; anorexia nervosa and bulimia. Severe Mental Illness, Serious Emotional Disturbances of a Child and any condition meeting these definitions is a Mental or Nervous Disorder no matter what the cause. One or more of these conditions may be specifically excluded in this Combined Evidence of Coverage and Disclosure Form.

However, medical services provided to treat medical conditions that are caused by behavior of the Member that may be associated with these mental conditions (for example, self-inflicted injuries) and treatment for Severe Mental Illness and Serious Emotional Disturbances of a Child are not subject to this limitation.

Negotiated Price (out-of-area services only) will often 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 Blue Cross uses for your claim because they will not be applied retroactively to claims already paid. For more information on payment for out-of-area services, see the Part entitled "GENERAL PROVISIONS." (Please also see the definition of "Host Blue.")

Non-Contracting Hospital is a Hospital that does not have a standard contract or a Prudent Buyer Plan Participating Hospital agreement with Anthem Blue Cross. No benefits are available for care furnished in Non-Contracting Hospitals, except for Medical Emergencies.

Non-Participating Provider (Non-Participating) is one of the following providers which does NOT have a Prudent Buyer Plan Participating Provider agreement in effect with Anthem Blue Cross for this plan at the time services are rendered:

- Ambulatory Surgical Center
- Clinical laboratory
- Durable medical equipment outlet
- Facility which provides diagnostic imaging services
- Home Health Agency or Visiting Nurse Association
- Home Infusion Therapy provider
- Hospice
- Hospital
- Licensed ambulance company
- Physician
- Retail Health Clinic
- Skilled Nursing Facility
- Urgent Care Center

Only a portion of the amount which a Non-Participating Provider charges for services will be paid by us. For non-Medical Emergency care provided by a Non-Participating Provider, the Member will be responsible for any charges billed by a Non-Participating Provider over the Maximum Allowed Amount specified in this Combined Evidence of Coverage and Disclosure Form. For Medical Emergency care provided by a Non-Participating Provider within the state of California, the Member will **not** be responsible for any charges over the Reasonable and Customary Value. See the Part entitled "NON-PARTICIPATING PROVIDER COMPREHENSIVE BENEFITS AND COPAYMENT LIST" to determine your payment responsibility when using Non-Participating Providers.

Office Visit is when you go to a Physician's office and have one or more of **ONLY** the following three services provided:

- History (gathering of information on an illness or injury)
- Examination
- Medical Decision Making (the Physician's actual diagnosis and treatment plan)

For purposes of this definition, "Office Visit" will not include any other services while at the office of a Physician (e.g., any surgery, Infusion Therapy, diagnostic X-ray, laboratory, pathology, and radiology) or any other services performed other than or in addition to any of the three services specifically listed above.

Participating Provider (Participating) is one of the following providers that has a Prudent Buyer Plan Participating Provider agreement in effect with us and has negotiated certain charges as the Maximum Allowed Amount they will charge our Members for Covered Services under this Combined Evidence of Coverage and Disclosure Form.

- Ambulatory Surgical Center
- Clinical laboratory
- Durable medical equipment outlet
- Facility which provides diagnostic imaging services
- Home Health Agency or Visiting Nurse Association
- Home Infusion Therapy provider
- Hospice
- Hospital
- Licensed ambulance company
- Physician
- Retail Health Clinic
- Skilled Nursing Facility
- Urgent Care Center

Physician means:

- A doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is licensed to practice where the care is provided, or
- One of the following providers, but only when the provider is 1) licensed to practice where the care is provided, 2) rendering a service within the scope of that license and such license is required to render the service, and 3) providing a service for which benefits are specified in this Combined Evidence of Coverage and Disclosure Form:
  - Acupuncturist
  - Audiologist*
  - Certified nurse midwife
  - Certified registered nurse anesthetist
  - Chiropractor (D.C.)
  - Clinical psychologist
  - Dentist (D.D.S.)
  - Dispensing optician

- Licensed clinical social worker (L.C.S.W.)
- Marriage & Family Therapist (M.F.T.)
- Occupational therapist (O.T.R.)*
- Optometrist (O.D.)
- Physical therapist (P.T. or R.P.T.)*
- Physician assistant*
- Podiatrist or chiropodist (D.P.M. or D.S.C.)
- Psychiatric mental health nurse
- Registered nurse practitioner
- Respiratory therapist*
- Speech pathologist*
- Speech therapist*

Note: The providers indicated by asterisks (*) are covered only by referral of a Physician (M.D. or D.O.) as defined above.

Psychiatric Emergency Medical Condition means a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

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

Reasonable and Customary Value: 1) For professional Non-Participating Providers, the Reasonable and Customary Value is determined by using a percentile of billed charges from a database of a third party that takes into consideration various factors, such as the amounts billed for same or similar services, and the geographic locations in which the services were rendered; 2) For facility Non-Participating Providers and Non-Contracting Hospitals, the Reasonable and Customary Value is determined by using a percentile of billed charges from a database of Anthem Blue Cross' actual claims experience, subject to certain thresholds based on each provider's cost-to-charge ratio as reported by the provider to a California governmental agency and the actual claim submitted to us.

Retail Health Clinic is a facility that provides limited basic medical care services to Members on a "walk-in" basis. These clinics normally operate in major Pharmacies or retail stores. Medical services are typically provided by medical professionals who provide basic medical services.

Serious Emotional Disturbances of a Child is defined by the presence of one or more Mental Disorders as identified in the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the Child's age according to expected developmental norm. 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: a) self care, b) school functioning, c) family relationships, or d) ability to function in the community, and either the Child is at risk of being removed from the home or has already been removed from the home, or the Mental Disorder and impairments have been present for more than six (6) months or are likely to continue for more than one (1) year without treatment; 2) the Child displays one of the following: a) psychotic features, b) risk of suicide, or c) risk of violence; 3) the Child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Note: Coverage for Serious Emotional Disturbances of a Child will be provided in accordance with the plan provisions for any other medical diagnosis and not in accordance with the plan provisions for Mental or Nervous Disorders.

Severe Mental Illness includes the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder (manic-depressive illness)
- Major depressive disorders
- Panic disorder
- Obsessive-compulsive disorder
- Anorexia nervosa
- Bulimia nervosa
- Pervasive developmental disorders, including autistic disorder, Rett's syndrome, childhood disintegrative disorder, Asperger's disorder, and other pervasive developmental disorders not otherwise specified including atypical autism

Note: Coverage for Severe Mental Illness will be provided in accordance with the plan provisions for any other medical diagnosis and not in accordance with the plan provisions for Mental or Nervous Disorders.

Skilled Nursing Facility is a facility 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.

Special Footwear is Medically Necessary Special Footwear, orthotic devices and services for foot disfigurements resulting from bone deformity, motor impairment, paralysis, or amputation. This includes, but is not limited to, disfigurement caused by cerebral palsy, arthritis, polio, spina bifida, diabetes, accident, injury or developmental disability. **Note:** Footwear for the treatment of weak, strained or flat feet, corns, calluses, bunions, hammertoes, fissures, plantar warts, cracks, ingrown toenails, or conditions caused by external sources, such as ill-fitting shoes or repeated friction, are not covered under this Combined Evidence of Coverage and Disclosure Form.

Spouse is the Subscriber's Spouse under a legally valid marriage.

Subscriber is the person enrolled according to the eligibility stated in this Combined Evidence of Coverage and Disclosure Form.

Totally Disabled is a person who is unable because of the disability to engage in any occupation to which he or she is suited by reason of training or experience, and is not in fact employed.

Urgent Care means those services necessary to prevent serious deterioration of your health or, in the case of pregnancy, the health of the unborn child, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed. Urgent Care services are not Medical Emergency services.

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, registered 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 us at the customer service number listed on your ID card or you can also search online using the "Provider Finder" function on our website at **www.anthem.com/ca**. Please call the Urgent Care Center directly for hours of operation and to verify that the center can help with the specific care that is needed.

Year is a twelve-month period starting each January 1 at 12:01 a.m. Pacific Standard Time.

The following notice(s) are not part of the Combined Evidence of Coverage and Disclosure Form. They are important mandated notices required by either state or federal law.

- Notice of Language Assistance
- HIPAA Notice of Privacy Practices
- Grievance Procedure
- Women's Health and Cancer Rights
- Member Rights and Responsibilities

Anthem Blue Cross

Language Assistance Notice

Effective January 1, 2009

IMPORTANT: You can get an interpreter at no cost to talk to your doctor or health plan. To get an interpreter or to ask about written information in your language, first call your health plan's phone number at 800-627-8797. Someone who speaks your language can help you. If you need more help, call the HMO Help Center at 888-466-2219.

IMPORTANTE: Puede obtener la ayuda de un interprete sin costo alguno para hablar con su médico o con su plan de salud. Para obtener la ayuda de un interprete o preguntar sobre información escrita en español, primero llame al número de teléfono de su plan de salud al 800-627-8797. Alguien que habla español puede ayudarle. Si necesita ayuda adicional, llame al Centro de ayuda de HMO al 888-466-2219. (Spanish)

重要提示：您與您的醫生或保健計畫交談時，可獲得免費口譯服務。如欲請翻譯員提供口譯，或欲查詢中文書面資 料，請先致電您的保健計畫，電話號碼：800-627-8797。講粵語或國語人士將爲您提供協助。如需更多協助，請致電 HMO 協助中心 888-466-2219。 (Cantonese or Mandarin)

중요: 사나 건강 플랜에 이야기할 때 무료로 통역사를 이용할 수 있습니다 . 통역사를 이용하거나 한국어로 된 서면 정보에관해 문의하려면 먼저 건강 플랜 800-627-8797로 전화하십시오. 한국어 구사자가 도와 드릴 수 있습니다. 도움이 필요하면 HMO 헬프 센터 888-466-2219로 전화하십시오. (Korean)

MAHALAGA: Maaari kang kumuha ng isang tagasalin nang walang bayad upang makipag-usap sa iyong doktor o sa planong pangkalusugan. Upang makakuha ng isang tagapagsalin o magtanong tungkol sa nakasulat na impormasyon sa Tagalog, mangyaring tawagan muna ang numero ng telepono ng iyong planong pangkalusugan sa 800-627-8797. Ang isang tao na nakapagsasalita ng Tagalog ay maaaring tumulong sa iyo. Kung kailangan mo ng dagdag na tulong, tawagan ang Sentro na Tumutulong ng HMO sa 888-466-2219. (Tagalog)

CHÚ Ý QUAN TRỌNG: Quý vị có thể nhận được dịch vụ thông dịch miễn phí khi khám tại bác sĩ hoặc khi liên hệ với chương trình bảo hiểm sức khỏe của quý vị. Để nhận được dịch vụ thông dịch hoặc yêu cầu văn bản thông tin bằng tiếng Việt, trước tiên hãy gọi số điện thoại chương trình bảo hiểm sức khỏe của quý vị theo số 800-627-8797. Sẽ có người nói được tiếng Việt để giúp đỡ quý vị. Nếu quý vị cần được giúp đỡ thêm, hãy gọi Trung tâm Hỗ trợ HMO theo số 888-466-2219. (Vietnamese)

Information that's important to you

Anthem Blue Cross
Health. Join In.℠

Every year, we're required to send you specific information about your rights, your benefits and more. This can use up a lot of trees, so we've combined a couple of these required annual notices. Please take a few minutes to read about:

- State notice of privacy practices
- HIPAA notice of privacy practices
- Breast reconstruction surgery benefits

Want to save more trees? Go to anthem.com/ca and sign up to receive these types of notices by e-mail.

State notice of privacy practices

As mentioned in our Health Insurance Portability and Accountability Act (HIPAA) notice, we must follow state laws that are stricter than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law. This applies to life insurance benefits, in addition to health, dental and vision benefits that you may have.

Your personal information

We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter.

We may collect PI about you from other persons or entities, such as doctors, hospitals or other carriers.

We may share PI with persons or entities outside of our company — without your OK in some cases. If we take part in an activity that would require us to give you a chance to opt out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI.

Because PI is defined as any information that can be used to make judgements about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you.

A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

HIPAA notice of privacy practices

This notice describes how health, vision and dental information about you may be used and disclosed, and how you can get access to this information with regard to your health benefits. Please review it carefully.

We keep the health and financial information of our current and former members private, as required by law, accreditation standards and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.

For health care operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.

For treatment activities: We do not provide treatment. This is the role of a health care provider, such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To you: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To others: You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As allowed or required by law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and with coroners, funeral directors or medical examiners (about decedents). PHI can also be shared with organ donation groups for certain reasons, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for Workers' Compensation, to respond to requests from the U.S. Department of Health and Human Services, and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law.
If you are enrolled with us through an employer-sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Genetic Information: If we use or disclose PHI for underwriting purposes, we are prohibited from using or disclosing PHI that is genetic information of an individual for such purposes.

Your rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI, or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask him or her to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also, let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI.

Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. Customer Service representatives can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How we protect information

We are dedicated to protecting your PHI, and have set up a number of policies and practices to help make sure your PHI is kept secure.

We keep your oral, written and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password-protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who do not belong out of areas where sensitive data is kept. Also, where required by law, our affiliates and nonaffiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Anthem Blue Cross
Health. Join In.℠

Potential impact of other applicable laws

HIPAA (the federal privacy law) generally does not preempt, or override, other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact information

Please call Customer Service at the phone number printed on your ID card. Representatives can help you apply your rights, file a complaint or talk with you about privacy issues.

Copies and changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you, as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Breast reconstruction surgery benefits

If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your Anthem Blue Cross benefits comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.

All applicable benefit provisions will apply, including existing deductibles, copayments and/or co-insurance. Contact your Plan administrator for more information.

Anthem Blue Cross

Important Notice To All Members Regarding Grievance Procedure

(*This notice affects only Department of Managed Health Care regulated Medical and Dental Plans and only applies to Anthem Blue Cross members*).

If you have a question about your eligibility, your plan's benefits or a claim, please call our Customer Service Department at 800-627-8797. You may also write our Customer Service Department concerning your grievance. Our customer service staff will answer your questions and assist in resolving your issue.

If you are not satisfied with the resolution based on your initial inquiry, you may request a copy of the Plan Grievance Form to complete and return to us, or ask our customer service representative to complete the form for you over the telephone. The Plan Grievance Form should be mailed to P.O. Box 9086, Oxnard, CA 93031-9086. Your issue will then become part of our formal grievance process and will be resolved accordingly.

All grievances received by us will be acknowledged in writing. After we have reviewed your grievance, we will send you a written statement on its resolution or pending status. If your case involves an imminent threat to your health, including, but not limited to, the potential loss of life, limb, or major bodily function, review of your grievance will be expedited.

If you are dissatisfied with the resolution of your grievance or if your grievance has not been resolved after at least thirty (30) days, you may submit your grievance to the Department of Managed Health Care for review prior to binding arbitration. If your case involves an imminent threat to your health, as described above, you are not required to complete our grievance process or to wait at least thirty (30) days, but may immediately submit your grievance to the Department of Managed Health Care for review.

If a Member has had coverage denied because proposed treatment is determined by us to be Investigative or Experimental, that Member may ask for review of that denial by an external, independent medical review organization contracting with the Department of Managed Health Care.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **800-627-8797** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **888-HMO-2219** and a TDD line **877-688-9891** for the hearing and speech impaired. The department's Web site, **hmohelp.ca.gov**, has complaint forms, IMR application forms and instructions online.

Your Rights and Responsibilities

We are committed to:

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

You have the right to:

- Participate with your health care professionals and providers in making decisions about your health care.
- Receive the benefits for which you have coverage.
- Be treated with respect and dignity.
- Privacy of your personal health information, consistent with state and federal laws, and our policies.
- Receive information about our organization and services, our network of health care professionals and providers, and your rights and responsibilities.
- Candidly discuss with your physicians and providers appropriate or medically necessary care for your condition, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's members' rights and responsibilities policies.
- Voice complaints or appeals about: our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
- Refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by your physician(s) of the medical consequences.
- Participate in matters of the organization’s policy and operations.

You have the responsibility to:

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

We are committed to providing quality benefits and customer service to our members. Benefits and coverage for services provided under the benefit program are governed by the Subscriber Agreement and not by this Member Rights and Responsibilities statement.