



SHASTA-TRINITY SCHOOLS
INSURANCE GROUP

www.stsigjpa.com

WELLNESS ADVANTAGE PLAN C2D

July 1, 2010
Revised through October 1, 2010

Prudent Buyer Plan
Summary Plan Description

Claims Administered by:

ANTHEM BLUE CROSS

on behalf of

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

IMPORTANT ENROLLMENT INFORMATION

In order to enroll under this Wellness Advantage Plan, an employee must do the following:

Phase 1 – To Be Completed Within 30 Days of Hire Date

- **Step 1** – View New Hire Video on the computer. Your Human Resources Department has the CD or you can view it online at <http://www.shastacoe.com/page.cfm?p=2768>. This takes about 45 minutes to view.
- **Step 2** – Complete the Wellness Assessment online at www.behappystaywell.com (access code: shasta).

Phase 2 – To Be Completed Within 90 Days of Hire Date

- **Step 3** – Get a Wellness Exam or Preventive Care service from your personal physician. If you had a Wellness Exam in the prior 12 months, you may provide your Explanation of Benefits to STSIG to get credit towards completing this step.
- **Step 4** – Attend a JPA-sponsored Health Seminar. STSIG has partnered with Mercy Medical Center Redding for the education component of our program. There will be events throughout the year that you may attend to help you satisfy this step. As an alternative, you may complete at least two online seminars at www.behappystaywell.com (either Healthy Living Programs or Online Seminars).

Participate in Condition Care Program with Anthem

The five chronic conditions that qualify you for participation in Anthem's Condition Care are as follows:

- Asthma
- Heart Failure
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease (CAD)
- Diabetes

Call Condition Care at 800/621-2232 to sign up.

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Dear Plan Beneficiary:

This Summary Plan Description provides a complete explanation of your benefits, limitations and other plan provisions which apply to you.

Employees and covered dependents (“beneficiaries”) are referred to in this booklet as “you” and “your”. The *plan administrator* is referred to as “we”, “us” and “our”.

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

Please read this Summary Plan Description (“*plan description*”) carefully so that you understand all the benefits your *plan* offers. Keep this Summary Plan Description handy in case you have any questions about your coverage.

Important: This is not an insured benefit plan. The benefits described in this *plan description* or any rider or amendments hereto are funded by the *plan administrator* who is responsible for their payment. Anthem Blue Cross Life and Health Insurance Company provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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

TYPES OF PROVIDERS

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

Participating Providers. The *plan* has made available to the *beneficiaries* a network of various types of "Participating Providers". These providers are called "participating" because they have agreed to participate in the *claims administrator's* preferred provider organization program (PPO), called the Prudent Buyer Plan. They have agreed to provide our *beneficiaries* with health care at a special low cost. The amount of benefits payable under this *plan* will be different for *non-participating providers* than for *participating providers*. See the definition of "Participating Providers" in the DEFINITIONS section for a complete list of the types of providers which may be *participating providers*.

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

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

Reproductive Health Care Services. Some *hospitals* and other providers do not provide one or more of the following services that may be covered under your *plan* contract and that you or your *dependent* might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective *physician* or clinic, or call the claims administrator at the customer service telephone number listed on your ID card to ensure that you can obtain the health care services that you need.

Contracting and Non-Contracting Hospitals. Another type of provider is the "contracting hospital". This is different from a *hospital* which is a *participating provider*. The *claims administrator* has contracted with most hospitals in California to obtain certain advantages for patients covered under the *plan*. While only some *hospitals* are *participating providers*, all eligible California hospitals are invited to be *contracting hospitals* and most--over **90%**--accept.

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

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

"Non-Participating Pharmacies" have not agreed to the *prescription drug negotiated rate*.

Centers of Expertise. The *claims administrator* has established the following separate *Centers of Expertise* (COE) networks. The facilities included in each of these COE networks provide the following specified medical services:

- **Transplant Facilities.** Transplant facilities have been organized to provide services for specified organ transplants (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures). Subject to any applicable co-payments/coinsurance or deductibles, these COE's agree to accept the *COE negotiated rate* as payment in full for covered services. **These procedures are covered only at a COE.**

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

A *participating provider* in the Prudent Buyer Plan network is not necessarily a COE facility.

SUMMARY OF BENEFITS

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

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

For your convenience, this summary provides a brief outline of your benefits. You need to refer to the entire *plan description* for more complete information about the benefits, conditions, limitations and exclusions of your *plan*.

Second Opinions. If you have a question about your condition or about a plan of treatment which your *physician* has recommended, you may receive a second medical opinion from another *physician*. This second opinion visit will be provided according to the benefits, limitations, and exclusions of this *plan*. 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.

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

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

DEDUCTIBLES

Calendar Year Deductibles with Wellness Advantage Phase 2

- Individual Deductible..... **\$250**
- Family Deductible **\$750**

Additional Calendar Year Deductibles without Wellness Advantage Phase 2

- Individual Deductible..... **\$250**
- Family Deductible **\$250**

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

- The Calendar Year Deductible will not apply to the following services provided by a *participating* or *non-participating provider*: (a) *physician's* services for routine examinations and immunizations under the Well Baby and Well Child Care benefit; and (b) Routine Physical Exams under the Preventive Care Benefits.
- The Calendar Year Deductible will not apply to office visits to a *physician* who is a *participating* or *non-participating provider*.

Note: This exception only applies to the charge for the visit itself. It does not apply to any other charges made during that visit, such as for testing procedures, surgery, etc.

- The Calendar Year Deductible will not apply to *covered expense* incurred for:
 - a. Physical therapy;
 - b. Speech therapy;
 - c. Ambulance services;
 - d. *Emergency* or non-emergency services provided in a *hospital* emergency room;
 - e. Routine pap smears; and
 - f. Routine mammograms

- The Calendar Year Deductible will not apply to transplant travel expenses in connection with an authorized transplant procedure provided at an approved COE.
- The Calendar Year Deductible will not apply to bariatric travel expense in connection with an authorized bariatric surgical procedure provided at an approved COE.

NON-CERTIFICATION PENALTY

- Non-Certification Penalty applicable to ALL inpatient admissions for *non-participating providers* when pre-service review is not performed.....**20%**

Exception: The Non-Certification Penalty will not apply to *emergency* admissions or services, nor to the services provided by a *participating provider*. See UTILIZATION REVIEW PROGRAM.

CO-PAYMENTS/COINSURANCE

You will be responsible for the following dollar co-payment per visit (if applicable) and/or the applicable percentage coinsurance for *covered expense* you incur:

DOLLAR CO-PAYMENTS

- *Physicians* Office Visit Charges (except for routine physical exams for *beneficiaries* age 7 or over) (*Participating and Non-Participating Provider*) **\$25**

Note: This only applies to the charge for the visit itself. It does not apply to any other charges made during that visit, such as for testing procedures, surgery, etc.

- **Well Baby Care** for *beneficiaries* under age 7 (*Participating and Non-Participating Providers*)..... **\$25**
- Immunizations for covered *children*..... **\$25**
- Physical Therapy and Speech Therapy..... **\$25**
- Emergency Room Services **\$75**
- Ambulance Services (per trip) **\$25**

PERCENTAGE COINSURANCE. You will be responsible for the following percentage coinsurance after subtracting any applicable dollar co-payment.

- **Physician Office Visits**
(Participating and Non-Participating Providers)20%
- **Non-emergency use of emergency room**
(Participating and Non-Participating Providers)30%
- **Emergency room services**
(Participating and Non-Participating Providers)20%
- **X-Ray and Laboratory services**
for other than routine pap smears and mammograms (Participating
and Non-Participating Providers).....20%
- **Skilled Nursing Facility Care**
(Participating Providers)15%
(Non-Participating Providers)40%
- **Home Health Care**
(Participating Providers)15%
(Non-Participating Providers)20%
- **Maternity Care**
(Participating Providers)20%
Participating in Future Moms Program (Participating Providers) ..10%
(Non-Participating Providers)40%
- **Hospital Services**
(Participating Providers)15%
(Non-Participating Providers)40%
- **Medical/Surgical**
(Participating Providers)20%
(Non-Participating Providers)40%
- **Pre-operative Testing**
(Participating Providers)20%
(Non-Participating Providers)40%
- **Physical Therapy and Speech Therapy**
(Participating and Non-Participating Providers)20%
- **Well Baby Care** for beneficiaries under age 7 (Participating and
Non-Participating Providers).....20%
- **Immunizations** for children
(Participating and Non-Participating Providers)No Charge

- **Preventive Care** for beneficiaries age 7 and over (*Participating* and *Non-Participating Providers*)**No Charge**
- **Routine Pap Smears or Routine Mammograms** (*Participating* and *Non-Participating Providers*)**No Charge**
- **Durable Medical Equipment** (*Participating Providers*)**20%**
(*Non-Participating Providers*)**40%**

All Services Other Than Those Previously Listed

- **Participating Providers****20%**
- **Other Health Care Providers** (This includes: certified RN anesthetists, blood banks, ambulance companies and *hospices*)**20%**
- **Non-Participating Providers****30%**

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

***Exceptions:**

- Your Coinsurance for *non-participating providers* will be the same as for *participating providers* for the following services. You may be responsible for charges which exceed *covered expense*.
 - a. *Emergency services* provided by other than a *hospital*;
 - b. The first 48 hours of *emergency services* provided by a *hospital* (the *participating provider* Coinsurance will continue to apply to a *non-participating provider* beyond the first 48 hours if you, in the *claims administrator's* judgment, cannot be safely moved);
 - c. An *authorized referral* from a *physician* who is a *participating provider* to a *non-participating provider* (See UTILIZATION REVIEW PROGRAM);
 - d. Charges by a type of *physician* not represented in the Prudent Buyer Plan network (for example, an audiologist); or
 - e. Cancer Clinical Trials.

- The Emergency Room Dollar Co-Payment will not apply if you are admitted as a *hospital* inpatient immediately following emergency room treatment. This Co-Payment will not apply toward the satisfaction of the Calendar Year Deductible, nor will it apply toward satisfaction of the Out-of-Pocket Amount.
- Your Co-Payment for specified organ transplants (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures) authorized by the *claims administrator* and performed at a designated *COE* will be the same as for *participating providers*. **Services for specified organ transplants are not covered when performed at other than a designated *COE*.** See UTILIZATION REVIEW PROGRAM.

NOTE: No Co-Payment/Coinsurance will be required for the transplant travel expenses authorized by the *claims administrator*. Transplant travel expense is available when the closest *COE* is more than 250 miles from the recipient or donor's residence.

- Your Co-Payment/Coinsurance for bariatric surgical procedures authorized by *claims administrator* and performed at a designated *COE* will be the same as for *participating providers*. **Services for bariatric surgical procedures are not covered when performed at other than a designated *COE*.** See UTILIZATION REVIEW PROGRAM.

NOTE: Co-Payment/Coinsurance do not apply for bariatric travel expenses authorized by the *claims administrator*. Bariatric travel expense is available when the closest *COE* is in excess of 50 miles from the *beneficiary's* residence.

Out-of-Pocket Amount*. After you have made the following total out-of-pocket payments for *covered expense* you incur during a *calendar year*, you will no longer be required to pay a Percentage Co-Insurance for the remainder of that *year*, but you remain responsible for costs in excess of *covered expense*.

Per Individual:

- *Participating providers and other health care providers*..... **\$3,000**
- *Non-participating providers*..... **\$6,000**

Per Family:

- *Participating providers and other health care providers*..... **\$6,000**
- *Non-participating providers*..... **\$12,000**

***Exceptions:**

- Any Dollar Co-Payments per visit that you make will not be applied toward the satisfaction of your Out-of-Pocket Amount. In addition, you will be required to continue to pay your Dollar Co-Payment for such care even after you have reached that amount.
- Expense which is applied toward any penalty, which is incurred for non-covered services or supplies, or which is in excess of the amount of *covered expense*, will not be applied toward your Out-of-Pocket Amount, and is always your responsibility.
- Expense which is applied toward any deductible, which is incurred for non-covered services or supplies, or which is in excess of the amount of *covered expense*, will not be applied toward your Out-of-Pocket Amount, and is always your responsibility.

MEDICAL BENEFIT MAXIMUMS

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

Home Health Care

- For covered home health services **65 visits**
per calendar year

Ambulatory Surgical Center

- For all covered services and supplies **\$350***
**Non-participating providers only*

Preventive Care

- For all *beneficiaries* age 7 and over: Covered office visits and x-ray and lab services for other than routine pap smears or mammograms (*participating provider and non-participating providers*)..... **\$500**
per calendar year*

*Note: Immunizations for *children* are not applied to the \$500 maximum.

Physical Therapy and Physical Medicine

- For covered outpatient services **40**
visits per calendar year

Speech Therapy

- For covered outpatient services **40**
visits per calendar year

Transplant Travel Expense

- For the Recipient and One Companion per Transplant Episode (limited to 6 trips per episode)
 - For transportation to the *COE*..... **\$250**
per trip for each person
for round trip coach airfare
 - For hotel accommodations..... **\$100**
per day, for up to 21 days per trip,
limited to one room,
double occupancy

- For expenses such as meals**\$25**
per day for each person,
for up to 21 days per trip
- For the Donor per Transplant Episode limited to one trip per episode)
 - For transportation to the COE.....**\$250**
for round trip coach airfare
 - For hotel accommodations.....**\$100**
per day, for up to 7 days
 - For expenses such as meals**\$25**
per day, up to 7 days

Bariatric Travel Expense

- For the *beneficiary* (limited to three (3) trips – one pre-surgical visit, the initial surgery and one follow-up visit)
 - For transportation to the COE.....up to **\$130**
per trip
- For the companion (limited to two (2) trips – the initial surgery and one follow-up visit)
 - For transportation to the COE.....up to **\$130**
per trip
- For the *beneficiary* and one companion (for the pre-surgical visit and the follow-up visit)
 - Hotel accommodationsup to **\$100**
per day, for up to 2 days per trip,
limited to one room,
double occupancy
- For one companion (for the duration of the *beneficiary's* initial surgery stay)
 - Hotel accommodationsup to **\$100**
per day, for up to 4 days,
limited to one room,
double occupancy

- For other reasonable expenses (excluding, tobacco, alcohol and drug expenses).....up to **\$25** per day, for up to days per trip

Lifetime Maximum

- For all medical benefits..... **\$5,000,000** during your lifetime

PRESCRIPTION DRUG BENEFITS

Note: This is a Mandatory Mail Order Prescription Drug plan. You are allowed three refills of the same prescription at a retail pharmacy. After that, remaining refills are managed by our state-of-the-art mail service pharmacy. If you use a retail pharmacy after the third refill, you will be responsible for the drug's retail cost.

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

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

Participating Pharmacies

- *Generic Drugs*..... **\$10**
- *Brand Name Drugs:*
 - *Formulary drugs* **\$20**
 - *Non-formulary brand name drugs* **\$30**
- *Compound medications*..... **\$30**

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

Non-Participating Pharmacies*

- *Generic Drugs*..... **\$10**
plus **50%** of the remaining *prescription drug covered expense*

- *Brand Name Drugs:*
 - *Formulary drugs* **\$20**
plus **50%** of the remaining *prescription drug covered expense*

 - *Non-formulary brand name drugs* **\$30**
plus **50%** of the remaining *prescription drug covered expense*

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

- *Generic Drugs*..... **\$20**

- *Brand Name Drugs:*
 - *Formulary drugs* **\$60**

 - *Non-formulary brand name drugs* **\$80**

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

- *Generic Drugs*..... **\$10**

- *Brand Name Drugs:*
 - *Formulary drugs* **\$20**

 - *Non-formulary brand name drugs* **\$30**

PRESCRIPTION DRUG BENEFIT MAXIMUM

Effective October 1, 2010, the plan will pay 100% up to the following amount of *prescription drug covered expense* for *prescription drugs* and over-the-counter-drugs for which your physician has written a prescription for the following:

- Smoking cessation..... **\$ 500**
during your lifetime

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

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

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

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

Mandatory Generic Program

Prescription drugs will always be dispensed by a *pharmacist* as prescribed by your *physician*. Your *physician* may order a *brand name drug* or a *generic drug* for you. You may request your *physician* to prescribe a *brand name drug* for you or you may request the *pharmacist* to give you a *brand name drug* instead of a *generic drug*. Under this *plan*, if a *generic drug* is available, and it is not determined that the *brand name drug* is *medically necessary* for you to have (see PRESCRIPTION DRUG FORMULARY: Prior Authorization below), you will have to pay the co-payment for the *generic drug* plus the difference in cost between the *prescription drug negotiated rate* for the *generic drug* and the *brand name drug*.

Special Programs

From time to time, the *claims administrator* may initiate various programs to encourage you to utilize more cost-effective or clinically-effective *drugs* including, but, not limited to, *generic drugs*, *mail service drugs*, *over-the-counter drugs* or *preferred drug* products. Such programs may involve reducing or waiving co-payments for those *generic drugs*, *over-the-counter drugs*, or the *preferred drug* products for a limited time. If the *claims administrator* initiates such a program, and determines that you

are taking a *drug* for a medical condition affected by the program, you will be notified in writing of the program and how to participate in it.

Half-tab Program

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

YOUR MEDICAL BENEFITS

HOW COVERED EXPENSE IS DETERMINED

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

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

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

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

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

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

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

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

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

DEDUCTIBLES, CO-PAYMENTS/COINSURANCE, NON-CERTIFICATION PENALTY, OUT-OF-POCKET AMOUNTS AND MEDICAL BENEFIT MAXIMUMS

After subtracting any applicable Deductible, Dollar Co-Payment and/or Percentage Coinsurance, benefits will be paid up to the amount of *covered expense*, not to exceed the applicable Medical Benefit Maximum. The Deductible amounts, Co-Payments/Coinsurance, Out-Of-Pocket Amounts and Medical Benefit Maximums are set forth in the SUMMARY OF BENEFITS.

DEDUCTIBLES

Each deductible under this *plan* is separate and distinct from the other. Only charges that are considered *covered expense* will apply toward satisfaction of any deductible.

Calendar Year Deductibles. Each *year*, you will be responsible for satisfying the Individual Calendar Year Deductible before the *plan* begins to pay benefits. If members of an enrolled family pay deductible expense in a *year* equal to the Family Deductible, the Calendar Year Deductible for all family members will be considered to have been met.

CO-PAYMENTS/COINSURANCE

After you have satisfied any applicable deductible, your Percentage Coinsurance will be subtracted from the amount of *covered expense* remaining.

Before the Percentage Coinsurance is applied, any applicable Dollar Co-Payment will first be deducted and then the applicable percentage will be applied to the amount of *covered expense* remaining after any deductible has been met. This will determine the dollar amount of your total Percentage Coinsurance.

OUT-OF-POCKET AMOUNTS

Satisfaction of the Out-of-Pocket Amount. If after you have met your Calendar Year Deductible, you pay Percentage Coinsurance equal to your Out-of-Pocket Amount during a *calendar year*, you will no longer be required to pay any Percentage Coinsurance for any *covered expense* you incur during the remainder of that *year*. Dollar Co-Payments will continue to apply to covered services after the Out-of-Pocket amount has been satisfied.

Participating Providers and Other Health Care Providers. Only *covered expense* for the services of a *participating provider* or *other health care provider* will be applied to the *participating provider* and *other health care provider* Out-of-Pocket Amount.

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

Non-Participating Providers. Only *covered expense* for the services of a *non-participating provider* will be applied to the *non-participating provider* Out-of-Pocket Amount. After this Out-of-Pocket Amount has been satisfied during a *calendar year*, you will no longer be required to pay any Percentage Coinsurance for the covered services provided by a *non-participating provider* for the remainder of that *year*.

Charges Which Do Not Apply Toward the Out-of-Pocket Amount.

The following charges will not be applied toward satisfaction of the Out-of-Pocket Amount:

- Charges which are not considered *covered expense*;
- Any expense applied to a deductible;
- Any expense applied to the non-certification penalty;
- Dollar Co-payments for services listed in the SUMMARY OF BENEFITS.

In addition, you will continue to be required to pay your Dollar Co-Payment for services listed in the SUMMARY OF BENEFITS even after the Out-of-Pocket Amount is reached.

Prior Plan Out-of-Pocket Amounts. If you were covered under the *prior plan*, any amount applied during the same *calendar year* toward your out-of-pocket amount under the *prior plan* will be applied toward your Out-of-Pocket Amount under this *plan*.

NON-CERTIFICATION PENALTY

Each time you are admitted to a non-participating *hospital* or *residential treatment* center without properly obtaining certification, you are responsible for paying the Non-Certification Penalty. This penalty will not apply to an *emergency* admission or procedure, nor to services provided at a *participating provider*. Certification is explained in UTILIZATION REVIEW PROGRAM.

MEDICAL BENEFIT MAXIMUMS

The *plan* does not make benefit payments for any *beneficiary* in excess of any of the Medical Benefit Maximums. Your Lifetime Maximum under this *plan* will be reduced by any benefits paid to you on your behalf under any other health plan we provide.

CONDITIONS OF COVERAGE

The following conditions of coverage must be met for expense incurred for services or supplies to be considered as *covered expense*.

1. You must incur this expense while you are covered under this *plan*. Expense is incurred on the date you receive the service or supply for which the charge is made.
2. The expense must be for a medical service or supply furnished to you as a result of illness or injury or pregnancy, unless a specific exception is made.

3. The expense must be for a medical service or supply included in MEDICAL CARE THAT IS COVERED. Additional limits on *covered expense* are included under specific benefits and in the SUMMARY OF BENEFITS.
4. The expense must not be for a medical service or supply listed in MEDICAL CARE THAT IS NOT COVERED. If the service or supply is partially excluded, then only that portion which is not excluded will be considered *covered expense*.
5. The expense must not exceed any of the maximum benefits or limitations of this *plan*.
6. Any services received must be those which are regularly provided and billed by the *provider*. In addition, those services must be consistent with the illness, injury, degree of disability and your medical needs. Benefits are provided only for the number of days required to treat your illness or injury.
7. All services and supplies must be ordered by a *physician*.

MEDICAL CARE THAT IS COVERED

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

Hospital

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

Skilled Nursing Facility. Inpatient services and supplies provided by a *skilled nursing facility*. The amount by which your room charge exceeds the prevailing two-bed room rate of the *skilled nursing facility* is not considered *covered expense*. The term "skilled nursing facility" includes *residential treatment center*.

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

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

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

In no event will benefits exceed 65 visits during a *calendar year*. A visit of four hours or less by a home health aide shall be considered as one home health visit.

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

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

Hospice Care. The services and supplies listed below are covered when provided by a *hospice* for the palliative treatment of pain and other symptoms associated with a terminal disease. You must be suffering from a terminal illness for which the prognosis of life expectancy is one year or less, as certified by your *physician* and submitted to the *claims administrator*. Covered services are available on a 24-hour basis for the management of your condition.

1. Interdisciplinary team care with the development and maintenance of an appropriate plan of care.
2. Short-term inpatient *hospital* care when required in periods of crisis or as respite care. Coverage of inpatient respite care is provided on an occasional basis and is limited to a maximum of five consecutive days per admission.
3. Skilled nursing services provided by or under the supervision of a registered nurse. Certified home health aide services and homemaker services provided under the supervision of a registered nurse.

4. Social services and counseling services provided by a qualified social worker.
5. Dietary and nutritional guidance. Nutritional support such as intravenous feeding or hyperalimentation.
6. Physical therapy, occupational therapy, speech therapy, and respiratory therapy provided by a licensed therapist.
7. Volunteer services provided by trained *hospice* volunteers under the direction of a *hospice* staff member.
8. Pharmaceuticals, medical equipment, and supplies necessary for the management of your condition. Oxygen and related respiratory therapy supplies.
9. Bereavement services, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following the *employee's* or the *dependent's* death. Bereavement services are available to surviving members of the immediate family for a period of one year after the death. Your immediate family means your spouse, children, step-children, parents, and siblings.
10. Palliative care (care which controls pain and relieves symptoms, but does not cure) which is appropriate for the illness.

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

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

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

4. Rental and purchase charges for durable medical equipment (as shown below); maintenance and repair charges for such equipment;
5. Laboratory services to monitor the patient's response to therapy regimen.

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

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

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

Professional Services

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

Reconstructive Surgery. Reconstructive surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or creating a normal appearance.

Ambulance. The following ambulance services:

1. Base charge, mileage and non-reusable supplies of a licensed ambulance company for ground service to transport you to and from a *hospital*.
2. Emergency services or transportation services that are provided to you by a licensed ambulance company as a result of a "911" emergency response system* request for assistance if you believe you have an *emergency* medical condition requiring such assistance.
3. Base charge, mileage and non-reusable supplies of a licensed air ambulance company to transport you from the area where you are first disabled to the nearest *hospital* where appropriate treatment is provided if, and only if, such services are *medically necessary* and ground ambulance service is inadequate.
4. Monitoring, electrocardiograms (EKGs; ECGs), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriately licensed person must render the services.

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

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

Radiation Therapy

Chemotherapy

Hemodialysis Treatment

Prosthetic Devices

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

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

1. Of no further use when medical needs end;

2. For the exclusive use of the patient;
3. Not primarily for comfort or hygiene;
4. Not for environmental control or for exercise; and
5. Manufactured specifically for medical use.

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

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

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

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

Dental Care

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

2. **General Anesthesia.** General anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a *hospital* or *ambulatory surgical center*. This applies only if (a) the *beneficiary* is less than seven years old, (b) the *beneficiary* is developmentally disabled, or (c) the *beneficiary's* health is compromised and general anesthesia is *medically necessary*. Charges for the dental procedure itself, including professional fees of a dentist, are not covered.
3. **Dental Injury.** Services of a *physician* (M.D.) or dentist (D.D.S. or D.M.D.) solely to treat an *accidental injury* to natural teeth. Coverage shall be limited to only such services that are *medically necessary* to repair the damage done by *accidental injury* and/or restore function lost as a direct result of the *accidental injury*. Damage to natural teeth due to chewing or biting is not *accidental injury*.
4. **Bony Impacted Wisdom Teeth.** Services of an oral surgeon for the extraction of bony impacted wisdom teeth.

Pregnancy and Maternity Care

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

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

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

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

Covered expense does not include charges for services received without first obtaining prior authorization, or which are provided at a facility other than a transplant center approved by the *claims administrator*. See UTILIZATION REVIEW PROGRAM for details.

You must obtain the *claims administrator's* prior authorization for all services related to specified organ transplants (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures) including, but not limited to preoperative tests and postoperative care. Specified organ transplants must be performed at a *Center of Expertise (COE)*. **Charges for services provided for or in connection with a specified organ transplant performed at a facility other than a COE will not be considered covered expense.** See UTILIZATION REVIEW PROGRAM for details.

Transplant Travel Expense. The following travel expenses in connection with an approved, specified organ transplant (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures) performed at a specific COE only when the recipient or donor's home is more than 250 miles from the specific COE, provided the expenses are approved by the *claims administrator* in advance.

1. For the recipient and a companion, per transplant episode, up to six trips per episode:
 - a. Round trip coach airfare to the COE, not to exceed **\$250** per person per trip.
 - b. Hotel accommodations, not to exceed **\$100** per day for up to 21 days per trip, limited to one room, double occupancy.
 - c. Other expenses, such as meals, not to exceed **\$25** per day for each person, for up to 21 days per trip.
2. For the donor, per transplant episode, limited to one trip:
 - a. Round trip coach airfare to the COE, not to exceed **\$250**.
 - b. Hotel accommodations, not to exceed **\$100** per day for up to 7 days.
 - c. Other expenses, such as meals, not to exceed **\$25** per day, for up to 7 days.

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

You must obtain prior authorization for all bariatric surgical procedures. **Charges for services provided for or in connection with a bariatric surgical procedure performed at a facility other than a COE will not be considered covered expense.**

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

- Transportation for the *beneficiary* to and from the *COE* up to **\$130** per trip for a maximum of three (3) trips (one pre-surgical visit, the initial surgery and one follow-up visit).
- Transportation for one companion to and from the *COE* up to **\$130** per trip for a maximum of two (2) trips (the initial surgery and one follow-up visit).
- Hotel accommodations for the *beneficiary* and one companion not to exceed **\$100** per day for the pre-surgical visit and the follow-up visit, up to two (2) days per trip or as *medically necessary*. Limited to one room, double occupancy.
- Hotel accommodations for one companion not to exceed **\$100** per day for the duration of the *beneficiary's* initial surgery stay, up to four (4) days. Limited to one room, double occupancy.
- Other reasonable expenses not to exceed **\$25** per day, up to four (4) days per trip. Tobacco, alcohol 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 *COE*. Details regarding reimbursement can be obtained by calling the customer service number on your I.D. card. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

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

1. Inpatient *hospital* services as stated in the "Hospital" provision of this section, services from a *residential treatment center*, and visits to a *day treatment center*.
2. *Physician* visits during a covered inpatient *stay*.
3. *Physician* visits for outpatient psychotherapy or psychological testing or outpatient rehabilitative care (such as physical therapy, occupational therapy, or speech therapy) for the treatment of *mental or nervous disorders* or substance abuse.

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

Well Baby and Well Child Care. The following services for a dependent *child* under 7 years of age:

1. A *physician's* services for routine physical examinations. (The **\$25** *physician* office visit co-payment as well as the percentage coinsurance shown in the SUMMARY OF BENEFITS will apply to these services.)
2. Immunizations given as standard medical practice for *children*. You will have to pay a **\$25** co-payment for each immunization given by a *participating* or *non-participating provider*.
3. Radiology and laboratory services in connection with routine physical examinations.

Preventive Care. The following services will be provided for *beneficiaries* age 7 and over up to a maximum payment of **\$500** per *calendar year* (immunizations for *children* are not included in the **\$500** maximum):

1. A *physician's* services for routine physical examinations. (The **\$25** *physician* office visit co-payment will NOT apply to these services.)
2. Immunizations given as standard medical practice for *children* to age 19. You will have to pay a **\$25** co-payment for each immunization given by a *participating* or *non-participating provider*.
3. Radiology and laboratory services in connection with routine physical examinations other than for routine pap smears or mammograms.

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

Cervical Cancer Screening. Services and supplies provided in connection with a routine test to detect cervical cancer, including pap smears, human papillomavirus (HPV) screening, and any cervical cancer screening test approved by the federal Food and Drug Administration upon referral by your *physician*.

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

1. Routine and diagnostic mammogram examinations.
2. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.

3. Reconstructive surgery performed to restore and achieve symmetry following a *medically necessary* mastectomy.
4. Breast prostheses following a mastectomy (see “Prosthetic Devices”).

Other Cancer Screening Tests. Services and supplies provided in connection with all generally medically accepted cancer screening tests. This coverage is provided according to the terms and conditions of this *plan* that apply to all other medical conditions.

Screening For Blood Lead Levels. Services and supplies provided in connection with screening for blood lead levels if your dependent *child* is at risk for lead poisoning, as determined by your *physician*, when the screening is prescribed by your *physician*.

Sterilization. Sterilization of males and females including vasectomies and tubal legations.

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

1. The treatment provided in a clinical trial must either:
 - a. Involve a *drug* that is exempt under federal regulations from a new drug application, or
 - b. Be approved by (i) one of the National Institutes of Health, (ii) the federal Food and Drug Administration in the form of an investigational new drug application, (iii) the United States Department of Defense, or (iv) the United States Veteran’s Administration.
2. You must be diagnosed with cancer to be eligible for participation in these clinical trials.
3. Participation in such clinical trials must be recommended by your *physician* after determining participation has a meaningful potential to benefit the *beneficiary*.
4. For the purpose of this provision, a clinical trial must have a therapeutic intent. Clinical trials to just test toxicity are not included in this coverage.

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

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

Routine patient care costs do not include any of the items listed below. You will be responsible for the costs associated with any of the following, in addition to the costs of non-covered services.

1. *Drugs* or devices not approved by the federal Food and Drug Administration that are associated with the clinical trial.
2. Services other than health care services, such as travel, housing, companion expenses and other nonclinical expenses that you may require as a result of the treatment provided for the purposes of the clinical trial.
3. Any item or service provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient.
4. Health care services that, except for the fact they are provided in a clinical trial, are otherwise specifically excluded from the *plan*.
5. Health care services customarily provided by the research sponsors free of charge to *beneficiaries* enrolled in the trial.

For payment for *non-participating providers*, the cost will be based on the lesser of the billed charge or the amount that ordinarily applies when services are provided by a *participating provider*.

Coverage for clinical trials is restricted to *participating providers* in the state of California unless the protocol for the clinical trial is not provided for at a California *hospital* or by a California *physician*.

Physical Therapy and Physical Medicine. The following services provided by a *physician* under a treatment plan which offers a reasonable expectation of significant improvement:

Physical therapy and physical medicine provided on an outpatient basis for the treatment of illness or injury including the therapeutic use of heat, cold, exercise, electricity, ultra violet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care which are customarily provided by physical therapists and osteopaths.)

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

Up to a combined maximum of **40** visits in a *year* for all covered services provided are payable.

But, if the *claims administrator* determines that an additional period of physical therapy or physical medicine is both *medically necessary* and likely to result in a significant improvement to your condition by measurably reducing your physical impairment during that period of additional care, the *claims administrator* will authorize a specific number of additional visits.

Such additional visits are not payable if pre-service review is not obtained. (See UTILIZATION REVIEW PROGRAM.)

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

- Injectable drugs and implants for birth control, administered in a *physician's* office, if *medically necessary*.
- Intrauterine contraceptive devices (IUDs) and diaphragms, dispensed by a *physician* if *medically necessary*.
- Professional services of a *physician* in connection with the prescribing, fitting, and insertion of intrauterine contraceptive devices or diaphragms.

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

Outpatient Speech Therapy. Outpatient speech therapy following injury or organic disease up to a maximum of **40** visits per *calendar year*.

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

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

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

2. Diabetes education program which:
 - a. Is designed to teach a *beneficiary* 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 *beneficiary* to properly use the equipment, supplies, and medications necessary to manage the disease; and
 - c. Is supervised by a *physician*.

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

3. The following items are covered under your *prescription drug* benefits:
 - a. Insulin, glucagon, and other *prescription drugs* for the treatment of diabetes.
 - b. Insulin syringes, disposable pen delivery systems for insulin administration.
 - c. Testing strips, lancets, and alcohol swabs.

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

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

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

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

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

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

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

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

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

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

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

Anthem Blue Cross Life and Health – Specialty Pharmacy Program
2825 W. Perimeter Road
Indianapolis, IN 46241
Phone 1-800-870-6419
Fax 1-800-824-2642

Prior Authorization. Certain *specialty pharmacy drugs* require written prior authorization of benefits in order for you to receive them. Prior authorization criteria will be based on medical policy and the pharmacy and therapeutics established guidelines. You may need to try a *drug* other than the one originally prescribed if the *claims administrator* determines that it should be clinically effective for you. However, if the *claims administrator* determines through prior authorization that the *drug* originally prescribed is *medically necessary*, you will be provided the *drug* originally requested. (If, when you first become a *beneficiary*, you are already being treated for a medical condition by a *drug* that has been appropriately prescribed and is considered safe and effective for your medical condition, the *claims administrator* will not require you to try a *drug* other than the one you are currently taking.) If approved, *specialty pharmacy drugs* requiring prior authorization for benefits will be provided to you after you pay the required co-payment/coinsurance.

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

If the request is for urgently needed *drugs*, after the *claims administrator* gets the request:

- The *claims administrator* will review it and decide if benefits will be approved within 72-hours. (As soon as the *claims administrator* can, based on your medical condition, as *medically necessary*, the *claims administrator* may take less than 72-hours to decide if benefits will be approved.) The *claims administrator* will tell you and your *physician* what has been decided - by telephone and in writing by facsimile to your *physician*, and in writing by mail to you.

- If more information is needed to make a decision, or the *claims administrator* cannot make a decision for any reason, the *claims administrator* will tell your *physician*, within 24-hours after the *claims administrator* gets the request, what information is missing and why they cannot make a decision. If, for reasons beyond the *claims administrator's* control, the *claims administrator* cannot tell your *physician* what information is missing within 24-hours, the *claims administrator* will tell your *physician* that there is a problem as soon as they know that they cannot respond within 24-hours. In either event, the *claims administrator* will tell you and your *physician* that there is a problem – in writing by facsimile, and by telephone, to your *physician*, and in writing by mail to you.
- As soon as the *claims administrator* can, based on your medical condition, as *medically necessary*, but, not more than 48-hours after the *claims administrator* has all the information they need to decide if benefits will be approved, the *claims administrator* will tell you and your *physician* what has been decided in writing - by fax to the *physician* and by mail to you.

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

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

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

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

If the *claims administrator* denies a request for prior authorization of a *specialty pharmacy drug*, you or your prescribing *physician* may appeal our decision by calling customer service at 1-800-274-7767.

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

- a. The first two months supply of a *specialty pharmacy drug* which is available through a participating retail *pharmacy*;
- b. *Drugs*, which due to medical necessity, must be obtained immediately; or
- c. A *beneficiary* who is unable to pay for delivery of their medication (i.e., no credit card).

How to obtain an exception to the specialty pharmacy program. If you believe that you should not be required to get your medication through the specialty pharmacy program, for any of the reasons listed above, you must complete an Exception to Specialty Drug Program form to request an exception and send it to the *claims administrator*. The form can be faxed or mailed to the *claims administrator*. If you need a copy of the form, you may call customer service at 1-800-274-7767 to request one. You can also get the form on-line at www.anthem.com/ca. If the *claims administrator* has given you an exception, it will be in writing and will be good for 12 months from the time it is given. After 12 months, if you believe that you should still not be required to get your medication through the specialty pharmacy program, you must again request an exception. If the *claims administrator* denies your request for an exception, it will be in writing and will tell you why the *claims administrator* did not approve the exception.

Urgent or emergency need of a *specialty pharmacy drug* subject to the specialty pharmacy program. If you are out of a *specialty pharmacy drug* which must be obtained through the specialty pharmacy program, the *claims administrator* 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 an emergency supply of medication if your doctor decides that it is appropriate and *medically necessary*. You may have to pay the applicable co-payment/coinsurance shown in SUMMARY OF BENEFITS: MEDICAL BENEFITS: CO-PAYMENTS/COINSURANCE for the 72-hour supply of your *drug*.

If you order your *specialty pharmacy 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 *claims administrator* will authorize an override of the specialty pharmacy program requirement for 30-day supply or less, to allow you to get an emergency supply of medication from a *participating pharmacy* near you. A Dedicated Care Coordinator from the specialty pharmacy program will coordinate the exception and you will not be required to pay an additional co-payment/coinsurance.

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

MEDICAL CARE THAT IS NOT COVERED

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

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

Experimental or Investigative. Any *experimental* or *investigative* procedure or medication.

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

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

Not Covered. Services received before your *effective date* or after your coverage ends.

Excess Amounts. Any amounts in excess of *covered expense* or the Lifetime Maximum.

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

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

Government Treatment. Any services provided by a local, state or federal government agency, except when payment under this *plan* is expressly required by federal or state law.

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

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

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

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

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

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

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

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

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use except as specifically stated under YOUR PRESCRIPTION DRUG BENEFITS section of this booklet.

Orthodontia. Braces and other orthodontic appliances or services.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental services, extraction of teeth (except for surgical services for the removal of bony impacted wisdom teeth), or treatment to the teeth or gums, or treatment to or for any disorders for the jaw joint, except as specifically stated in the "Dental Care" or "Jaw Joint Disorders" provisions of MEDICAL CARE THAT IS COVERED. Cosmetic dental surgery or other dental services for beautification.

Hearing Aids or Tests. Hearing aids. Routine hearing tests.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, except as specifically provided under "Preventive Care (Beneficiaries Age 7 and Over)" provision of MEDICAL CARE THAT IS COVERED. Eyeglasses or contact lenses, except as specifically stated in the "Prosthetic Devices" provision of MEDICAL CARE THAT IS COVERED.

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

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

Weight Alteration Programs (Inpatient and Outpatient). Weight loss or weight gain programs including, but not limited to, dietary evaluations and counseling, exercise programs, behavioral modification programs, surgery, laboratory tests, food and food supplements, vitamins and other nutritional supplements associated with weight loss or weight gain. Dietary evaluations and counseling, and behavioral modification programs are covered for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered, as stated in the "Bariatric Surgery" provision of MEDICAL CARE THAT IS COVERED.

Scalp hair prostheses. Scalp hair prostheses, including wigs or any form of hair replacement.

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

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

Sterilization Reversal. Reversal of sterilization.

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

Elective Abortions. Elective abortions, unless the life of the mother is endangered by the continuation of pregnancy.

Surrogacy. Any services or supplies provided in connection with a surrogate pregnancy, i.e., the bearing of a child by another woman for an infertile couple.

Orthopedic Supplies. Orthopedic shoes (other than shoes joined to braces) or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications as specifically stated in the "Prosthetic Devices" provision of MEDICAL CARE THAT IS COVERED.

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

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

Chronic Pain. Treatment of chronic pain, except as specifically provided under the "Hospice Care" or "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED.

Exercise Equipment. Exercise equipment, or any charges for activities, instrumentalities, or facilities normally intended or used for developing or maintaining physical fitness, including, but not limited to, charges from a physical fitness instructor, health club or gym, even if ordered by a *physician*.

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

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

Food or Dietary Supplements. Food or dietary supplements, except as described under the provisions "Special Food Products" and "Home Infusion Therapy" under MEDICAL CARE THAT IS COVERED.

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

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specifically stated in the "Well Baby and Well Child Care", "Preventive Care", "Cervical Cancer Screening", "Breast Cancer", "Prostate Cancer Screening", or "Screening For Blood Lead Levels" provisions of MEDICAL CARE THAT IS COVERED.

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

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

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

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specifically stated in the "Home Infusion Therapy" and "Prescription Drug for Abortion" provisions of MEDICAL CARE THAT IS COVERED or under YOUR PRESCRIPTION DRUG BENEFITS section of this booklet. Non-prescription, over-the-counter patent or proprietary drugs or medicines. Cosmetics, health or beauty aids.

Specialty Pharmacy Drugs. *Specialty pharmacy drugs* that must be obtained from the specialty pharmacy program, but, which are obtained from a retail *pharmacy* are not covered by this *plan*. **You will have to pay the full cost of the specialty pharmacy drugs you get from a retail pharmacy that you should have obtained from the specialty pharmacy program.**

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

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

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

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

PRE-EXISTING CONDITION EXCLUSION

No payment will be made for services or supplies for the treatment of a *pre-existing condition*. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period prior to your coverage under this *plan*. Generally, this six-month period ends the day before your coverage becomes effective. However if you were subject to a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The *pre-existing condition* exclusion does not apply to pregnancy nor to a child who is enrolled in the *plan* within 31 days after birth, adoption, or placement for adoption.

This exclusion may last up to six months from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period (see "Eligibility Date" under the section HOW COVERAGE BEGINS AND ENDS). However, you can reduce the length of this exclusion period by the number of days of your prior *creditable coverage*. Most prior health coverage is *creditable coverage* and can be used to reduce the *pre-existing condition* exclusion if you have not experienced a significant break in coverage. The maximum allowable break in coverage is 180 days if your prior coverage was provided through an employer and ended because your employment (or the person's employment through whom you had this coverage) ended, the availability of coverage through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated. For prior coverage that was not provided through an employer, such as individual coverage or coverage through a government program such as Medicaid, the maximum allowable break in coverage is 63 days. Please see "Creditable Coverage" in the DEFINITIONS section for a complete list of the types of coverage for which credit is given.

To reduce the six-month exclusion period by your *creditable coverage*, you should give us a copy of any certificates of creditable coverage you have. There is no time limit within which you must provide a certificate in order to receive credit for your prior coverage. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or carrier. There are also other ways that you can show you have *creditable coverage*. Please contact us if you need help demonstrating *creditable coverage*. All questions about the *pre-existing condition* exclusion and *creditable coverage* should be directed to the customer service telephone number listed on your identification card.

REIMBURSEMENT FOR ACTS OF THIRD PARTIES

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

1. We will automatically have a lien, to the extent of benefits provided, upon any recovery, whether by settlement, judgment or otherwise, that you receive from the third party, the third party's insurer, or the third party's guarantor. The lien will be in the amount of benefits we paid under this *plan* for the treatment of the illness, disease, injury or condition for which the third party is liable, but, not more than the amount allowed by California Civil Code Section 3040.
2. You must advise us in writing, within 60 days of filing a claim against the third party and take necessary action, furnish such information and assistance, and execute such papers as we may require to facilitate enforcement of our rights. You must not take action which may prejudice our rights or interests under your *plan*. Failure to give us such notice or to cooperate with us, or actions that prejudice our rights or interests will be a material breach of this *plan* and will result in your being personally responsible for reimbursing us.
3. We will be entitled to collect on our lien even if the amount you or anyone recovered for you (or your estate, parent or legal guardian) from or for the account of such third party as compensation for the injury, illness or condition is less than the actual loss you suffered.

YOUR PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG COVERED EXPENSE

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

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

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

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

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

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

PRESCRIPTION DRUG CO-PAYMENTS

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

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

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

HOW TO USE YOUR PRESCRIPTION DRUG BENEFITS

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

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

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

**Prescription Drug Program
P.O. Box 4165
Woodland Hills, CA 91365-4165**

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

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

**Prescription Drug Program
P.O. Box 4165
Woodland Hills, CA 91365-4165**

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

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

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

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

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

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

Order forms can be obtained by contacting:

**Prescription Drug Program - Mail Service
PO Box 746000
Cincinnati, OH 45274-6000
1-866-274-6825**

When You Order Your Prescription Through Specialty Pharmacy. You can only order your *prescription* for a *specialty pharmacy drug* through the specialty pharmacy program unless you are given an exception from the specialty drug program (see PRESCRIPTION DRUG CONDITIONS OF SERVICE). Anthem Blue Cross – Specialty Pharmacy Program only fills *specialty pharmacy drug prescriptions*. Anthem Blue Cross – Specialty Pharmacy Program will deliver your medication to you by mail or common carrier.

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

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

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

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

Specialty Pharmacy Program
2825 W. Perimeter Road
Indianapolis, IN 46241
Phone 1-877-241-3489
Fax 1-800-824-2642

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

PRESCRIPTION DRUG UTILIZATION REVIEW

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

PRESCRIPTION DRUG FORMULARY

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

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

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

In order for you to get a *drug* that requires prior authorization, your *physician* must make a written request to the *claims administrator* for you to get it using an Outpatient Prescription Drug Prior Authorization of Benefits form. The form can be facsimiled or mailed to the *claims administrator*. If your *physician* needs a copy of the form, he or she may call the *claims administrator* at 1-800-700-2541 (or TTY/TDD 1-800-905-9821) to request one. The form is also available on-line at www.anthem.com/ca.

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

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

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

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

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

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

If you have any questions regarding whether a *drug* in the *claims administrator's prescription drug formulary*, or requires prior authorization, please call the *claims administrator* at 1-800-700-2541 (or TTY/TDD 1-800-905-9821).

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

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

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

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

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

PRESCRIPTION DRUG CONDITIONS OF SERVICE

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

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

6. **If it is a *specialty drug*, it must be obtained by using the specialty drug program.** See the section HOW TO USE YOUR PRESCRIPTION DRUG BENEFITS: WHEN YOU ORDER YOUR PRESCRIPTION THROUGH SPECIALTY PHARMACY for how to get your *drugs* by using the specialty drug program. **You will have to pay the full cost of any *specialty drugs* you get from a retail *pharmacy* that you should have obtained from the specialty drug program. If you order a *specialty drug* through the mail service program, it will be forwarded to the specialty drug program for processing and will be processed according to specialty drug program rules.**

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

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

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

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

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

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

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

9. Certain *drugs* have specific quantity supply limits based on the *claims administrator's* analysis of prescription dispensing trends and the Food and Drug Administration dosing recommendations.
10. For the mail service program, the *prescription* must not exceed a 90-day supply.

11. The *drug* will be covered under YOUR PRESCRIPTION DRUG BENEFITS only if it is not covered under another benefit of your *plan*.
12. *Drugs* for the treatment of impotence and/or sexual dysfunction are limited to six tablets/units for a 30-day period and are available at retail *pharmacies* only. Documented evidence of contributing medical condition must be submitted to us for review.

PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED

1. Outpatient *drugs* and medications which the law restricts to sale by *prescription*. Formulas prescribed by a *physician* for the treatment of phenylketonuria. These formulas are subject to the copayment for *brand name drugs*.
2. Insulin.
3. Syringes when dispensed for use with insulin.
4. *Prescription* oral contraceptives; contraceptive diaphragms. Contraceptive diaphragms are limited to one per *year* and are subject to the copayment for *brand name drugs*.
5. Injectable *drugs* which are self-administered by the subcutaneous route (under the skin) by the patient or *dependent*. *Drugs* with Food and Drug Administration (FDA) labeling for self-administration.
6. All compound *prescription drugs* which contain at least one covered *prescription* ingredient.
7. Diabetic supplies (i.e. test strips and lancets).
8. Inhaler spacers and peak flow meters for the treatment of pediatric asthma. These items are subject to the copayment for *brand name drugs*.
9. *Prescription drugs* for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.
10. Effective October 1, 2010 the *plan* will cover *prescription drugs* and over-the-counter smoking cessation products including gums, patches, lozenges, nasal spray and inhalers. Both *prescription drugs* and over-the-counter products will require a prescription provided by your physician.

PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED

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

1. Immunizing agents, biological sera, blood, blood products or blood plasma. While not covered under this *prescription drug* benefit, these items are covered under the “Blood,” “Well Baby and Well Child Care,” and “Preventive Care or Physical Exam,” provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.
2. Hypodermic syringes and/or needles except when dispensed for use with insulin. While not covered under this *prescription drug* benefit, these items are covered under the “Home Health Care,” “Hospice Care,” “Infusion Therapy or Home Infusion Therapy,” and “Diabetes” provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.
3. *Drugs* and medications used to induce spontaneous and non-spontaneous abortions. While not covered under this *prescription drug* benefit, FDA approved medications that may only be dispensed by or under direct supervision of a *physician*, such as *drugs* and medications used to induce non-spontaneous abortions, are covered as specifically stated in the “Prescription Drug for Abortion” provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to the benefit.
4. *Drugs* and medications dispensed or administered in an outpatient setting; including, but not limited to, outpatient *hospital* facilities and *physicians’* offices. While not covered under this *prescription drug* benefit, these services are covered as specified under the “Hospital,” “Home Health Care,” “Hospice Care,” and “Infusion Therapy or Home Infusion Therapy” provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.
5. Professional charges in connection with administering, injecting or dispensing of *drugs*. While not covered under this *prescription drug* benefit, these services are covered as specified under the “Professional Services” and “Infusion Therapy or Home Infusion Therapy” provisions (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

6. *Drugs* and medications which may be obtained without a *physician's* written *prescription*, except insulin or niacin for cholesterol lowering.
7. *Drugs* and medications dispensed by or while you are confined in a *hospital, skilled nursing facility, rest home, sanatorium, convalescent hospital, or similar facility*. While not covered under this *prescription drug* benefit, such *drugs* are covered as specified under the "Hospital", "Skilled Nursing Facility", and "Hospice Care", provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits. While you are confined in a rest home, sanitarium, convalescent hospital or similar facility, *drugs* and medications supplied and administered by your *physician* are covered as specified under the "Professional Services" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to the benefit. Other *drugs* that may be prescribed by your *physician* while you are confined in a rest home, sanitarium, convalescent hospital or similar facility, may be purchased at a *pharmacy* by the *member*, or a friend, relative or care giver on your behalf, and are covered under this *prescription drug* benefit.
8. Durable medical equipment, devices, appliances and supplies, even if prescribed by a *physician*, except *prescription* contraceptive diaphragms as specified under PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED. While not covered under this *prescription drug* benefit, these items are covered as specified under the "Durable Medical Equipment", "Hearing Aid Services", and "Diabetes" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.
9. Services or supplies for which you are not charged.
10. Oxygen. While not covered under this *prescription drug* benefit, oxygen is covered as specified under the "Hospital", "Skilled Nursing Facility", "Home Health Care" and "Hospice Care" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.
11. Cosmetics and health or beauty aids. However, health aids that are *medically necessary* and meet the requirements for durable medical equipment as specified under the "Durable Medical Equipment" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), are covered, subject to all terms of this *plan* that apply to that benefit.

12. *Drugs* labeled "Caution, Limited by Federal Law to Investigational Use" or Non-FDA approved investigational *drugs*. Any *drugs* or medications prescribed for *experimental* indications. If you are denied a *drug* because the *claims administrator* determines that the *drug* is *experimental* or *investigative*, you may ask that the denial be reviewed by an external independent medical review organization. (See the section "Independent Medical Review of Denials of Experimental or Investigative Treatment" (see Table of Contents) for how to ask for a review of your *drug* denial.)
13. Any expense incurred for a *drug* or medication in excess of: *prescription drug maximum allowed amount*.
14. *Drugs* which have not been approved for general use by the State of California Department of Health Services or the Food and Drug Administration. This does not apply to *drugs* that are *medically necessary* for a covered condition.
15. Over-the-counter smoking cessation *drugs*. This does not apply to *medically necessary drugs* that you can only get with a *prescription* under state and federal law. This exclusion will no longer apply effective October 1, 2010.
16. *Drugs* used primarily for cosmetic purposes (e.g., Retin-A for wrinkles). However, this will not apply to the use of this type of *drug* for *medically necessary* treatment of a medical condition other than one that is cosmetic.
17. *Drugs* used primarily for the purpose of treating infertility, unless *medically necessary* for another covered condition.
18. Anorexiant and *drugs* used for weight loss except when used to treat morbid obesity (e.g., diet pills and appetite suppressants).
19. *Drugs* obtained outside of the United States unless they are furnished in connection with *urgent care* or an *emergency*.
20. Allergy desensitization products or allergy serum. While not covered under this *prescription drug* benefit, such *drugs* are covered as specified under the "Hospital", "Skilled Nursing Facility", and "Professional Services" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

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

COORDINATION OF BENEFITS

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

DEFINITIONS

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

Allowable Expense is any necessary, reasonable and customary item of expense which is at least partially covered by 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 trustee plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.
4. Medicare. This does not include Medicare when, by law, its benefits are secondary to those of any private insurance program or other non-governmental program.

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

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

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

EFFECT ON BENEFITS

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

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

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

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

- a. If the parent with custody of that *child* for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that *child* as a dependent pays first.
- b. If the parent with custody of that *child* for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:
 - i. The plan which covers that *child* as a dependent of the parent with custody.
 - ii. The plan which covers that *child* as a dependent of the stepparent (married to the parent with custody).
 - iii. The plan which covers that *child* as a dependent of the parent without custody.

- iv. The plan which covers that *child* as a dependent of the stepparent (married to the parent without custody).
 - c. Regardless of a and b above, if there is a court decree which establishes a parent's financial responsibility for that *child's* health care coverage, a plan which covers that *child* as a dependent of that parent pays first.
4. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But, if either plan does not have a provision regarding laid-off or retired employees, provision 6 applies.
5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan do not agree under these circumstances with the order of benefit determination provisions of This Plan, this rule will not apply.
6. If a *beneficiary* has dental coverage which provides benefits for surgical services related to the removal of bony impacted wisdom teeth.
7. 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 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.

BENEFITS FOR MEDICARE ELIGIBLE BENEFICIARIES

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

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

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

For Retired Employees and Their Spouses. If you are a *retired employee* or the spouse of a *retired employee* and you are eligible for Medicare Part A because you made the required number of quarterly contributions to the Social Security System, your benefits under this *plan* will be subject to the section entitled COORDINATION OF BENEFITS and the provision "Coordinating Benefits With Medicare", below.

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

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

1. Medicare must provide benefits first to any services covered both by Medicare and under this *plan*.

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

The *plan* will apply any charges paid by Medicare for services covered under this *plan* toward your *plan* deductible, if any.

UTILIZATION REVIEW PROGRAM

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

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

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

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

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

UTILIZATION REVIEW REQUIREMENTS

Utilization reviews are conducted for the following services:

- All inpatient *hospital stays* and *residential treatment center* admissions.

- *Facility-based care* for the treatment of *mental or nervous disorders* and substance abuse.
- Organ and tissue transplants.
- Visits for physical therapy and physical medicine beyond those described under the "Physical Therapy and Physical Medicine" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.
- Home infusion therapy.
- Home health care.
- Admissions to a *skilled nursing facility*.
- Bariatric surgical services performed at a *Centers of Expertise* facility.
- Select imaging procedures, including but not limited to: Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scan), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and Nuclear Cardiac Imaging. You may call the toll-free customer service telephone number on your identification card to find out if an imaging procedure requires pre-service review.

Exceptions: Utilization review is not required for inpatient *hospital stays* for the following services:

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

There are three stages of utilization review:

1. **Pre-service review** determines in advance the medical necessity and appropriateness of certain procedures or admissions and the appropriate length of stay, if applicable. Pre-service review is required for the following services:
 - Scheduled, non-emergency inpatient *hospital stays* and *residential treatment center* admissions (except inpatient *stays* for maternity care or mastectomy and lymph node dissection).
 - *Facility-based care* for the treatment of *mental or nervous disorders* and substance abuse.
 - Organ and tissue transplants.

- Visits for physical therapy and physical medicine beyond those described under the "Physical Therapy and Physical Medicine" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.
 - Home infusion therapy.
 - Home health care.
 - Admissions to a *skilled nursing facility*.
 - Bariatric surgical services performed at a *Centers of Expertise* facility.
 - Select imaging procedures, including but not limited to: Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scan), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and Nuclear Cardiac Imaging.
2. **Concurrent review** determines whether services are *medically necessary* and appropriate when the *claims administrator* is notified while service is ongoing, for example, an emergency admission to the hospital.
 3. **Retrospective review** is performed to review services that have already been provided. This applies in cases when pre-service or concurrent review was not completed, or in order to evaluate and audit medical documentation subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified.

EFFECT ON BENEFITS

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

1. The appropriate utilization reviews must be performed in accordance with this *plan*. When pre-service review is not performed as required for an inpatient *hospital* or *residential treatment center* admission or for *facility-based care* for the treatment of *mental or nervous disorders* and substance abuse, the benefits to which you would have been otherwise entitled will be subject to the Non-Certification Penalty shown in the SUMMARY OF BENEFITS.
2. When pre-service review is performed and the admission, procedure or service is determined to be *medically necessary* and appropriate, benefits will be provided for the following:

- Organ and tissue transplants as follows:
 - a. For kidney, bone, skin or cornea transplants if the *physicians* on the surgical team and the facility in which the transplant is to take place are approved for the transplant requested.
 - b. For transplantation of liver, heart, heart-lung, lung, kidney-pancreas or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures if the providers of the related preoperative and postoperative services are approved and the transplant will be performed at a *Centers of Expertise (COE)* facility.
- A specified number of additional visits for physical therapy and physical medicine if you need more visits than is provided under the "Physical Therapy and Physical Medicine" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.
- Services of a home infusion therapy provider if the attending *physician* has submitted both a prescription and a plan of treatment before services are rendered.
- Home health care services if:
 - a. The services can be safely provided in your home, as certified by your attending *physician*;
 - b. Your attending *physician* manages and directs your medical care at home; and
 - c. Your attending *physician* has established a definitive treatment plan which must be consistent with your medical needs and lists the services to be provided by the *home health agency*.
- Services provided in a *skilled nursing facility* if you require daily skilled nursing or rehabilitation, as certified by your attending *physician*.
- Bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss if:
 - a. The services are to be performed for the treatment of morbid obesity.
 - b. The *physicians* on the surgical team and the facility in which the surgical procedure is to take place are approved for the surgical procedure requested; and

- c. The bariatric surgical procedure will be performed at a *Centers of Expertise (COE)* facility.
- Select imaging procedures, including, but not limited to: Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and nuclear cardiac imaging.

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

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

HOW TO OBTAIN UTILIZATION REVIEWS

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

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

1. For all scheduled services that are subject to utilization review, you or your *physician* must initiate the pre-service review at least three working days prior to when you are scheduled to receive services.
2. You must tell your *physician* that this *plan* requires pre-service review. *Physicians* who are *participating providers* will initiate the review on your behalf. A *non-participating provider* may initiate the review for you, or you may call the *claims administrator* directly. The toll-free number for pre-service review is printed on your identification card.
3. If you do not receive the reviewed service within 60 days of the certification, or if the nature of the service changes, a new pre-service review must be obtained.

4. The *claims administrator* will determine if services are *medically necessary* and appropriate. For inpatient *hospital* and *residential treatment center* stays, the *claims administrator* will, if appropriate, specify a specific length of *stay* for services. For *facility-based care* for the treatment of *mental or nervous disorders* and substance abuse the *claims administrator* will, if appropriate, specify the type and level of services, as well as their duration. You, your *physician* and the provider of the service will receive a written confirmation showing this information.

Concurrent Reviews

1. If pre-service review was not performed, you, your *physician* or the provider of the service must contact the *claims administrator* for concurrent review. For an *emergency* admission or procedure, the *claims administrator* must be notified within one working day of the admission or procedure, unless extraordinary circumstances* prevent such notification within that time period.
2. When *participating providers* have been informed of your need for utilization review, they will initiate the review on your behalf. You may ask a *non-participating provider* to call the toll free number printed on your identification card or you may call directly.
3. When it has been determined that the service is *medically necessary* and appropriate, the *claims administrator* will, depending upon the type of treatment or procedure, specify the period of time for which the service is medically appropriate. The *claims administrator* will also determine the medically appropriate setting.
4. If it is determined that the service is not *medically necessary* and appropriate, your *physician* will be notified by telephone no later than 24 hours following the *claims administrator's* decision. The *claims administrator* will send written notice to you and your *physician* within two business days following the decision. However, care will not be discontinued until your *physician* has been notified and a plan of care that is appropriate for your needs has been agreed upon.

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

Retrospective Reviews

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

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

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

THE MEDICAL NECESSITY REVIEW PROCESS

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

1. A decision on the medical necessity of a pre-service request will be made no later than 5 business days from receipt of the information reasonably necessary to make the decision, and based on the nature of your medical condition.
2. A decision on the medical necessity of a concurrent request will be made no later than one business day from receipt of the information reasonably necessary to make the decision, and based on the nature of your medical condition. However, care will not be discontinued until your *physician* has been notified and a plan of care that is appropriate for your needs has been agreed upon.
3. A decision on the medical necessity of a retrospective review will be made and communicated in writing no later than 30 days from receipt of the information necessary to make the decision to you and your *physician*.

4. If the *claims administrator* does not have the information they need, they will make every attempt to obtain that information from you or your *physician*. If unsuccessful and a delay is anticipated, the *claims administrator* will notify you and your *physician* of the delay and what is needed to make a decision. The *claims administrator* will also inform you of when a decision can be expected following receipt of the needed information.
5. All pre-service, concurrent and retrospective reviews for medical necessity are screened by clinically experienced, licensed personnel (called "Review Coordinators") using pre-established criteria and the *claims administrator's* medical policy. These criteria and policies are developed and approved by practicing providers not employed by the *claims administrator*, and are evaluated at least annually and updated as standards of practice or technology changes. Requests satisfying these criteria are certified as *medically necessary*. Review Coordinators are able to approve most requests.
6. A written confirmation including the specific service determined to be *medically necessary* will be sent to you and your provider no later than 2 business days after the decision, and your provider will be initially notified by telephone within 24 hours of the decision for pre-service and concurrent reviews.
7. If the request fails to satisfy these criteria or medical policy, the request is referred to a Peer Clinical Reviewer. Peer Clinical Reviewers are health professionals clinically competent to evaluate the specific clinical aspects of the request and render an opinion specific to the medical condition, procedure and/or treatment under review. Peer Clinical Reviewers are licensed in California with the same license category as the requesting provider. When the Peer Clinical Reviewer is unable to certify the service, the requesting *physician* is contacted by telephone for a discussion of the case. In many cases, services can be certified after this discussion. If the Peer Clinical Reviewer is still unable to certify the service, your provider will be given the option of having the request reviewed by a different Peer Clinical Reviewer.
8. Only the Peer Clinical Reviewer may determine that the proposed services are not *medically necessary* and appropriate. Your *physician* will be notified by telephone within 24 hours of a decision not to certify and will be informed at that time of how to request reconsideration. Written notice will be sent to you and the requesting provider within two business days of the decision. This written notice will include:
 - an explanation of the reason for the decision,

- reference of the criteria used in the decision to modify or not certify the request,
 - the name and phone number of the Peer Clinical Reviewer making the decision to modify or not certify the request,
 - how to request reconsideration if you or your provider disagree with the decision.
9. Reviewers may be plan employees or an independent third party chosen at the sole and absolute discretion of the *claims administrator*.
10. You or your *physician* may request copies of specific criteria and/or medical policy by writing to the address shown on your plan identification card. Medical necessity review procedures may be disclosed to health care providers through provider manuals and newsletters.

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

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

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

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

PERSONAL CASE MANAGEMENT

The personal case management program enables you to obtain medically appropriate care in a more economical, cost-effective and coordinated manner during prolonged periods of intensive medical care. Through a case manager, the *claims administrator* has the right to recommend an alternative plan of treatment which may include services not covered under this *plan*. The *plan administrator* does not have an obligation to provide personal case management. These services are provided at the sole and absolute discretion of the *claims administrator*.

HOW PERSONAL CASE MANAGEMENT WORKS

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

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

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

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

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

EFFECT ON BENEFITS

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

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

DISAGREEMENTS WITH MEDICAL MANAGEMENT DECISIONS

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

QUALITY ASSURANCE

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

HOW COVERAGE BEGINS AND ENDS

HOW COVERAGE BEGINS

ELIGIBLE STATUS

1. **Employees.** You are in an eligible status if you are an active employee or retired employee for whom the coverage provided by this *plan* is in effect. For the purposes of this *plan* only, members of the District School Boards will be considered to be “active employees”.
2. **Dependents.** The following are eligible to enroll as *dependents*: (a) Either the *employee’s spouse* or *domestic partner*; and (b) An unmarried *child*.

Definition of Dependents

1. **Spouse** is the *employee’s* spouse under a legally valid marriage between persons of the opposite sex. Spouse does not include any person who is in active service in the armed forces.
2. **Domestic partner** is the *employee’s* same sex (or opposite sex if one or both persons are over age 62) domestic partner under a legally registered and valid domestic partnership. Domestic partner does not include any person who is: (a) covered as an *employee*; or (b) in active service in the armed forces.

For a domestic partnership, other than one that is legally registered and valid, in order for the *employee* to include their domestic partner as a *dependent*, the *employee* and domestic partner must meet the following requirements:

- a. Both persons have a common residence.
- b. Neither person is married to someone else nor a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.
- c. The two persons are not related by blood in a way that would prevent them from being married to each other in California, or if they reside in another state or commonwealth, that state or commonwealth;
- d. Both persons are at least 18 years of age.
- e. Either of the following:
 - i. Both persons are members of the same sex; or
 - ii. One or both of the persons meet the eligibility criteria under Title II of the Social Security Act as defined in 42 U.S.C. Section 402(a) for old-age insurance benefits or Title XVI of the Social Security Act as defined in 42 U.S.C. Section 1381 for aged individuals. Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a domestic partnership unless one or both of the persons are over the age of 62.
- f. Both persons are capable of consenting to the domestic partnership.
- g. Both partners must provide the *plan administrator* with a signed, notarized, affidavit certifying they meet all of the requirements set forth in 2.a through 2.e above, inclusive.

As used above, "have a common residence" means that both domestic partners share the same residence. It is not necessary that the legal right to possess the common residence be in both of their names. Two people have a common residence even if one or both have additional residences. Domestic partners do not cease to have a common residence if one leaves the common residence but intends to return.

3. **Child** is the *employee's spouse's or domestic partner's* unmarried natural child, stepchild, legally adopted child, or a child for whom the *employee, spouse, or domestic partner* has been appointed legal guardian by a court of law, subject to the following:

a. The child depends on the *employee, spouse or domestic partner* for financial support or the *employee, spouse or domestic partner* is legally required to provide group health coverage for the child pursuant to an administrative or court order. A child is considered financially dependent if he or she qualifies as a dependent for federal income tax purposes.

b. The unmarried child is under 19 years of age, or if over the age of 19, that child is eligible until his or her 25th birthday, provided he or she satisfied either of the following conditions:

- He or she is enrolled as a full-time student (for 12 or more credits) in a properly accredited two year community college, four year college or university, or an accredited post-high school trade or technical school;

OR

- He or she is considered financially dependent as described in item (a) above.

An overage dependent who enters or returns to an eligible status will become eligible for coverage on the first day of the month following the date an enrollment application is filed on their behalf.

c. A child who is in the process of being adopted is considered a legally adopted child if we receive legal evidence of both: (i) the intent to adopt; and (ii) that the *employee, spouse or domestic partner* have either: (a) the right to control the health care of the child; or (b) assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption.

Legal evidence to control the health care of the child means a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or relinquishment form, signed by the child's birth parent, or other appropriate authority, or in the absence of a written document, other evidence of the *employee's, the spouse's or domestic partner's* right to control the health care of the child.

- d. A child for whom the *employee's, spouse or domestic partner* is a legal guardian is considered eligible on the date of the court decree (the "eligibility date"). We must receive legal evidence of the decree.
- e. The term "child" does not include: (i) any person who is covered as an *employee's*; or (ii) any person who is in active service in the armed forces.
- f. If both parents are covered as *employee's*, their children may be covered as the *dependents* of either, but not of both.

ELIGIBILITY DATE

1. For *employees*, you become eligible for coverage on the first day of the month coinciding with or following your date of hire. (This is your "waiting" period.)
2. For *dependents*, you become eligible for coverage on the later of: (a) the date the *employee* becomes eligible for coverage; or, (b) the date you meet the *dependent* definition.

ENROLLMENT

To enroll as an *employee*, or to enroll *dependents*, the *employee* must properly file an application. An application is considered properly filed, only if it is personally signed, dated, and given to the *plan administrator* within 31 days from your eligibility date. If this step is not followed, your coverage may be denied.

EFFECTIVE DATE

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

1. **Timely Enrollment:** If you enroll for coverage before, on, or within 31 days after your eligibility date, then your coverage will begin as follows: (a) for *employees*, on your eligibility date; and (b) for *dependents*, on the later of (i) the date the *employee's* coverage begins, or (ii) the first day of the month after the *dependent* becomes eligible. If you become eligible before the *plan* takes effect, coverage begins on the effective date of the *plan*, provided the enrollment application is on time and in order.
2. **Late Enrollment:** If you enroll more than 31 days after your eligibility date, you must wait until the next Open Enrollment Period to enroll.

3. **Disenrollment:** If you voluntarily choose to disenroll from coverage under this *plan*, you will be eligible to reapply for coverage as set forth in the “Enrollment” provision above, during the next Open Enrollment period (see OPEN ENROLLMENT PERIOD).

For late enrollees and disenrollees: You may enroll earlier than the next Open Enrollment Period if you meet any of the conditions listed under SPECIAL ENROLLMENT PERIODS.

Important Note for Newborn and Newly-Adopted Children. If the *employee* (or *spouse* or *domestic partner*, if the *spouse* or *domestic partner* is enrolled) is already covered:(1) any *child* born to the *employee* or *spouse* will be covered from the moment of birth; and (2) any *child* being adopted by the *employee*, *spouse* or *domestic partner* will be covered from the date on which either: (a) the adoptive *child's* birth parent, or other appropriate legal authority, signs a written document granting the *employee*, *spouse* or *domestic partner* the right to control the health care of the *child* (in the absence of a written document, other evidence of the *employee's*, *spouse's* or *domestic partner's* right to control the health care of the *child* may be used); or (b) the *employee*, *spouse* or *domestic partner* assumed a legal obligation for full or partial financial responsibility for the *child* in anticipation of the *child's* adoption. The written document referred to above includes, but is not limited to, a health facility minor release report, a medical authorization form, or relinquishment form.

In both cases, coverage will be in effect for 31 days. For coverage to continue beyond this 31-day period, the *employee* must enroll the *child* within the 31-day period by submitting a membership change form to the *plan administrator*.

Special Enrollment Periods

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

1. You have met all of the following requirements:
 - a. You were covered under another health plan as an individual or dependent, including coverage under a COBRA continuation, the Healthy Families Program, or no share-of-cost Medi-Cal coverage.

- b. Your coverage under the other health plan wherein you were covered as an individual or dependent ended because you lost eligibility under the other plan or employer contributions toward coverage under the other plan terminated, your coverage under a COBRA continuation was exhausted, you lost coverage under the Healthy Families Program as a result of exceeding the program's income or age limits, or you lost no share-of-cost Medi-Cal coverage. Loss of eligibility under another plan does not include a loss due to: failure to pay required monthly contributions when due; failure to exhaust COBRA continuation coverage, if elected; or causes such as making a fraudulent claim or intentional misrepresentation of a material fact in connection with the *plan*.
 - c. You properly file an application with the *plan administrator* within 31 days from the date on which you lose coverage. Coverage will be effective on the first of the month following the date you file the enrollment application.
- 2. A court has ordered coverage be provided for a *spouse*, *domestic partner* or dependent *child* under your employee health plan and an application is filed within 31 days from the date the court order is issued or is filed within the period required by law. Coverage will be effective on the first of the month following the date you file the enrollment application.
- 3. You have a change in family status through either marriage or domestic partnership, or the birth, adoption, or placement for adoption of a *child*:
 - a. If you are enrolling following marriage or domestic partnership, you and your new *spouse* or *domestic partner* must enroll within 31 days of the date of marriage or domestic partnership. Your new *spouse* or *domestic partner's* children may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above. Coverage will be effective on the first day of the month following the date you file the enrollment application.
 - b. If you are enrolling following the birth, adoption, or placement for adoption of a *child*, your *spouse* (if you are already married) or *domestic partner*, who is eligible but not enrolled, may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above. Application must be made within 31 days of the birth or date of adoption or placement for adoption; coverage will be effective as of the date of birth, adoption, or placement for adoption.

4. You meet or exceed a lifetime limit on all benefits under another health plan. Application must be made within 31 days of the date a claim or a portion of a claim is denied due to your meeting or exceeding the lifetime limit on all benefits under the other plan. Coverage will be effective on the first day of the month following the date you file the enrollment application.

RIGHTS REGARDING A DIFFERENT PLAN

Subject to the special enrollment requirements, if you are enrolled in this *plan*, but your dependent declines coverage due to other coverage and then subsequently loses that other coverage, you and your dependent may both enroll in a different plan sponsored by the *plan administrator*.

Subject to the special enrollment requirements, if you enrolled in this *plan* and subsequently obtain a new eligible dependent, both you and your dependent may enroll in a different plan sponsored by the *plan administrator*.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

If we determine that your separated or divorced spouse or any state child support or Medicaid agency has obtained a qualified medical child support order (QMCSO), through a court order or an administrative process established under the state law plan, you will be required to provide coverage for any child(ren) named in the QMCSO. If a QMCSO requires that you provide health coverage for your child(ren), we must enroll the child(ren) upon application from your separated/divorced spouse, the state child support agency or Medicaid agency and withhold from your pay your share of the cost of such coverage. You may not drop coverage for the child(ren) unless you submit written evidence to us that the child support order is no longer in effect. The *plan* may make benefit payments for the child(ren) covered by the QMCSO directly to the custodial parent or legal guardian of such child(ren). We have discretion to adopt procedures to determine if a child support order satisfies the requirements of a QMCSO. Participants and beneficiaries can obtain a copy of the procedures governing QMCSO determinations from us without charge. If you are not enrolled for coverage, you will be required to enroll along with the child and your share of the cost of such coverage will be withheld from your pay.

OPEN ENROLLMENT PERIOD

There is an open enrollment period once each *year*, between May 1st and June 15th. During that time, an individual who meets the eligibility requirements as an *employee* or *dependent* under this *plan*, may enroll.

An *employee* may also enroll any eligible *dependents* at that time. Persons eligible to enroll as *dependents* may enroll only under the *employee's plan*.

For anyone so enrolling, coverage under this *plan* will begin on the first day of the month following the end of the Open Enrollment Period. Coverage under the former plan ends when coverage under this *plan* begins.

HOW COVERAGE ENDS

Your coverage ends without notice as provided below:

1. If the *plan* terminates, your coverage ends at the same time. This *plan* may be canceled or changed without notice to you.
2. If the *plan* no longer provides coverage for the class of *beneficiaries* to which you belong, your coverage ends on the effective date of that change. If this *plan* is amended to delete coverage for *dependents*, a *dependent's* coverage ends on the effective date of that change.
3. Coverage for *dependents* ends when *employee's* coverage ends.
4. Coverage ends at the end of the month in which required monthly contributions cease.
5. If you voluntarily cancel coverage at any time, coverage ends on the due date for the required monthly contribution coinciding with or following the date of voluntary cancellation which you provide to us.
6. If you no longer meet the requirements set forth in the "Eligible Status" provision of HOW COVERAGE BEGINS, your coverage ends at the end of the month in which you are no longer eligible to participate in the *plan*.

Exceptions to item 6:

- a. **Leave of Absence.** If you are an *employee* and the required monthly contributions are paid, your coverage may continue: (i) for up to six months during a temporary leave of absence; (ii) for up to twelve months during a sabbatical year's leave of absence; or (iii) for the duration of an extended leave of absence due to illness certified annually by the *plan administrator*.

- b. **Handicapped Children:** If a *child* reaches the age limits shown in the "Eligible Status" provision of this section, the *child* will continue to qualify as a *dependent* if he or she is (i) covered under this *plan*, (ii) still financially dependent on the *employee*, *spouse* or *domestic partner*, and (iii) incapable of self-sustaining employment due to a physical handicap or mental retardation. A *physician* must certify this disability in writing. The *plan administrator* must receive the certification, within 31 days of the date the *child* otherwise becomes ineligible. When a period of two years has passed, the *plan administrator* may request proof of continuing dependency and disability, but not more often than once each year.

This exception will last until the *child* is no longer handicapped or dependent on the *employee*, *spouse* or *domestic partner* for financial support. A *child* is considered financially dependent if he or she qualifies as a dependent for federal income tax purposes.

- 7. A *beneficiary's plan* coverage or eligibility for coverage may be terminated if:
 - a. The *beneficiary* submits any claim that contains false or fraudulent elements under state or federal law;
 - b. A civil or criminal court finds that the *beneficiary* has submitted claims that contain false or fraudulent elements under state or federal law;
 - c. A *beneficiary* has submitted a claim that, in good faith judgment and investigation, he or she knew or should have known, contained false or fraudulent elements under state or federal law.

Note: If a marriage or domestic partnership terminates, the *employee* must give or send to the *plan administrator* written notice of the termination. Coverage for a former *spouse* or *domestic partners*, and their dependent *children*, if any, ends according to the "Eligible Status" provisions. If the *plan administrator* suffers a loss as a result of the *employee* failing to notify the *plan administrator* of the termination of their marriage or domestic partnership, the *plan administrator* may seek recovery from the *employee* for any actual loss resulting thereby. Failure to provide written notice to the *plan administrator* will not delay or prevent termination of the marriage or domestic partnership. If the *employee* notifies the *plan administrator* in writing to cancel coverage for a former *spouse* or *domestic partner* and the children of the *spouse* or *domestic partner*, if any, immediately upon termination of the *employee's* marriage or domestic partnership, such notice will be considered compliance with the requirements of this provision.

You may be entitled to continued benefits under terms which are specified elsewhere under FAMILY AND MEDICAL LEAVE ACT (FLMA), NON-FLMA LEAVE OF ABSENCE, CONTINUATION OF COVERAGE, CALCOBRA CONTINUATION OF COVERAGE CONTINUATION FOR DISABLED DISTRICT EMPLOYEES, COVERAGE FOR SURVIVING SPOUSES OF CERTIFICATED EMPLOYEES and HIPAA COVERAGE.

FAMILY AND MEDICAL LEAVE ACT (FLMA)

If you qualify for an approved family or medical leave of absence (as defined in the Family Medical Leave Act of 1993), eligibility may continue for the duration of the leave if you pay any required monthly contributions toward the cost of the coverage. We have the responsibility to provide you with prior written notice of the terms and conditions under which required monthly contributions must be made. Failure to make required monthly contributions within 31 days of the due date established by us will result in the termination of coverage. Subject to certain exceptions, if you fail to return to work after the leave of absence, we have the right to recover from you any required monthly contributions toward the cost of coverage made on your behalf during the leave, as outlined in the FMLA.

If coverage is terminated for failure to make required monthly contributions while you are on an approved family or medical leave of absence (as defined in the Family Medical Leave Act of 1993), coverage for you and your eligible *dependents* will be automatically reinstated on the date you return to employment if you and your dependents are otherwise eligible under the *plan*. Any new pre-existing condition limitation and any waiting periods will not apply. However, all accumulated benefit year and lifetime maximums will apply. Coverage continued under this provision is in addition to COBRA continuation Coverage.

It is the intent of this *plan* to comply with all existing FMLA regulations. If for some reason the information presented in the *plan* differs from actual FMLA regulations, this *plan* reserves the right to administer the FMLA in accordance with such actual regulations.

NON-FMLA LEAVE OF ABSENCE

If coverage ends while you are on a non-FMLA approved leave of absence, coverage for you and your eligible dependents will be reinstated on the first day of the month following the date you return to employment if you and your dependents meet the eligibility requirements. The maximum period for an approved leave of absence is six months. All accumulated benefit year and lifetime maximums will apply when you and your dependents are reinstated. In addition to the above, this *plan* will comply with all applicable state leave laws that apply to self-funded plans if they require earlier reinstatement of coverage.

CONTINUATION OF COVERAGE

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

DEFINITIONS

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

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

Qualified Beneficiary means: (a) a person enrolled for this COBRA continuation coverage who, on the day before the Qualifying Event, was covered under this *plan* as either an *employee* or *dependent*; and (b) a *child* who is born to or placed for adoption with the *employee* during the COBRA continuation period. Qualified Beneficiary does not include any person who was not enrolled during the Initial Enrollment Period, including any *dependents* acquired during the COBRA continuation period, with the exception of newborns and adoptees as specified above. It does not include domestic partners if they are eligible under HOW COVERAGE BEGINS AND ENDS.

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

1. For Employees and Dependents:

- a. The *employee's* termination of employment, for any reason other than gross misconduct; or
- b. A reduction in the *employee's* work hours.

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

- a. The *plan* expressly includes coverage for retirees; and

- b. Such cancellation or reduction of benefits occurs within one year before or after the employer's filing for bankruptcy.

3. **For Dependents:**

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

ELIGIBILITY FOR COBRA CONTINUATION

An *employee* or *dependent*, **other than a *domestic partner*, and a *child of a domestic partner***, may choose to continue coverage under the *plan* if your coverage would otherwise end due to a Qualifying Event.

TERMS OF COBRA CONTINUATION

Notice. The *plan administrator* will notify either the *employee* or *dependent* of the right to continue coverage under COBRA, as provided below:

1. For Qualifying Events 1, or 2, the *plan administrator* will notify the *employee* of the right to continue coverage.
2. For Qualifying Events 3(a) or 3(d) above, a *dependent* will be notified of the COBRA continuation right.
3. You must inform the *plan administrator* within 60 days of date of loss of coverage due to Qualifying Events 3(b) or 3(c) above if you wish to continue coverage. The *plan administrator* in turn will promptly give you official notice of the COBRA continuation right.

If you choose to continue coverage you must notify the *plan administrator* within 60 days after the date that *plan* coverage is lost, or, if later, 60 days from the date you receive notice of your COBRA continuation right. The COBRA continuation coverage may be chosen for all *beneficiaries* within a family, or only for selected *beneficiaries*.

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 required monthly contribution, must be delivered to the *plan administrator* within 45 days after you elect COBRA continuation coverage.

Additional Dependents. A *spouse* acquired during the COBRA continuation period or a child acquired during the COBRA continuation period, due to birth, adoption or placement for adoption, is eligible to be enrolled as a *dependent*. The standard enrollment provisions of the *plan* apply to enrollees during the COBRA continuation period.

Open Enrollment. You may change coverage or add dependents at open enrollment.

Cost of Coverage. The *plan administrator* may require that you pay the entire cost of your COBRA continuation coverage. This cost, called the "required monthly contribution", must be remitted to the *plan administrator* each month during the COBRA continuation period.

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

1. A *spouse* whose COBRA continuation began due to divorce, separation or death of the *employee*;
2. A *child* if neither the *employee* nor the *spouse* has enrolled for this COBRA continuation coverage (if more than one *child* is so enrolled, the required monthly contribution 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, an *employee* or *dependent*, who is a Qualified Beneficiary, may be entitled to an extended COBRA continuation period. This period will in no event continue beyond 36 months from the date of the first qualifying event.

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

You must notify the *plan administrator* of a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a second qualifying event may affect the right to extend the period of continuation coverage.

Special Second Election Period for Certain Eligible Employees Who Did Not Elect COBRA. Certain employees and former employees who were eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA) are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period of 60 days or less (but only if the election is made within six months after *plan* coverage is lost). If you are an employee or former employee and you qualify for TAA or ATAA, contact the *plan administrator* promptly after qualifying for TAA or ATAA or you will lose any right that you may have to elect COBRA during a special election period. Contact the *plan administrator* for more information about the special election period.

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

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

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

1. The end of 18 months from the date of loss of coverage due to the Qualifying Event, if the Qualifying Event was termination of employment or reduction in work hours;*
2. The end of 36 months from the date of loss of coverage due to the Qualifying Event, if the Qualifying Event was the death of the *employee*, divorce or legal separation, or the end of dependent *child* status;*
3. The end of 36 months from the date the *employee* became entitled to Medicare, if the Qualifying Event was the *employee's* entitlement to Medicare. If entitlement to Medicare does not result in coverage terminating and Qualifying Event 1 occurs within 18 months after Medicare entitlement, coverage for Qualified Beneficiaries other than the *employee* will end 36 months from the date the *employee* became entitled to Medicare;
4. The date the *plan* terminates;
5. The end of the period for which required monthly contributions are last paid;

6. The date, following the election of COBRA, the *beneficiary* first becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the *beneficiary*, in which case this COBRA continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied; or
7. The date, following the election of COBRA, the *beneficiary* first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

*For a *beneficiary* whose COBRA continuation coverage began under a *prior plan*, this term will be dated from the time of loss of coverage due to the Qualifying Event under that *prior plan*. Additional note: If COBRA continuation under this *plan* began on or after January 1, 2003 and ends in accordance with item 1, the *beneficiary* may further elect to continue coverage for medical benefits only under CalCOBRA for the balance of 36 months (COBRA and CalCOBRA combined). All COBRA eligibility must be exhausted before the *beneficiary* is eligible to further continue coverage under CalCOBRA. Please see CALCOBRA CONTINUATION OF COVERAGE in this booklet for more information.

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

If your COBRA continuation under this *plan* ends in accordance with items 1, 2, 3, or 4 you may be eligible for HIPAA coverage. Please see HIPAA COVERAGE in this *plan description* for more information.

If continuation coverage ends due to items 2 or 7 above, the surviving spouse of an active employee or of a retired employee is eligible for the coverage specified in this *plan* under COVERAGE FOR SURVIVING SPOUSES.

EXTENSION OF CONTINUATION DURING TOTAL DISABILITY

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

Eligibility for Extension. To continue coverage for up to 29 months from the date of the original Qualifying Event, the disabled *beneficiary* 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 *beneficiary* must furnish the *plan administrator* with proof of the Social Security Administration's determination of disability during the first 18 months of the COBRA continuation period and no later than 60 days after the later of the following events:

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

Cost of Coverage. The cost of coverage (called the "required monthly contribution") during this extension shall be subject to the following conditions:

1. If the disabled *beneficiary* continues coverage during this extension, this charge shall be **150%** of the applicable rate for the length of time the disabled *beneficiary* remains covered, depending upon the number of covered dependents. If the disabled *beneficiary* does not continue coverage during this extension, this charge shall remain at **102%** of the applicable rate.
2. The cost for extended continuation coverage must be remitted to the *plan administrator* each month during the period of extended continuation coverage. The *plan administrator* may require that you pay the entire cost of the extended continuation coverage.

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

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

1. The end of the month following a period of 30 days after the Social Security Administration's final determination that you are no longer totally disabled;
2. The end of 29 months from the Qualifying Event*;
3. The date the *plan* terminates;
4. The end of the period for which required monthly contributions are last paid;
5. The date, following the election of COBRA, the *beneficiary* first becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the *beneficiary*, in which case this COBRA extension will end at the end of the period for which the pre-existing condition exclusion or limitation applied; or
6. The date, following the election of COBRA, the *beneficiary* first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

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

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

CALCOBRA CONTINUATION OF COVERAGE

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

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

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

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

TERMS OF CALCOBRA CONTINUATION

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

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

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

Cost of Coverage. You will be required to pay the entire cost of your CalCOBRA continuation coverage (this is the "required monthly contribution"). This cost must be remitted to the *plan administrator* each month during the CalCOBRA continuation period. This cost will be:

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

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

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

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

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

1. The date that is 36 months after the date of your qualifying event under federal COBRA*;
2. The date the *plan* terminates;
3. The date coverage is no longer provided to the class of *employees* to which you belong;
4. The end of the period for which the required monthly contribution is last paid;
5. The date you become covered under any other health plan, unless the other health plan contains an exclusion or limitation relating to a pre-existing condition that you have. In this case, this continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied;
6. The date you become entitled to Medicare; or
7. The date you become covered under a federal COBRA continuation.

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

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

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

CONTINUATION FOR DISABLED DISTRICT EMPLOYEES

If you become disabled as a result of a violent act directed at you while performing duties in the scope of employment as a district employee, your benefits under this *plan* may be continued.

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

Cost of Coverage. The employer may require that you pay the entire cost of your continuation coverage. This cost (called the "required monthly contribution") must be remitted to the *plan administrator* each month during your continuation.

When Continuation Coverage Begins. When continuation coverage is elected and the required monthly contribution is paid, coverage is reinstated back to the date you became disabled, so that no break in coverage occurs, but only if you elect to continue coverage within sixty (60) days after your coverage terminates. For *dependents* acquired and properly enrolled during the continuation, coverage begins according to the enrollment provisions of this *plan*.

When Continuation Coverage Ends. This continuation coverage ends for the *employee* on the earliest of:

1. The date this *plan* terminates;
2. The end of the period for which required monthly contributions are last paid; or
3. The date the maximum benefits of this *plan* are paid.

For *dependents*, this continuation coverage ends according to the provisions of the section entitled HOW COVERAGE BEGINS AND ENDS.

COVERAGE FOR SURVIVING SPOUSES OF CERTIFICATED EMPLOYEES

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

1. Required monthly contributions are not paid, or
2. The *plan administrator* cancels coverage for the class of *employees* to which the *beneficiary* belongs, or
3. The *plan* terminates.

Note: The cost of continuing coverage under this provision may be more than the cost of coverage the employer provides to its employees or their *dependents*. You may be responsible for all or part of the required monthly contributions.

HIPAA COVERAGE

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

HIPAA Coverage

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

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

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

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

GENERAL PROVISIONS

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

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

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

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

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

- Billed charges for your covered services, or

- Negotiated price that the on-site Blue Cross and/or Blue Shield Licensee (“Host Blue”) passes on to the *claims administrator*.

Often, the “negotiated price,” referred to above, will consist of a simple discount, which reflects the actual price paid by the Host Blue. But, sometimes it is an estimated price that factors in expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect **average** expected savings with your health care provider or with a specified group of providers.

If the negotiated price reflects average expected savings, it may result in greater variation (more or less) from the actual price paid than will the estimated price. The estimated or average price may be adjusted in the future to correct for over- or underestimation of past prices. Regardless of how the negotiated price is determined, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating *beneficiary* liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge.

Should any state statutes mandate *beneficiary* liability calculation methods that differ from the usual BlueCard Program method noted above in the second paragraph of this section, or require a surcharge, we would then calculate your co-payment for any covered health care services using the methods outlined by the applicable state statute in effect at the time you received your care.

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

Terms of Coverage

1. In order for you to be entitled to benefits under the *plan*, both the *plan* and your coverage under the *plan* must be in effect on the date the expense giving rise to a claim for benefits is incurred.
2. The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date you receive the service or supply for which the charge is made.

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

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

Continuity of Care. If the *claims administrator* terminates their contractual relationship with a *participating provider* and you are undergoing a course of treatment from that provider at the time the contract is terminated, you may be able to continue to receive services from that provider (but only if such provider agrees to continue to comply with the same contractual requirements that applied prior to termination).

To qualify, you must have an acute or a serious chronic condition, a high risk pregnancy, or a pregnancy in the second or third trimester. You may request this continuity of care by calling the *claims administrator* at the customer service telephone number listed on your ID card.

If approved, services may be received for a limited period of time, but no longer than 90 days, unless you cannot be safely transferred to a *participating provider*. Coverage is provided according to the terms and conditions of this *plan* applicable to *participating providers*.

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

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

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

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

Notice of Claim. You or the provider of service must submit a request for payment of benefits within one year after the date you receive the service or supply for which the claim is made. If a provider submits a claim on your behalf, you will be responsible for the timeliness of the submission. If you do not provide this information to us within one year of the date of the service or supply, benefits for that health service or supply will be denied or reduced, in our or the *claims administrator's* discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an inpatient *stay*, the date of service is the date your inpatient *stay* ends. Services received and charges for services must be itemized, and clearly and accurately described. Claim forms must be used; cancelled checks or receipts are not acceptable. Claims for services rendered in a foreign country should be presented in English and in U.S. dollars and cents.

Timely Payment of Claims. Any benefit due under this *plan* shall be due once the *claims administrator* has received proper, written proof of loss, together with such reasonable necessary additional information the *claims administrator* may require to determine our obligation.

Payment to Providers. The benefits of this *plan* will be paid directly to *contracting hospitals, participating providers, COE* and medical transportation providers. Also, *non-contracting hospitals* and other providers of service will be paid directly when you assign benefits in writing. If you are a MediCal member and you assign benefits in writing to the State Department of Health Services, the benefits of this *plan* will be paid to the State Department of Health Services. These payments will fulfill the *plan's* obligation to you for those covered services.

Right of Recovery. When the amount we paid exceeds our liability under this *plan*, we have the right to recover the excess amount. This amount may be recovered from you, the person to whom payment was made or any other plan.

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

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

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

Certificate of Creditable Coverage. Certificates of creditable coverage are issued automatically when your coverage under this *plan* ends. We will also provide a certificate of creditable coverage in response to your request, or to a request made on your behalf, at any time while you are covered under this *plan* and up to 24 months after your coverage under this *plan* ends. The certificate of creditable coverage documents your coverage under this *plan*. To request a certificate of creditable coverage, please call the customer service telephone number listed on your ID card.

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

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

Also, under arrangements with some Providers certain discounts, payments, rebates, settlements, incentives, adjustments and/or allowances, including, but not limited to, pharmacy rebates, may be based on aggregate payments made by the *claims administrator* or an affiliate in respect to all health care services rendered to all persons who have coverage through a program provided or administered by the *claims administrator* or an affiliate. They are not attributed to specific claims or plans and do not inure to the benefit of any covered individual or group, but may be considered by the *claims administrator* or an affiliate in determining its fees or subscription charges or premiums.

BINDING ARBITRATION

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

The Federal Arbitration Act will 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 will apply.

The *beneficiary* and the *plan administrator* agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The *beneficiary* and the *plan administrator* agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class arbitration, the *beneficiary* waives any right to pursue, on a class basis, any such controversy or claim against the *plan administrator* and the *plan administrator* waives any right to pursue on a class basis any such controversy or claim against the *beneficiary*.

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 begun by the *beneficiary* making written demand on the *plan administrator*. The arbitration will be conducted by Judicial Arbitration and Mediation Services (“JAMS”) according to its applicable Rules and Procedures.

If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the *beneficiary* and the *plan administrator*, or by order of the court, if the *beneficiary* and the *plan administrator* cannot agree. The arbitration will be held at a time and location mutually agreeable to the beneficiary and the *plan administrator*.

DEFINITIONS

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

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

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

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

1. There is no *participating provider* who practices in the appropriate specialty, which provides the required services, or which has the necessary facilities within a 30-mile radius of, or 30 minutes normal travel time from, your residence or place of work;
2. You are referred in writing to the *non-participating provider* by the *physician* who is a *participating provider*; and
3. The referral has been authorized by the *claims administrator* before services are rendered.

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

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

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

Beneficiary is the *employee* or *dependent*.

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

Centers of Expertise (COE) are health care providers which have a Centers of Expertise Agreement in effect with the claims administrator at the time services are rendered. *COE* transplant facilities agree to accept the *COE negotiated rate* as payment in full for covered services. A participating provider in the Prudent Buyer Plan network is not necessarily a *COE*. A provider's participation in the Prudent Buyer Plan network or other agreement with the *claims administrator* is not a substitute for a Centers of Expertise Agreement.

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

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 an NDC number.

All claims for reimbursement for Compound Medications must be submitted electronically (by the *pharmacy*) and will be paid at the *prescription drug negotiated rate*. Compound Medications may be limited to distribution at designated *pharmacies*.

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

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

Creditable coverage is any individual or group plan that provides medical, hospital and surgical coverage, including continuation or conversion coverage, coverage under Medicare or Medicaid, TRICARE, the Federal Employees Health Benefits Program, programs of the Indian Health Service or of a tribal organization, a state health benefits risk pool, coverage through the Peace Corps, the State Children's Health Insurance Program, or a public health plan established or maintained by a state, the United States government, or a foreign country, or any political subdivision of a state, the U.S. government, or a foreign country. Creditable coverage does not include accident only, credit, coverage for on-site medical clinics, disability income, coverage only for a specified disease or condition, hospital indemnity or other fixed indemnity insurance, Medicare supplement, long-term care insurance, dental, vision, workers' compensation insurance, automobile insurance, no-fault insurance, or any medical coverage designed to supplement other private or governmental plans. Creditable coverage is used to reduce the length of the *pre-existing condition* exclusion period under this *plan*.

If your prior coverage was through an employer, you will receive credit for that coverage if it ended because your employment ended, the availability of medical coverage offered through employment or sponsored by the employer terminated, or the employer's contribution toward medical coverage terminated, and any lapse between the date that coverage ended and the date you become eligible under this *plan* is no more than 180 days (not including any waiting period imposed under this *plan*).

If your prior coverage was not through an employer, you will receive credit for that coverage if any lapse between the date that coverage ended and the date you become eligible under this *plan* is no more than 63 days (not including any waiting period imposed under this *plan*).

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

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

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

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

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

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

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

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

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

Employee is the person who, by meeting the *plan's* eligibility requirements for employees, is allowed to choose membership under this *plan* for himself or herself and his or her eligible *dependents*. Such requirements are outlined in HOW COVERAGE BEGINS AND ENDS.

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

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

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

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

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

Home infusion therapy provider is a provider licensed according to state and local laws as a pharmacy, and must be either certified as a home health care provider by Medicare, or accredited as a home pharmacy by the Joint Commission on Accreditation of Health Care Organizations. Home infusion therapy providers are licensed to provide the *beneficiary* with intra-venous medications in the *beneficiary's* home.

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

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

For the limited purpose of inpatient care for the acute phase of a *mental or nervous disorder*, or substance abuse, “hospital” also includes *psychiatric health facilities*.

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

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

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

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

Mental or nervous disorders, for the purposes of this *plan*, are conditions that affect thinking and the ability to figure things out, perception, mood and behavior. A mental or nervous disorder is recognized primarily by symptoms or signs that appear as distortions of normal thinking, distortions of the way things are perceived (e.g., seeing or hearing things that are not there), moodiness, sudden and/or extreme changes in mood, depression, and/or unusual behavior such as depressed behavior or highly agitated or manic behavior. Mental or nervous disorders include *severe mental disorders* as defined in this plan (see definition of “severe mental disorders”).

Any condition meeting this definition is a mental or nervous disorder no matter what the cause of the condition may be.

Negotiated rate is the amount *participating providers* agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by Prudent Buyer Plan Participating Provider Agreements. Note: If Medicare is the primary payor, the negotiated rate may be determined by Medicare’s approved amount (see HOW COVERED EXPENSE IS DETERMINED).

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

Non-participating pharmacy is a *pharmacy* which does not have a Participating Pharmacy Agreement in effect with the *claims administrator* at the time services are rendered. In most cases, you will be responsible for a larger portion of your pharmaceutical bill when you go to a non-participating pharmacy.

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

1. A *hospital*;
2. A *physician*;
3. An *ambulatory surgical center*;
4. A *home health agency*;
5. A facility which provides diagnostic imaging services;
6. A durable medical equipment outlet;
7. A *skilled nursing facility*;
8. A clinical laboratory; or
9. A *home infusion therapy provider*.

They are not *participating providers*. Remember that only a portion of the amount which a *non-participating provider* charges for services may be treated as *covered expense* under this *plan*. See YOUR MEDICAL BENEFITS: HOW COVERED EXPENSE IS DETERMINED.

Other health care provider is one of the following providers:

1. A certified registered nurse anesthetist;
2. A blood bank;
3. A licensed ambulance company; or
4. A *hospice*.

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

Participating pharmacy is a *pharmacy* which has a Participating Pharmacy Agreement in effect with the *pharmacy benefit manager* at the time services are rendered. Call your local *pharmacy* to determine whether it is a participating pharmacy or call the toll-free customer service telephone number.

Participating provider is one of the following providers which has a Prudent Buyer Plan Participating Provider Agreement in effect with the *claims administrator* at the time services are rendered:

1. A *hospital*;
2. A *physician*;
3. An *ambulatory surgical center*;
4. A *home health agency*;
5. A facility which provides diagnostic imaging services;
6. A durable medical equipment outlet;
7. A *skilled nursing facility*;
8. A clinical laboratory; or
9. A *home infusion therapy provider*.

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

Pharmacy means a licensed retail pharmacy.

Physician means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or

2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, and such license is required to render that service, is providing a service for which benefits are specified in this booklet, and when benefits would be provided if the services were provided by a physician as defined above:
- a. A dentist (D.D.S. or D.M.D.)
 - b. An optometrist (O.D.)
 - c. A dispensing optician
 - d. A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
 - e. A licensed clinical psychologist
 - f. A licensed clinical social worker (L.C.S.W.)
 - g. A marriage and family therapist (M.F.T.)
 - h. A physical therapist (P.T. or R.P.T.)*
 - i. A speech pathologist*
 - j. An audiologist*
 - k. An occupational therapist (O.T.R.)*
 - l. A respiratory care practitioner (R.C.P.)*
 - m. A *psychiatric mental health nurse* (R.N.)*
 - n. A nurse midwife**
 - o. A registered dietitian (R.D.)* for the provision of diabetic medical nutrition therapy only

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

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

Plan is the set of benefits described in this *summary plan description* and in the amendments to this *summary plan description*, if any. These benefits are subject to the terms and conditions of the *plan*. If changes are made to the plan, an amendment or revised *summary plan description* will be issued to each *beneficiary* affected by the change. (The word "plan" here does not mean the same as "plan" as used in ERISA.)

Plan administrator refers to SHASTA-TRINITY SCHOOLS INSURANCE GROUP, the entity which is responsible for the administration of the *plan*.

Pre-existing condition means an illness, injury or condition which existed during the six-month period immediately prior to either (a) your *effective date* or (b) the first day of any waiting period required by the *plan administrator*, whichever is earlier. A condition is considered to have existed when you: (1) sought or received medical advice for that condition; (2) received medical care or treatment for that condition; or (3) received medical supplies, drugs or medicines for that condition.

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

Prescription drug covered expense is the expense you incur for a covered *prescription drug*, but not more than the *prescription drug maximum allowed amount*. Expense is incurred on the date you receive the service or supply.

Prescription drug maximum allowed amount is the maximum amount we will allow for any *drug*. The amount is determined by us using prescription drug cost information provided to us by the *pharmacy benefits manager*. The amount is subject to change. You may determine the prescription drug maximum allowed amount of a particular drug by calling 1-800-700-2541 (or TTY/TDD 1-800-905-9821).

Prescription drug formulary (formulary) is a list which we have developed of outpatient *prescription drugs* which may be cost-effective, therapeutic choices. Any *participating pharmacy* can assist you in purchasing *drugs* listed on the formulary. You may also get information about covered formulary drugs by calling 1-800-700-2541 or going to our internet website anthem.com/ca.

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

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

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

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

Reasonable charge is a charge the *claims administrator* considers not to be excessive based on the circumstances of the care provided, including: (1) level of skill; experience involved; (2) the prevailing or common cost of similar services or supplies; and (3) any other factors which determine value.

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

Severe mental disorders include the following psychiatric diagnoses specified in California Health and Safety Code section 1374.72: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, and bulimia.

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

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

Skilled nursing facility is an institution that provides continuous skilled nursing services. It must be licensed according to state and local laws and be recognized as a skilled nursing facility under Medicare. The term “skilled nursing facility” includes *residential treatment center*.

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.

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

Spouse meets the *plan’s* eligibility requirements for spouses as outlined under HOW COVERAGE BEGINS AND ENDS.

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

Totally disabled dependent is a *dependent* who is unable to perform all activities usual for persons of that age.

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

Totally disabled retired employees are retired employees who are unable to perform all activities usual for persons of that age.

Transplant Centers of Expertise negotiated rate (COE negotiated rate) is the fee *COE* agree to accept as payment for covered services. It is usually lower than their normal charge. COE negotiated rates are determined by Centers of Expertise Agreements.

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

We (us, our) refers to SHASTA-TRINITY SCHOOLS INSURANCE GROUP.

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

You (your) refers to the *employee* and *dependent* who are enrolled for benefits under this *plan*.

FOR YOUR INFORMATION

ORGAN DONATION

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

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

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

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

www.donatelifecalifornia.org/

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

PLAN INFORMATION

The following information, together with the preceding material, forms a summary plan description. The benefit plan description covers group medical coverage to eligible employees of SHASTA-TRINITY SCHOOLS INSURANCE GROUP. SHASTA-TRINITY SCHOOLS INSURANCE GROUP'S Group Medical Plan is administered on a self insured basis with benefit claims processed by Anthem Blue Cross, on behalf of Anthem Blue Cross Life and Health Insurance Company (Claims Administrator).

1. **Plan Name.** The designated name of the Plan is: SHASTA-TRINITY SCHOOLS INSURANCE GROUP.
2. **Plan Sponsor.** The name and address of the entity which established and maintains the Plan is:

Shasta-Trinity Schools Insurance Group
6724 Lockheed Drive, Suite 3A
Redding, Ca. 96002
3. **Plan Numbers:**

The Employer's Identification Number (EIN) is 68-0258745.

The Plan Number is 501.
4. **Type of Plan.** The Plan is an employee welfare benefit plan providing group medical benefits.
5. **Source of Plan Contributions.** The contributions necessary to finance the Plan are provided by the employer and the employees.
6. **Plan Year.** The Plan's records are maintained on a plan year basis beginning each year on July 1st and ending on the following June 30th.
7. **Type of Administration/Funding.** Benefits are furnished under a health care plan funded by the Plan Sponsor. Anthem Blue Cross, on behalf of Anthem Blue Cross Life and Health Insurance Company, furnishes only certain claim processing and provider contracting services and has no financial responsibility for benefits.

Anthem Blue Cross address is:

Anthem Blue Cross
21555 Oxnard Street
Woodland Hills, California 91367

8. **Plan Administrator.** The name and address of the Plan Administrator is:

Shasta-Trinity Schools Insurance Group
6724 Lockheed Drive, Suite 3A
Redding, Ca. 96002

9. **Agent for Service of Legal Process.** The name and address of the designated agent for the service of legal process for the Plan is:

Shasta-Trinity Schools Insurance Group
6724 Lockheed Drive, Suite 3A
Redding, Ca. 96002

10. **Description of Benefits.** The Plan Description sets forth the benefits provided under this Prudent Buyer Plan. A brief explanation of these benefits may be found in the section entitled SUMMARY OF BENEFITS. A more detailed description of the benefits appears in the sections entitled YOUR MEDICAL BENEFITS; YOUR PRESCRIPTION DRUG BENEFITS.

Statement of Rights Under the Newborns' and Mother's Health Protection Act

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

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

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

11. **Eligibility for Participation.** The eligibility requirements for participation under this Prudent Buyer Plan are set forth in the Plan Description in the section entitled HOW COVERAGE BEGINS AND ENDS under the subsection HOW COVERAGE BEGINS.
12. **Grounds for Ineligibility or Loss or Denial of Benefits.** Details describing the circumstances which may result in: (a) disqualification from this Prudent Buyer Plan; (b) ineligibility for benefits; or (c) denial, loss, forfeiture or suspension of benefits under the Plan are set forth and identified in the Plan Description, as outlined below:
 - Reasons for ineligibility or loss of benefits may be found in the section entitled HOW COVERAGE BEGINS AND ENDS under the subsection HOW COVERAGE ENDS.
 - Benefits may be denied or suspended if statements a Plan participant has made in connection with obtaining coverage were false.
 - Information concerning situations under which benefits may be reduced or denied may also be found in the SUMMARY OF BENEFITS and DEFINITIONS sections and in the sections identified in the DESCRIPTION OF BENEFITS portion of this summary.
13. **Right to Amend or Terminate Plan.** The plan sponsor reserves the right to discontinue or change the Plan in any manner, at any time, for any reason, subject to any applicable legal requirement for prior notice.
14. **Plan is Not a Contract of Employment.** Nothing contained in this Plan will be construed as a contract or condition of employment between the employer and the employee. All employees are subject to discharge to the same extent as if this Plan had never been adopted.
15. **Claims Procedures.** The Plan Description contains information on reporting claims, including the time limitations on submitting a claim. Claim forms may be obtained from the Plan Administrator or the Claims Administrator.

If your claim is denied in whole or in part, you will receive a notice of the denial. The notice will explain the reason for the denial.

You, your beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request with the Claims Administrator for a review. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed and issues outlining the basis of the appeal may be submitted. You may have representation throughout the review procedure. Your request for review must be filed within 60 days after the receipt of the written notice of denial of a claim. A decision will be rendered by the Claims Administrator normally within 30 days after the receipt of the request for review. If there are special circumstances, the decision shall be rendered as soon as possible, but no later than 120 days after receipt of the request for review. The decision, after the review, shall be in writing and shall include specific reasons for the decision. This decision shall include specific reference to the pertinent benefit provisions of the Plan on which the decision is based.

An appeal of an adverse benefit decision is filed when submitted in writing to:

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

The written appeal will be treated as received by the Plan on the date that it is deposited in the U.S. Mail for first class delivery in a properly stamped envelope containing the above name and address. The postmark on any such envelope will be proof of the date of mailing.

An appeal of an adverse benefit determination of an urgent care claim may also be made by phone. The phone number to call is 1-800-757-1256.

In making a decision regarding an appeal of an adverse benefit decision, Anthem Blue Cross may refer the claim to the Plan Administrator. Benefits under this Plan will be paid only if the Claims Administrator or Plan Administrator decides in their discretion that the applicant is entitled to them.

16. **HIPAA Privacy Statement.** A federal law—the Health Insurance Portability and Accountability Act of 1996 (HIPAA)—imposes limits on how group health plans, carriers, and medical providers may use or disclose plan participants’ “protected health information” (PHI). It also gives individuals specified privacy rights, such as the right to access and copy their PHI that is held by health plans, carriers and providers, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated. For a complete description of your rights under HIPAA, review the Plan’s separate Privacy Notice. You may have received more than one Privacy Notice if benefits under this Plan are provided by various carriers and/or are self-funded by the Plan.

It is the policy of this Plan and of the plan sponsor not to retaliate or discriminate against, or intimidate any participant who exercises his/her privacy rights. Nor will we require anyone to waive his/her privacy rights as a condition of treatment, payment, enrollment in a health plan, or eligibility for benefits.

Medical and dental benefits under this Plan are self-funded, which means that benefits are paid from the general assets of the plan sponsor and are not guaranteed by an insurance company. Plan participants will receive a Privacy Notice from the Plan. The Privacy Notice informs participants about how their PHI can be used or disclosed by the Plan, its “business associates” and the plan sponsor, and also provides information about individuals’ privacy rights. The plan has designated a “Privacy Official.” If you have any questions about the Plan’s Privacy Policy, please contact the Human Resources Department for information on how to contact the Privacy Official.

This Plan, and the plan sponsor, will not use or further disclose your PHI except pursuant to an Authorization Form signed by the patient, or as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA’s privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor.