SISC III

SELF-INSURED SCHOOLS OF CALIFORNIA

Schools Helping Schools

Prudent Buyer Plan Benefit Booklet

PBC 80-C/20 10/15 – 04FX

A New Way For Your Health Records To Connect

Connecting your health records.

As an Anthem Blue Cross member, you're automatically enrolled in Cal INDEX. A new, state-of-the-art system in California that gives doctors quick access to your health history.

With your complete, up-to-date info in hand, doctors can help keep you safe from dangerous interactions with other drugs you're taking, avoid sending you for tests you've already taken — and make sure you're getting the best care possible.

Safe and Secure

Only participating doctors treating you can see your information. And the latest security measures keep your data safe, including a Chief Privacy Officer dedicated to protecting it.

This program is 100% optional. If you want to opt out of having your health information part of Cal INDEX, go to calindex.org/opt-out or call 1-888-510-7142.

MDLIVE

Your *plan* includes MDLIVE, a 24/7/365 service where you have access to doctors and pediatricians to help you anytime, anywhere about your medical care. You can register by calling MDLIVE toll free at **888-632-2738** or going on the internet at mdlive.com/sisc, be prepared to provide your name, the patient's name (if you're not calling for yourself), the *member's* identification number, and the patient's phone number.

Services are provided either through online video, where you see a doctor using your computer over the internet, over the telephone or through secure email.

The doctor will ask you some questions to help determine your health care needs. Based on the information you provide, the advice will include general health care and pediatric care of you or your dependent's condition. When to use MDLIVE:

- If you're considering the ER or urgent care center for a non-emergency medical issue.
- Your primary care doctor is not available.
- Traveling and in need of medical care.
- During or after normal business hours, nights, weekends and holidays.
- Request prescriptions or get refills.

We have made arrangements with an independent company to make MDLIVE available to you as a special service. It may be discontinued without notice.

Note: MDLIVE is an optional service. Remember, register to get started.

ConditionCare

Your *plan* includes ConditionCare to help you better understand and manage specific chronic health conditions and improve your overall quality of life. ConditionCare provides you with current and accurate data about Asthma, Diabetes, Congestive Heart Failure (CHF), Coronary Artery Disease (CAD) and Chronic Obstructive Pulmonary Disease (COPD) plus education to help you better manage and monitor your condition. ConditionCare also provides depression screening.

You may be identified for participation through paid claims history, hospital discharge reports, physician referral, or Case Management, or you may request to participate by calling ConditionCare toll free at **1-800-621-2232**. Participation is voluntary and confidential. These programs are available at no cost to you. Once identified as a potential participant, a ConditionCare representative will contact you. If you choose to

participate, a program to meet your specific needs will be designed. A team of health professionals will work with you to assess your individual needs, identify lifestyle issues, and support behavioral changes that can help resolve these issues. Your program may include:

- Mailing of educational materials outlining positive steps you can take to improve your health; and/or
- Phone calls from a nurse or other health professional to coach you through self-management of your condition and to answer questions.

ConditionCare offers you assistance and support in improving your overall health. It is not a substitute for your *physician's* care.

Dear Plan Member:

The benefits of this *plan* are provided for *medically necessary* services and supplies for the *subscriber* and enrolled dependents for a covered condition, subject to all of the terms and conditions of this *plan*, the *participation agreement* between the *participating employers* and SISC III, and the eligibility rules of SISC III.

This Benefit Booklet provides a complete explanation of your benefits, limitations and other *plan* provisions which apply to you.

Subscribers and covered dependents ("members") 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 Benefit Booklet ('*benefit booklet")* carefully so that you understand all the benefits your *plan* offers. Keep this Benefit Booklet handy in case you have any questions about your coverage.

Important: This is not an insured benefit plan. The benefits described in this Benefit Booklet 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).

COMPLAINT NOTICE

All complaints and disputes relating to coverage under this *plan* must be resolved in accordance with the *plan's* grievance procedures. Grievances may be made by telephone (please call the Member Services number on your Identification Card) or in writing (write to the Customer Service Department named on your identification card marked to the attention of the Customer Service Department). If you wish, the Customer Service will provide a Complaint Form which you may use to explain the matter.

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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 BENEFIT BOOKLET ENTITLED DEFINITIONS.

Participating Providers in California. The *plan* has made available to the *members* a network of various types of "Participating Providers". These providers are called "participating" because they have agreed to participate in the *claims administrator's* preferred provider organization program (PPO), called the Prudent Buyer Plan. *Participating providers* have agreed to a rate they will accept as reimbursement for covered services. The amount of benefits payable under this *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 *claims administrator's* website at **www.anthem.com/ca/sisc**. The listings include the credentials of *participating providers* such as specialty designations and board certification.

How to Access Primary and Specialty Care Services

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

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

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

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

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

Participating Providers Outside of California

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

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

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

Physicians. "Physician" means more than an M.D. Certain other practitioners are included in this term as it is used throughout the *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 care were provided by a medical doctor. As with the other terms, be sure to read the definition of "Physician" to determine which providers' services are covered. Only providers listed in the definition are covered as *physicians*. Please note also that certain providers' services are covered only upon referral of an M.D. (medical doctor) or D.O. (doctor of osteopathy). Providers for whom referral is required are indicated in the definition of "physician" by an asterisk (*).

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

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

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

Centers of Medical Excellence and Blue Distinction. The *claims administrator* is providing access to *Centers of Medical Excellence* (CME) networks, *Blue Distinction* (*BD*) and *Blue Distinction+ (BD+) Facility*. The facilities included in each of these networks are selected to provide the following specified medical services. Please refer to the DEFINITIONS section for a further description of these facilities:

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

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

- **Orthopedic Surgery Facilities.** Hospital facilities have been organized to provide inpatient services only for hip replacements, knee replacements and certain spine procedures listed in this *benefit booklet*. **These procedures are covered only when performed at a *Blue Distinction+ (BD+) Facility*.**

Care Outside the United States—BlueCard Worldwide

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

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

Payment Information

- **Participating BlueCard Worldwide hospitals.** In most cases, you should not have to pay upfront for inpatient care at participating BlueCard Worldwide *hospitals* except for the out-of-pocket costs you normally pay (non-covered services, deductible, copays, and coinsurance). The *hospital* should submit your claim on your behalf.
- **Doctors and/or non-participating hospitals.** You will have to pay upfront for outpatient services, care received from a *physician*, and inpatient care from a *hospital* that is not a participating BlueCard Worldwide *hospital*. Then you can complete a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim Filing

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

Additional Information About BlueCard Worldwide Claims.

- You are responsible, at your expense, for obtaining an English-language translation of foreign country provider claims and medical records.
- Exchange rates are determined as follows:
  - For inpatient *hospital* care, the rate is based on the date of admission.
  - For outpatient and professional services, the rate is based on the date the service is provided.

Claim Forms

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

www.bcbs.com/bluecardworldwide.

The address for submitting claims is on the form.

SUMMARY OF BENEFITS

THE BENEFITS OF THIS PLAN ARE PROVIDED ONLY FOR THOSE SERVICES THAT ARE DETERMINED TO BE MEDICALLY NECESSARY. THE FACT THAT A PHYSICIAN PRESCRIBES OR ORDERS A SERVICE DOES NOT, IN ITSELF, MEAN THAT THE SERVICE IS MEDICALLY NECESSARY OR THAT THE SERVICE IS COVERED UNDER THIS PLAN. CONSULT THIS BENEFIT BOOKLET OR TELEPHONE 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 "MAXIMUM ALLOWED AMOUNT") THAT ARE DEFINED IN THE DEFINITIONS SECTION. WHEN READING THROUGH THIS BENEFIT BOOKLET, CONSULT THE DEFINITIONS SECTION TO BE SURE THAT YOU UNDERSTAND THE MEANINGS OF THESE ITALICIZED WORDS.

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

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

Triage or Screening Services. If you have questions about a particular health condition or if you need someone to help you determine whether or not care is needed, triage or screening services are available to you from us by telephone. Triage or screening services are the evaluation of your health by a *physician* or a nurse who is trained to screen for the purpose of determining the urgency of your need for care. Please contact the MDLIVE 24/7/365 at the telephone number listed on your identification card 24 hours a day, 7 days a week.

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

Telehealth. This *plan* provides benefits for covered services that are appropriately provided through telehealth, subject to the terms and conditions of the *plan*. In-person contact between a health care provider and the patient is not required for these services, and the type of setting where these services are provided is not limited. “Telehealth” is the means of providing health care services using information and communication technologies in the consultation, diagnosis, treatment, education, and management of the patient’s health care when the patient is located at a distance from the health care provider. Telehealth does not include consultations between the patient and the health care provider, or between health care providers, by telephone, facsimile machine, or electronic mail.

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

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

MEDICAL BENEFITS

CALENDAR YEAR DEDUCTIBLES

- Member Deductible.....**$200**
- Family Deductible **$500**

Note: All deductible amounts will apply toward the satisfaction of the out-of-pocket amount.

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

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

– The Calendar Year Deductible will not apply to office visits to a *physician* who is a *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 diabetes education program services provided by a *physician* who is a *participating provider*.

– The Calendar Year Deductible will not apply to hospice care services provided by a *physician* who is a *participating provider*.

– The Calendar Year Deductible will not apply to transplant travel expenses authorized by the *claims administrator* in connection with a specified transplant procedure provided at a designated *Centers of Medical Excellence* (*CME)* or a *Blue Distinction* (*BD*).

– The Calendar Year Deductible will not apply to bariatric travel expense in connection with an authorized bariatric surgical procedure provided at a designated *Blue Distinction* (*BD*) or a *Blue Distinction+ (BD+)*.

– The Calendar Year Deductible will not apply to transgender travel expense in connection with an approved transgender surgery.

– The Calendar Year Deductible will not apply to consultations or second opinions provided by the *claims administrators* Telemedicine Network Specialty Center. The Calendar Year Deductible will apply to all other services provided by a Telemedicine Network Presentation Site or Specialty Center.

CO-PAYMENTS

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

- *Participating Providers*.....**20%**
- *Other Health Care Providers* **20%**
- *Non-Participating Providers* subject to *Scheduled Amounts* (See the SCHEDULES FOR NON-PARTICIPATING PROVIDERS) or Maximum Dollar Amounts for services or supplies, as shown under MEDICAL BENEFIT MAXIMUMS .....**No Co-Payment** except *member* is responsible for any amount exceeding *the maximum allowed amount*
- All other *Non-Participating Providers*.....**20%**

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

***Exceptions:**

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

– Your Co-Payment for office visits to a *physician* who is a *participating provider* will be **$20**. This Co-Payment will not apply toward the satisfaction of the Calendar Year Deductible.

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

– Your Co-Payment for diabetes education program services provided by a *physician* who is a *participating provider* will be **$20**. This Co-Payment will not apply toward the satisfaction of the Calendar Year Deductible.

– Your Co-Payment for covered outpatient services and supplies provided by a *non-participating hospital,* including outpatient surgery will be **50%** of the *maximum allowed amount.* This Co-Payment does not apply to *emergencies* as defined in the DEFINITIONS section.

– Your Co-Payment for acupuncture services provided by a *non-participating provider* will be **50%** of *the maximum allowed amount*.

– Your Co-Payment for consultations or second opinions provided by the *claims administrators* Telemedicine Network Specialty Center will be **$20**. This Co-Payment will not apply toward the satisfaction of the Calendar Year Deductible.

  Note: This exception applies only to the consultation or second opinion portion of the Specialty Center's bill. It does not apply to any other charges made.

– In addition to the Co-Payments shown above, you will be required to pay an additional **$100** Co-Payment for emergency room services and supplies. This 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.

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

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

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

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

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

– Your Co-Payment for orthopedic surgical procedures (knee replacements, hip replacements and spinal procedures) determined to be *medically necessary* and performed at a designated *Blue Distinction+ (BD+)* will be the same as for *participating providers*. **Services for orthopedic surgical procedures are not covered when performed at other than a designated *Blue Distinction+ (BD+)*.** See UTILIZATION REVIEW PROGRAM.

NOTE: Co-Payments do not apply to orthopedic surgical travel expenses authorized by the *claims administrator*. Orthopedic surgical travel expense coverage is available when the closest *Blue Distinction+ (BD+)* is 50 miles or more from the *member's* residence.

– Co-Payments do not apply to transgender travel expenses authorized by us. Transgender travel expense coverage is available when the facility at which the surgery or series of surgeries will be performed is 75 miles or more from the *member's* residence.

Important Note About Maximum Allowed Amount And Your Co-Payment: The *maximum allowed amount* for *non-participating providers* is significantly lower than what providers customarily charge. (See the SCHEDULES FOR NON-PARTICIPATING PROVIDERS.) You must pay all of this excess amount in addition to your Co-Payment.

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

- Member Out-of-Pocket Maximum **$1,000**
- Family Out-of-Pocket Maximum **$3,000**

***Exceptions:**

– Your Co-Payment for covered outpatient services and supplies provided by a *non-participating hospital,* including outpatient surgery will not be applied toward the satisfaction of your Out-of-Pocket Amount. In addition, you will be required to continue to pay your Co-Payment for such services even after you have reached that amount.

– Any Co-Payments and Coinsurance you make for covered services and supplies provided by a *non-participating provider,* except emergency services and supplies will not be applied toward the satisfaction of your Out-of-Pocket Amount. In addition, you will be required to continue to pay your Co-Payment for such services even after you have reached that amount.

– Any expense which is in excess of the *non-participating provider* amount for inpatient hospital services will not be applied toward the satisfaction of your Out-of-Pocket Amount.

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

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:

Hospital (Non-Participating Provider)*

- For covered inpatient *hospital* services and supplies ..... **$600** per day

* The maximum does not apply to *emergency services*.

Skilled Nursing Facility

- For covered *skilled nursing facility* care ..... **100 days** per *calendar year*
- For covered *skilled nursing facility* care in a *non-participating provider* facility ..... **$600** per day

Mental or Nervous Disorders or Substance Abuse (Non-Participating Provider)*

- For covered inpatient *hospital* services and supplies ..... **$600** per day

  * The maximum does not apply to *emergency services*.

Home Health Care

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

Home Infusion Therapy

- For all covered services and supplies received during any one day **$600***

  ***Non-participating providers** only

Ambulatory Surgical Center

- For all covered services and supplies **$350***

  ***Non-participating providers** only

Outpatient Hemodialysis

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

  ***Non-participating providers** only

Advanced Imaging Procedures

- For all covered services ..... **$800*** per procedure

  ***Non-participating providers** only

Ambulance

- For air ambulance transportation that is not related to an *emergency* ..... **$50,000*** per trip

  ***Non-participating providers** only

Acupuncture

- For all covered services ..... **12 visits** per *calendar year*

Hearing Aid Services

- Hearing aids **$700**
  in a 24-month period

Transplant Travel Expense

- For all authorized travel expense
  in connection with a specified transplant
  performed at a designated *Centers of Medical Excellence* (*CME)*
  or *Blue Distinction* (*BD*) **$10,000**
  per transplant

Unrelated Donor Searches

- For all charges for unrelated donor searches for
  covered bone marrow/stem cell transplants **$30,000**
  per transplant

Bariatric Travel Expense

- For the *member* and one companion (limited to three (3) maximum trips – one pre-operative trip, one surgery trip and one post-operative trip (if needed)
  - For transportation to the *Blue Distinction* (*BD*)
    or *Blue Distinction+ (BD+)* **$3,000**
    per surgery
  - Flight ..... Economy / Coach
    (preferred seats for surgery trip
    when aisle seat is not available)
  - Check in bag fees ..... 1 bag each
    for each flight
  - Ground Transportation (rental) ..... Economy / Intermediate / Standard
  - Ground Transportation (personal car) ..... 57.5 cents per mile
    (for 2015, will change yearly
    based on IRS guidelines)

Hip, Knee Replacements or Spine Surgery Travel Expense

- For the *member* and one companion (limited to three (3) maximum trips – one pre-operative trip, one surgery trip and one post-operative trip (if needed)
  - For transportation to the *Blue Distinction+ (BD+)* **$2,000**
    per trip maximum
- For the *member* and one companion (limited to one (1) night stay per pre-operative trip / post-operative trip (if needed) and (7) nights per surgery trip
  - Hotel accommodations **$150**
    per day maximum
  - Flight ..... Economy / Coach
    (preferred seats for surgery trip
    when aisle seat is not available)
  - Check in bag fees ..... 1 bag each
    for each flight

– Ground Transportation (rental) ..... Economy / Intermediate / Standard

– Ground Transportation (personal car) ..... 57.5 cents per mile (for 2015, will change yearly based on IRS guidelines)

Transgender Travel Expense

- For all travel expenses authorized by us in connection with authorized transgender surgery or surgeries ..... up to **$10,000** per surgery or series of surgeries

Lifetime Maximum

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

YOUR MEDICAL BENEFITS

MAXIMUM ALLOWED AMOUNT

General

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

Below are examples which illustrate how the *maximum allowed amount* works. These examples are for illustration purposes only.

1. **Example:** The plan has a *member* Co-Payment of 20% for *participating provider* services after the Deductible has been met.

   The *member* receives services from a *participating* surgeon. The charge is $2,000. The *maximum allowed amount* under the plan for the surgery is $1,000. The *member's* Co-Payment responsibility when a *participating* surgeon is used is 20% of $1,000, or $200. This is what the *member* pays. The plan pays 80% of $1,000, or $800. The *participating* surgeon accepts the total of $1,000 as reimbursement for the surgery regardless of the charges.

2. **Example:** The plan has a *member* Co-Payment of 20% for *non-participating provider* services after the Deductible has been met.

   The *member* receives services from a *non-participating* surgeon. The charge is $2,000. The *maximum allowed amount* under the plan for the surgery is $1,000. The *member's* Co-Payment responsibility when a *non-participating* surgeon is used is 20% of $1,000, or $200. The plan pays the remaining 80% of $1,000, or $800. In addition, the *non-participating* surgeon could bill the *member* the difference between $2,000 and $1,000. So the *member's* total out-of-pocket charge would be $200 plus an additional $1,000, for a total of $1,200.

3. **Example:** The plan has no co-payment for *non-participating provider* services subject to Scheduled Amounts after the Deductible has been met.

   The *member* receives services from a *non-participating* surgeon subject to scheduled amounts. The charge is $2,000. The *maximum allowed amount* under the plan for the surgery is $500. The *member* pays no co-payment when a *non-participating* surgeon subject to scheduled amounts is used. The plan pays the remaining 100% of $500. In addition, the *non-participating* surgeon could bill the *member* the difference between $2,000 and $500. So the *member's* total out-of-pocket charge would be $1,500. The scheduled amounts are often much less than the billed amount and the member is responsible for all billed charges not paid by the plan.

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

Provider Network Status

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

Participating Providers. For covered services performed by a *participating provider* the *maximum allowed amount* for this *plan* will be the rate the *participating provider* has agreed with the *claims administrator* to accept as reimbursement for the covered services. Because *participating providers* have agreed to accept the *maximum allowed amount* as payment in full for those covered services, they should not send you a bill or collect for amounts above the *maximum allowed amount.* However, you may receive a bill or be asked to pay all or a portion of the *maximum allowed amount* to the extent you have not met your Deductible or have a Co-Payment. Please call the customer service telephone number on your ID card for help in finding a *participating provider* or visit www.anthem.com/ca.

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

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

Non-Participating Providers.

Providers who are not in the Prudent Buyer network are *non-participating providers,* subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers. The *maximum allowed amount* for services provided by a *non-participating provider* will always be the lesser of the billed charge or the *scheduled amount*. See the SCHEDULES FOR NON-PARTICIPATING PROVIDERS, and the definition of "Scheduled Amount" in the DEFINITIONS section. You will be responsible for any billed charge which exceeds the *scheduled amount* for services provided by a *non-participating provider.*

Other Health Care Providers.

Other health care providers are providers for which there is no network. They are subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers. For covered services you receive from an *other health care provider* the *maximum allowed amount* will be based on the *claims administrator's* applicable *non-participating provider* rate or fee schedule for this plan, an amount negotiated by the *claims administrator* or a third party vendor which has been agreed to by the *non-participating provider,* an amount derived from the total charges billed by the *non-participating provider,* or an amount based on information provided by a third party vendor, or an amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services (“CMS”). When basing the *maximum allowed amount* upon the level or method of reimbursement used by CMS, the *claims administrator* will update such information, which is unadjusted for geographic locality, no less than annually.

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

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

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

***Exceptions:**

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

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

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

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

Member Cost Share

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

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

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

Authorized Referrals

In some circumstances the *claims administrator* may authorize *participating provider* cost share amounts (Deductibles or Co-Payments) to apply to a claim for a covered service you receive from a *non-participating provider*. In such circumstance, you or your *physician* must contact the *claims administrator* in advance of obtaining the covered service. It is your responsibility to ensure that the *claims administrator* has been contacted. If the *claims administrator* authorizes a *participating provider* cost share amount to apply to a covered service received from a *non-participating provider*, you also may still be liable for the difference between the *maximum allowed amount* and the *non-participating provider's* charge. Please call the customer service telephone number on your ID card for *authorized referral* information or to request authorization.

CALENDAR YEAR DEDUCTIBLE, CO-PAYMENTS, OUT-OF-POCKET AMOUNTS AND MEDICAL BENEFIT MAXIMUMS

After your Calendar Year Deductible and your Co-Payment is subtracted, the *plan* will pay, benefits up to the *maximum allowed amount*, not to exceed any applicable Medical Benefit Maximum. The Calendar Year Deductible amounts, Co-Payments, Out-of-Pocket Amounts and Medical Benefit Maximums are set forth in the SUMMARY OF BENEFITS.

CALENDAR YEAR DEDUCTIBLES

Each *year*, you will be responsible for satisfying the Member Calendar Year Deductible before benefits are paid. 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. No further Calendar Year Deductible expense will be required for any enrolled *member* of your family.

Covered charges incurred from October through December and applied toward the Calendar Year Deductible for that *year* also counts toward the Calendar Year Deductible for the next *year*.

Note: All deductible amounts will apply toward the satisfaction of the out-of-pocket amount.

CO-PAYMENTS

After you have satisfied the Calendar Year Deductible, your Co-Payment will be subtracted from the remaining *maximum allowed amount*.

If your Co-Payment is a percentage, the *plan* will apply the applicable percentage to the *maximum allowed amount* remaining after the Calendar Year Deductible has been met. This will determine the dollar amount of your Co-Payment.

OUT-OF-POCKET AMOUNTS

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

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

- Any Co-Payments and Coinsurance you make for covered services and supplies provided by a *non-participating provider,* except emergency services and supplies;
- Any expense which is in excess of the *non-participating provider* amount for inpatient hospital services;
- Charges for covered outpatient services and supplies provided by a *non-participating hospital,* including outpatient surgery;
- Charges for services or supplies not covered under this plan; and
- Charges which exceed the *maximum allowed amount.*

MEDICAL BENEFIT MAXIMUMS

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

CONDITIONS OF COVERAGE

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

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

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

Hospital

1. Inpatient services and supplies, provided by a *hospital*. The *maximum allowed amount* will not include charges in excess of the *hospital's* prevailing two-bed room rate unless there is a negotiated per diem rate between the *claims administrator* and the *hospital,* or unless your *physician* orders, and the *claims administrator* authorizes, a private room as *medically necessary*. For inpatient services and supplies provided by a *non-participating provider* facility, our maximum payment is limited to **$600** per day.*

   *The *non-participating provider* facility maximum does not apply to *emergency services*.

2. Services in *special care units*.

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

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

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

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

For services and supplies provided by a *non-participating provider* facility, our maximum payment is limited to **$600** per day.

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

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

1. Services of a registered nurse or licensed vocational nurse under the supervision of a registered nurse or a *physician*.

2. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy, or respiratory therapy.

3. Services of a medical social service worker.

4. Services of a health aide who is employed by (or who contracts with) a *home health agency*. Services must be ordered and supervised by a registered nurse employed by the *home health agency* as professional coordinator. These services are covered only if you are also receiving the services listed in 1 or 2 above.

5. *Medically necessary* supplies provided by the *home health agency*.

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

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

Home health care services are 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. Palliative care is care that controls pain and relieves symptoms but is not intended to cure the illness. You must be suffering from a terminal illness for which the prognosis of life expectancy is one year or less, as certified by your *physician* and submitted to the *claims administrator*. Covered services are available on a 24-hour basis for the management of your condition.

1. Interdisciplinary team care with the development and maintenance of an appropriate plan of care.
2. Short-term inpatient *hospital* care when required in periods of crisis or as respite care. Coverage of inpatient respite care is provided on an occasional basis and is limited to a maximum of five consecutive days per admission.
3. Skilled nursing services provided by or under the supervision of a registered nurse. Certified home health aide services and homemaker services provided under the supervision of a registered nurse.
4. Social services and counseling services provided by a qualified social worker.
5. Dietary and nutritional guidance. Nutritional support such as intravenous feeding or hyperalimentation.
6. Physical therapy, occupational therapy, speech therapy, and respiratory therapy provided by a licensed therapist.
7. Volunteer services provided by trained *hospice* volunteers under the direction of a *hospice* staff member.
8. Pharmaceuticals, medical equipment, and supplies necessary for the management of your condition. Oxygen and related respiratory therapy supplies.
9. Bereavement services, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following the *member'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 in your home by a *home infusion therapy provider* or in any other outpatient setting by a qualified health care provider, for the intravenous administration of your total daily nutritional intake or fluid requirements, 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); but, 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. Benefits for durable medical equipment will not be covered if rendered by a *non-participating* provider;

5. Laboratory services to monitor the patient's response to therapy regimen. Benefits for laboratory services will not be covered if rendered by a *non-participating* provider.

The *plan's* maximum payment will not exceed **$600** per day for services or supplies provided by a *non-participating provider*.

Home infusion therapy services are subject to pre-service review to determine medical necessity. (See UTILIZATION REVIEW PROGRAM).

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

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

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

Retail Health Clinic. Services and supplies provided by medical professionals who provide basic medical services in a retail health clinic including, but not limited to:

1. Exams for minor illnesses and injuries.

2. Preventive services and vaccinations.

3. Health condition monitoring and testing.

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

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

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

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

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

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

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

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

The *plan's* maximum payment will not exceed **$50,000** per trip for air ambulance transportation that is not related to an *emergency* when performed by a *non-participating provider*.

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

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

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

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

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

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

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

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

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

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

Diagnostic Services. Outpatient diagnostic imaging and laboratory services. This does not include services covered under the "Advanced Imaging Procedures" provision of this section. Benefits for diagnostic services will not be covered if rendered by a *non-participating* provider.

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

Advanced imaging procedures, when performed by a *non-participating provider*, will have a maximum benefit of **$800** per procedure.

Radiation Therapy

Chemotherapy.

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

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 are limited to a maximum of two therapeutic shoes and two inserts per *calendar year*; and
   e. Orthopedic footwear used as an integral part of a brace; shoe inserts that are custom molded to the patient.

   Benefits for prosthetic devices will not be covered if rendered by a *non-participating* provider.

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.

Rental charges that exceed the reasonable purchase price of the equipment are not covered. Benefits for durable medical equipment will not be covered if rendered by a *non-participating* provider. The *claims administrator* will determine whether the item satisfies the conditions above.

Specific durable medical equipment is subject to pre-service review to determine medical necessity. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

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

1. Nebulizers, including face masks and tubing, inhaler spacers, and peak flow meters.

2. Education for pediatric asthma, including education to enable the *child* to properly use the items listed above. This education will be covered under the *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 a*mbulatory surgical center*. This applies only if (a) the *member* is less than seven years old, (b) the *member* is developmentally disabled, or (c) the *member's* health is compromised and general anesthesia is *medically necessary*. Charges for the dental procedure itself, including professional fees of a dentist, are not covered.

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

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

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

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

Pregnancy and Maternity Care

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

   a. Prenatal and postnatal care;

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

   c. Involuntary complications of pregnancy;

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

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

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

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

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

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

1. The recipient; or

2. The donor.

Benefits for an organ donor are as follows:

- When both the person donating the organ and the person getting the organ are covered *members* under this *plan*, each will get benefits under their plans.

- When the person getting the organ is a covered *member* under this *plan*, but the person donating the organ is not, benefits under this *plan* are limited to benefits not available to the donor from any other source. This includes, but is not limited to, other insurance, grants, foundations, and government programs.

- If a *member* covered under this *plan* is donating the organ to someone who is **not** a covered *member*, benefits are not available under this *plan*.

The *maximum allowed amount* for a donor, including donor testing and donor search, is limited to expense incurred for *medically necessary* medical services only. The *maximum allowed amount* for services incidental to obtaining the transplanted material from a living donor or a human organ transplant bank will be covered. Such charges, including complications from the donor procedure for up to six weeks from the date of procurement, are covered. Services for treatment of a condition that is not directly related to or a direct result of, the transplant are not covered. The *plan's* payment for unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants will not exceed **$30,000** per transplant.

Covered services are subject to any applicable deductibles, co-payments and medical benefit maximums set forth in the SUMMARY OF BENEFITS. The *maximum allowed amount* does not include charges for services received without first obtaining the *claims administrator's* prior authorization or which are provided at a facility other than a transplant center approved by the *claims administrator*. See UTILIZATION REVIEW PROGRAM for details.

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

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

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

Specified Transplants

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

Transplant Travel Expense

Certain travel expenses incurred in connection with an approved, specified transplant (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures) performed at a designated *Centers of Medical Excellence (CME)* or *Blue Distinction (BD)* that is 75 miles or more from the recipient's or donor's place of residence are covered, provided the expenses are authorized by the *claims administrator* in advance. The *plan's* maximum payment will not exceed **$10,000** per transplant for the following travel expenses incurred by the recipient and one companion* or the donor:

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

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

The Calendar Year Deductible will not apply and no co-payments will be required for transplant travel expenses authorized in advance by the *claims administrator*. The *plan* will provide benefits for lodging and ground transportation, up to the current limits set forth in the Internal Revenue Code.

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

Details regarding reimbursement can be obtained by calling the customer service number on your identification card. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

Bariatric Surgery. Services and supplies in connection with *medically necessary* surgery for weight loss, only for morbid obesity and only when performed at a designated *Blue Distinction* (*BD*) or *Blue Distinction+ (BD+)* facility. See UTILIZATION REVIEW PROGRAM for details.

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

Bariatric Travel Expense. Certain travel expenses incurred in connection with an approved, specified bariatric surgery, performed at a designated *Blue Distinction* (*BD*) or *Blue Distinction+ (BD+)* that is fifty (50) miles or more from the *member's* place of residence, are covered, provided the expenses are authorized by the *claims administrator* in advance. The fifty (50) mile radius around the *Blue Distinction* (*BD*) or *Blue Distinction+ (BD+)* will be determined by the *bariatric Blue Distinction* (*BD*) or *Blue Distinction+ (BD+) coverage area*. (See DEFINITIONS) The *plan's* maximum payment will not exceed **$3,000** per surgery for the following travel expenses incurred by the *member* and/or one companion:

- Transportation for the *member* and/or one companion to and from the *Blue Distinction* (*BD*) or *Blue Distinction+ (BD+)* facility (limited to a three (3) trip maximum for (one pre-operative trip, one surgery trip and one post-operative trip (if needed).
- Flight for the *member* and one companion to and from the *Blue Distinction* (*BD*) or *Blue Distinction+ (BD+)* facility will only be Economy / Coach seating (preferred seats for surgery trip when aisle seat is not available).
- Check in bag fees will be 1 bag for member, 1 bag for companion for each flight.
- Ground Transportation (rental) will only be Economy / Intermediate / Standard.
- Ground Transportation (personal car) will be 57.5 cents per mile (for 2015, will change yearly based on IRS guidelines.
- Other reasonable expenses. Lodging expenses for band adjustments and expenses for tobacco, alcohol, drug and meal expenses are excluded from coverage.

Bariatric travel expense reimbursement is supported through our vendor, HealthBase.

For reimbursable expenses by HealthBase, the *member* must first call customer service who will submit the referral to HealthBase. HealthBase will contact the *member* to begin travel arrangements. Bariatric travel expense will only be covered through HealthBase.

<u>Travel benefit details</u>

- Flight:
  - Travel benefit offers an economy class flight. In case of any seat upgrades, you will be responsible for any upgrade cost.
  - If you check-in a bag and the airline charges a fee, only one check-in bag charge per eligible traveler is reimbursable. Please save your receipts.

- Rental car:
  - Type of rental car: Economy / Intermediate / Standard.
  - At the time picking up the rental car, your driver's license will need to be shown.
  - When you return the rental car, it should have "full" fuel. If you do not return it with a full tank, the rental car company will charge you a fee, and that fee is not included in the travel benefit; therefore you will be responsible for that fee. Please save your fuel receipts for reimbursement.
  - Toll, GPS, parking charges, etc. are not included in the travel benefit program. You are responsible for such charges.
  - Travel benefit includes rental car rate, taxes and insurance for the planned dates. Any additional products that you purchase will be your responsibility and you are to pay the rental car company directly.
  - Taxi charges are not included in the travel benefit.
- Personal car:
  - If you are eligible to use your car for driving to the *Blue Distinction* (*BD*) or *Blue Distinction+ (BD+)* facility, instead of flight or car rental, the mileage reimbursement is 57.5 cents per mile. You are responsible for all insurances, fuel charges, car maintenance, toll charges, GPS, parking charges, etc.
- Hotel:
  - Only room rent and taxes are included in the travel benefit.
  - Any charges for meals, laundry, minibar, internet, phone, movies, parking, etc. are not included in the travel benefit program. You are responsible for such charges.
  - At the time of check-in, the hotel staff will require your credit card for incidental charges and/or security deposit.
- Reimbursement:
  - After your trip, HealthBase will send you the expense reimbursement form. You can submit the form to HealthBase with your receipts by fax or postal mail. HealthBase will process the expense reimbursement form and send you a check to your home address for the approved expenses.

Hip, Knee Replacement or Spine Surgery. Inpatient services and supplies provided for *medically necessary* hip, knee replacement or spine surgery when performed by a designated *Blue Distinction+ (BD+)* hospital facility. Benefits for the following services are as follows:

- Total Knee Replacement
- Revision Knee Replacement
- Total Hip Replacement
- Revision Hip Replacement
- Discectomy
- Decompression (without fusion)
- Primary Fusion
- Revision Fusion

Covered services are subject to any applicable deductibles and co-payments set forth in the SUMMARY OF BENEFITS.

To find a *Blue Distinction+ (BD+)* hospital facility, please contact Customer Service and/or visit http://www.anthem.com/ca/SISC.

Hip, knee replacement or spine surgery services are subject to pre-service review to determine medical necessity. Benefits are provided for inpatient services for medically necessary hip replacement, knee replacement or spine surgery. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

Hip, Knee Replacement or Spine Surgery Travel Expense. The following travel expense benefits will be provided when the *member's* home is fifty (50) miles or more from a low cost facility, provided the expenses are authorized by the *claims administrator* in advance and only when performed at a designated *Blue Distinction+ (BD+)* facility. See UTILIZATION REVIEW PROGRAM for details

- Transportation for the *member* and one companion to and from the *Blue Distinction+ (BD+)* facility (limited to a three (3) trip maximum and **$2,000** per trip maximum for (one pre-operative trip, one surgery trip and one post-operative trip (if needed).
- Hotel accommodations for the *member* and one companion not to exceed **$150** per day maximum for one (1) night stay per pre-operative trip / post-operative trip (if needed) and (7) nights per surgery trip.
- Flight for the *member* and one companion to and from the *Blue Distinction+ (BD+)* facility will only be Economy / Coach seating (preferred seats for surgery trip when aisle seat is not available).
- Check in bag fees will be 1 bag for member, 1 bag for companion for each flight.
- Ground Transportation (rental) will only be Economy / Intermediate / Standard.
- Ground Transportation (personal car) will be 57.5 cents per mile (for 2015, will change yearly based on IRS guidelines.

Hip, knee replacement or spine surgery travel expense reimbursement is supported through our vendor, HealthBase.

For reimbursable expenses by HealthBase, the *member* must first call customer service who will submit the referral to HealthBase. HealthBase will contact the *member* to begin travel arrangements. Hip, knee replacement or spine surgery travel expense will only be covered through HealthBase.

Travel benefit details

- Flight:
  - Travel benefit offers an economy class flight. In case of any seat upgrades, you will be responsible for any upgrade cost.
  - If you check-in a bag and the airline charges a fee, only one check-in bag charge per eligible traveler is reimbursable. Please save your receipts.
- Rental car:
  - Type of rental car: Economy / Intermediate / Standard.
  - At the time picking up the rental car, your driver's license will need to be shown.
  - When you return the rental car, it should have "full" fuel. If you do not return it with a full tank, the rental car company will charge you a fee, and that fee is not included in the travel benefit; therefore you will be responsible for that fee. Please save your fuel receipts for reimbursement.
  - Toll, GPS, parking charges, etc. are not included in the travel benefit program. You are responsible for such charges.
  - Travel benefit includes rental car rate, taxes and insurance for the planned dates. Any additional products that you purchase will be your responsibility and you are to pay the rental car company directly.
  - Taxi charges are not included in the travel benefit.

- Personal car:
  - If you are eligible to use your car for driving to the *Blue Distinction+ (BD+)* facility, instead of flight or car rental, the mileage reimbursement is 57.5 cents per mile. You are responsible for all insurances, fuel charges, car maintenance, toll charges, GPS, parking charges, etc.
- Hotel:
  - Only room rent and taxes are included in the travel benefit.
  - Any charges for meals, laundry, minibar, internet, phone, movies, parking, etc. are not included in the travel benefit program. You are responsible for such charges.
  - At the time of check-in, the hotel staff will require your credit card for incidental charges and/or security deposit.
- Reimbursement:
  - After your trip, HealthBase will send you the expense reimbursement form. You can submit the form to HealthBase with your receipts by fax or postal mail. HealthBase will process the expense reimbursement form and send you a check to your home address for the approved expenses.

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

Coverage is provided for specific services according to *plan* benefits that apply to that type of service generally, if the *plan* includes coverage for the service in question. If a specific coverage is not included, the service will not be covered. For example, transgender surgery would be covered on the same basis as any other covered, *medically necessary* surgery.

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

Transgender Travel Expense. Certain travel expenses incurred in connection with an approved transgender surgery, when the *hospital* at which the surgery is performed is 75 miles or more from your place of residence, provided the expenses are authorized in advance by us. Our maximum payment will not exceed $10,000 per transgender surgery, or series of surgeries (if multiple surgical procedures are performed), for the following travel expenses incurred by you and one companion:

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

The Calendar Year Deductible will not apply and no co-payments will be required for transgender travel expenses authorized in advance by us. We will provide benefits for lodging, transportation, and other reasonable expenses up to the current limits set forth in the Internal Revenue Code, not to exceed the maximum amount specified above. This travel expense benefit is not available for non-surgical transgender services.

Details regarding reimbursement can be obtained by calling the customer service number on your identification 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, or to prevent the deterioration of chronic conditions.

1. Inpatient *hospital* services and services from a *residential treatment center* as stated in the "Hospital" provision of this section, for inpatient services and supplies. For inpatient services and supplies provided by a *non-participating provider* facility, our maximum payment is limited to **$600** per day.*

   *The *non-participating provider* facility maximum does not apply to *emergency services*.

2. Partial hospitalization, including intensive outpatient programs and visits to a *day treatment center*. Partial hospitalization is covered as stated in the "Hospital" provision of this section, for outpatient services and supplies.

3. *Physician* visits during a covered inpatient *stay*.

4. *Physician* visits for outpatient psychotherapy or psychological testing for the treatment of *mental or nervous disorders* or substance abuse. This includes nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa.

5. Behavioral health treatment for pervasive developmental disorder or autism. See the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM for a description of the services that are covered. **Note:** You must obtain pre-service review for all behavioral health treatment services for the treatment of pervasive developmental disorder or autism in order for these services to be covered by this *plan* (see UTILIZATION REVIEW PROGRAM for details). No benefits are payable for these services if pre-service review is not obtained.

(**Note:** The *maximum allowed amount* for *non-participating providers* will not exceed the *scheduled amount*. See the SCHEDULES FOR NON-PARTICIPATING PROVIDERS.)

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

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

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

2. Immunizations prescribed by the examining *physician.*

3. Radiology and laboratory services and tests ordered by the examining *physician* in connection with a routine physical examination, excluding any such tests related to an illness or injury. Those radiology and laboratory services and tests related to an illness or injury will be covered as any other medical service available under the terms and conditions of the provision "Diagnostic Services".

4. Health screenings as ordered by the examining *physician* for the following: breast cancer, including BRCA testing if appropriate (in conjunction with genetic counseling and evaluation), cervical cancer, including human papillomavirus (HPV), prostate cancer, colorectal cancer, and other medically accepted cancer screening tests, blood lead levels, high blood pressure, type 2 diabetes mellitus, cholesterol, obesity, and screening for iron deficiency anemia in pregnant women.

5. Human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.

6. Counseling and risk factor reduction intervention services for sexually transmitted infections, human immunodeficiency virus (HIV), contraception, tobacco use, and tobacco use-related diseases.

7. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:

a. All FDA-approved contraceptive methods for women that can only be administered in a *physician's* office, including over-the-counter items, if prescribed by a *physician*. Also covered are sterilization procedures and counseling.

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

c. Gestational diabetes screening.

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

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

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

Services under the Preventive Care Services benefit are covered only if provided by a *participating provider*.

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

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

http://www.ahrq.gov

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

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

1. Diagnostic mammogram examinations in connection with the treatment of a diagnosed illness or injury. Routine mammograms will be covered initially under the Preventive Care Services benefit.

2. Breast cancer (BRCA) testing, if appropriate, in conjunction with genetic counseling and evaluation. When done as a *preventive care service*, BRCA testing will be covered under the Preventive Care Services benefit.

3. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.

4. Reconstructive surgery of both breasts performed to restore and achieve symmetry following a *medically necessary* mastectomy.

5. Breast prostheses following a mastectomy (see "Prosthetic Devices").

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

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

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

1. Federally funded trials approved or funded by one or more of the following:

a. The National Institutes of Health,

b. The Centers for Disease Control and Prevention,

c. The Agency for Health Care Research and Quality,

d. The Centers for Medicare and Medicaid Services,

e. A cooperative group or center of any of the four entities listed above or the Department of Defense or the Department of Veterans Affairs,

f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants, or

g. Any of the following departments if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines (1) to be comparable to the system of peer review of investigations and studies used by the National Institutes of Health, and (2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:

   i. The Department of Veterans Affairs,

   ii. The Department of Defense, or

   iii. The Department of Energy.

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

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

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

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

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

1. The investigational item, device, or service itself.

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

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

4. Any item, device, or service that is paid for, or should have been paid for, by the sponsor of the trial.

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

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

1. Physical therapy and physical medicine and chiropractic care 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 chiropractors, physical therapists and osteopaths.)

2. Occupational therapy provided on an outpatient basis when the ability to perform daily life tasks has been lost or reduced by, or has not been developed due to, illness or injury including programs which are designed to rehabilitate mentally, physically or emotionally handicapped persons. Occupational therapy

programs are designed to maximize or improve a patient's upper extremity function, perceptual motor skills and ability to function in daily living activities.

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.

Outpatient visits will require medical necessity review after the first 5 visits per *calendar year*. Visits are counted on an annual basis per member, per provider office.

The review process for Physical Therapy, Physical Medicine, Occupational Therapy and Chiropractic Care will be managed by American Specialty Health Networks, Inc. (ASH Networks) through a Health Care Service Agreement with Anthem Blue Cross Life and Health Insurance Company (Anthem). The program is designed to assure that the services you receive are *medically necessary* and appropriate, and that your benefits are used to your best advantage.

All Physical Therapy, Physical Medicine, Occupational Therapy and Chiropractic Care, regardless of the provider type, will be submitted by your provider to ASH Networks for medical necessity review. If the service is within the first 5 visits per *member*, per provider, the service will be automatically authorized. After 5 visits, services provided by *participating providers* and *non-participating providers* may or may not be authorized as *medically necessary* by ASH Networks.

Medical necessity review after the first 5 visits is not required, however it is highly recommended. If the services requested by a non-par provider do not meet *medical necessity* criteria, the member will be financially responsible for services not approved as medically necessary. Services for Physical Therapy, Physical Medicine, Occupational Therapy and Chiropractic Care are subject to medical necessity by ASH Networks which allows providers and members to know up front what will be covered. Benefits for physical medicine will not be covered if rendered by a *non-participating* provider. If authorization is not obtained, claims for Physical Therapy, Physical Medicine, Occupational Therapy and Chiropractic Care will be reviewed upon receipt of the claim.

There is no limit on the number of covered visits for *medically necessary* Physical Therapy, Physical Medicine, Occupational Therapy and Chiropractic Care. But additional visits in excess of the number of visits stated above must be authorized in advance.

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*.

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

Speech Therapy.

Acupuncture. The services of a *physician* for acupuncture treatment to treat a disease, illness or injury, including a patient history visit, physical examination, treatment planning and treatment evaluation, electroacupuncture, cupping and moxibustion. The *plan* will pay for up to 12 visits during a *calendar year*.

If we apply covered charges toward the Calendar Year Deductible and do not provide payment, that visit is included in the visit maximum (12 visits) for that *year*.

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

1. Audiological evaluations to measure the extent of hearing loss and determine the most appropriate make and model of hearing aid.
2. Hearing aids (monaural or binaural) including ear mold(s), the hearing aid instrument, batteries, cords and other ancillary equipment up to a maximum payment of **$700** per *member* once in a twenty-four (24) month period.
3. Visits for fitting, counseling, adjustments and repairs for a one year period after receiving the covered hearing aid.

No benefits will be provided for the following:

1. Charges for a hearing aid which exceeds specifications prescribed for the correction of hearing loss.
2. Surgically implanted hearing devices (i.e., cochlear implants, audient bone conduction devices). *Medically necessary* surgically implanted hearing devices may be covered under your *plan's* benefits for prosthetic devices (see “Prosthetic Devices”).

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

   Diabetes education services are covered under *plan* benefits for office visits to *physicians*.
3. The following item is covered as a medical supply:
   a. alcohol swabs.

   Insulin and other prescriptive medications, insulin syringes, lancets, urine testing strips, blood glucose testing strips and disposable pen delivery systems for insulin administration are covered under your drug card plan unless you are enrolled in Medicare Part B as primary. If Medicare Part B covers any of the aforementioned under part B, this medical plan will cover as secondary.
4. Screenings for gestational diabetes are covered under your Preventive Care Services benefit. Please see that provision for further details.

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

1. A Christian Science sanatorium will be considered a hospital for purposes of this *plan*. The sanatorium must be accredited by the Department of Care of the First Church of Christ, Scientist; Boston, Massachusetts.

2. The term physician includes a Christian Science practitioner approved and accredited by the Mother Church, The First Church of Christ, Scientist; Boston, Massachusetts.

3. Benefits for the following services will be provided when you manifest symptoms of a covered illness or injury and receive Christian Science treatment for such symptoms.

   a. **Christian Science Sanatorium**. Services provided by a Christian Science sanatorium if you are admitted for active care of any illness or injury.

   b. **Christian Science Practitioner**. Office visits for services of a Christian Science practitioner providing treatment for a diagnosed illness or injury according to the healing practices of Christian Science.

NO BENEFITS ARE AVAILABLE FOR SPIRITUAL REFRESHMENT. All other provisions under the section of this *benefit booklet* entitled YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS NOT COVERED apply equally to Christian Science benefits as to all other benefits and providers of care.

Jaw Joint Disorders (TMJ). 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. Prior authorization is available for (i) surgical treatment of jaw joint disorders or conditions.

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

Telemedicine Program. Coverage will be provided for *telemedicine*, as defined in the DEFINITIONS section, for *members* only when provided by the *claim administrators* Telemedicine Network of designated providers specifically equipped and trained to provide *telemedicine* health care services.

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

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

Non-duplication of benefits applies to *pharmacy drugs* under this *plan*. When benefits are provided for *pharmacy drugs* under the *plan's* medical benefits, they will not be provided under any prescription drug plan sponsored by SISC III. Conversely, if benefits are provided for *pharmacy drugs* under your prescription drug plan sponsored by SISC III, they will not be provided under the *plan's* medical benefits.

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

In order for you to get a *specialty pharmacy drug* that requires prior authorization, your *physician* must make a request to the *claims administrator* for you to get it. The request may be made by either telephone or facsimile to the *claims administrator*. At the time the request is initiated, specific clinical information will be requested

from your *physician* based on medical policy and/or clinical guidelines, based specifically on your diagnosis and/or the *physician's* statement in the request or clinical rationale for the *specialty pharmacy drug*.

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

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

If you have any questions regarding whether a *specialty pharmacy drug* requires prior authorization, please call the telephone number on your I.D. card.

If a request for prior authorization of a *specialty pharmacy drug* is denied, you or your prescribing *physician* may appeal the decision by calling the telephone number on your I.D. card.

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

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, except as specifically stated under EXTENSION OF BENEFITS.

Non-Licensed Providers. Treatment or services rendered by non-licensed health care providers and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed provider under the supervision of a licensed *physician*, except as specifically provided or arranged by the *claims administrator*. This exclusion does not apply to the *medically necessary* treatment of pervasive developmental disorder or autism, to the extent stated in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.

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

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

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 *member* and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

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

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use if the program is not affiliated with the *claims administrator*. Smoking cessation *drugs*.

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

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

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

This exclusion does not apply to the following:

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

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

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

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a *home health agency, hospice* or *home infusion therapy provider* as specifically stated in the "Home Health Care", "Hospice Care", "Home Infusion Therapy", "Physical Therapy, Physical Medicine, Occupational Therapy and Chiropractic Care" provisions of MEDICAL CARE THAT IS COVERED. This exclusion also does not apply to the *medically necessary* treatment of *severe mental disorders*, or to the *medically necessary* treatment of pervasive developmental disorder or autism, to the extent stated in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.

Speech Therapy. Speech therapy except as stated in the "Speech Therapy" provision of MEDICAL CARE THAT IS COVERED. This exclusion also does not apply to the *medically necessary* treatment of *severe mental disorders*, or to the *medically necessary* treatment of pervasive developmental disorder or autism, to the extent stated in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.

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.

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

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

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

This exclusion does not apply to *medically necessary* treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as stated in the "Bariatric Surgery" provision of MEDICAL CARE THAT IS COVERED.

Transgender Services. Services and supplies in connection with transgender services, except as specifically stated in the "Transgender Services" provision under the section MEDICAL CARE THAT IS COVERED.

Sterilization Reversal. Reversal of sterilization.

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

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

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

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

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

Educational or Academic Services. This plan does not cover:

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

This exclusion does not apply to the *medically necessary* treatment of pervasive developmental disorder or autism, to the extent stated in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.

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

Telephone, Facsimile Machine and Web Consultations. Consultations provided by telephone, facsimile machine or by internet, except as provided under the "Christian Science Benefits" and "Telemedicine Program" provisions of MEDICAL CARE THAT IS COVERED.

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 "Preventive Care Services" provision of MEDICAL CARE THAT IS COVERED. Executive physical examinations and routine full body scans.

Acupuncture. Acupuncture treatment except as specifically stated in the "Acupuncture" provision of MEDICAL CARE THAT IS COVERED. Acupressure, or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

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

Physical Therapy or Physical Medicine. Services of a *physician* for physical therapy or physical medicine, except when provided during a covered inpatient confinement, or as specifically stated in the "Home Health Care", "Hospice Care", "Home Infusion Therapy", "Physical Therapy, Physical Medicine, Occupational Therapy and Chiropractic Care" provisions of MEDICAL CARE THAT IS COVERED. This exclusion also does not apply to the *medically necessary* treatment of *severe mental disorders*, or to the *medically necessary* treatment of pervasive developmental disorder or autism, to the extent stated in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specifically stated in the "Home Infusion Therapy" or "Preventive Care Services" provisions of MEDICAL CARE THAT IS COVERED. Non-prescription, over-the-counter patent or proprietary drugs or medicines, except as specifically stated in this *benefit booklet*. Cosmetics, health or beauty aids.

Specialty drugs. Lost or stolen *specialty drugs*. *Specialty drugs* that must be obtained from the specialty drug program, but, which are obtained from another vendor, including but not limited to 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**. This does not apply to exceptions that have been approved.

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

Private Duty Nursing. Private duty nursing services.

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

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

Transportation and Travel Expense. Expense incurred for transportation, except as specifically stated in the "Ambulance", "Transplant Travel Expense", "Bariatric Travel Expense", Transgender Travel Expense and "Hip, Knee Replacement or Spine Surgery Travel Expense" provisions of MEDICAL CARE THAT IS COVERED. Mileage reimbursement except as specifically stated in the "Transplant Travel Expense", "Bariatric Travel

Expense", Transgender Travel Expense and "Hip, Knee Replacement or Spine Surgery Travel Expense" provisions of MEDICAL CARE THAT IS COVERED and approved by the *claims administrator*. Charges incurred in the purchase or modification of a motor vehicle. Charges incurred for child care, telephone calls, laundry, postage, or entertainment. Frequent flyer miles; coupons, vouchers or travel tickets; prepayments of deposits.

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

BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM

This *plan* provides coverage for behavioral health treatment for Pervasive Developmental Disorder or autism for services provided to *members* up to the age of 21. This coverage is provided according to the terms and conditions of this *plan* that apply to all other medical conditions, except as specifically stated in this section.

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

You must obtain pre-service review for all behavioral health treatment services for the treatment of Pervasive Developmental Disorder or autism in order for these services to be covered by this *plan* (see UTILIZATION REVIEW PROGRAM for details). No benefits are payable for these services if pre-service review is not obtained.

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

DEFINITIONS

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

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

Intensive Behavioral Intervention means any form of Applied Behavioral Analysis that is comprehensive, designed to address all domains of functioning, and provided in multiple settings, across all settings, depending on the individual's needs and progress. Interventions can be delivered in a one-to-one ratio or small group format, as appropriate.

Qualified Autism Service Provider is either of the following:

- A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for Pervasive Developmental Disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified; or

- A person licensed as a physician and surgeon (M.D. or D.O.), physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to state law, who designs, supervises, or provides treatment for Pervasive Developmental Disorder or autism, provided the services are within the experience and competence of the licensee.

The *claims administrator's* network of *participating providers* is limited to licensed Qualified Autism Service Providers who contract with the *claims administrator* and who may supervise and employ Qualified Autism Service Professionals or Qualified Autism Service Paraprofessionals who provide and administer Behavioral Health Treatment.

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

- Provides behavioral health treatment,

- Is employed and supervised by a Qualified Autism Service Provider,

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

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

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

BEHAVIORAL HEALTH TREATMENT SERVICES COVERED

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

- The treatment must be prescribed by a licensed physician and surgeon (an M.D. or D.O.) or developed by a licensed clinical psychologist,
- The treatment must be provided under a treatment plan prescribed by a Qualified Autism Service Provider and administered by one of the following: (a) Qualified Autism Service Provider, (b) Qualified Autism Service Professional supervised and employed by the Qualified Autism Service Provider, or (c) Qualified Autism Service Paraprofessional supervised and employed by a Qualified Autism Service provider, and
- The treatment plan must have measurable goals over a specific timeline and be developed and approved by the Qualified Autism Service Provider for the specific patient being treated. The treatment plan must be reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate, and must be consistent with applicable state law that imposes requirements on the provision of Applied Behavioral Analysis services and Intensive Behavioral Intervention services to certain persons pursuant to which the Qualified Autism Service Provider does all of the following:
    - Describes the patient's behavioral health impairments to be treated,
    - Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the intervention plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported,
    - Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Pervasive Developmental Disorder or autism,
    - Discontinues Intensive Behavioral Intervention services when the treatment goals and objectives are achieved or no longer appropriate, and
    - The treatment plan is not used for purposes of providing or for the reimbursement of respite care, day care, or educational services, and is not used to reimburse a parent for participating in the treatment program. No coverage will be provided for any of these services or costs. The treatment plan must be made available to us upon request.

SUBROGATION AND REIMBURSEMENT

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

Subrogation

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

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

Reimbursement

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

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

1. The amount the *plan* paid on your behalf is not repaid or otherwise recovered by the *plan*; or
2. You fail to cooperate.

- In the event that you fail to disclose the amount of your settlement to the *plan*, the *plan* shall be entitled to deduct the amount of the *plan*'s lien from any future benefit under the *plan*.
- The *plan* shall also be entitled to recover any of the unsatisfied portion of the amount the *plan* has paid or the amount of your Recovery, whichever is less, directly from the Providers to whom the *plan* has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the *plan* will not have any obligation to pay the Provider or reimburse you.
- The *plan* is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or make you whole.

Your Duties

- You must notify the *plan* promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with the *plan* in the investigation, settlement and protection of the *plan's* rights. In the event that you or your legal representative fail to do whatever is necessary to enable the *plan* to exercise its subrogation or reimbursement rights, the *plan* shall be entitled to deduct the amount the *plan* paid from any future benefits under the *plan*.
- You must not do anything to prejudice the *plan*'s rights.
- You must send the *plan* copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify the *plan* if you retain an attorney or if a lawsuit is filed on your behalf.

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

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

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

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

COORDINATION OF BENEFITS

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

DEFINITIONS

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

Allowable Expense is any necessary, reasonable and customary item of expense which is at least partially covered by any plan covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid. An expense that is not covered by any plan covering the person for whom a claim is made is not Allowable Expense.

The following are not Allowable Expense:

1. Use of a private hospital room is not an Allowable Expense unless the patient's stay in a private *hospital* room is *medically necessary* in terms of generally accepted medical practice, or one of the plans routinely provides coverage for *hospital* private rooms.
2. If you are covered by two plans that calculate benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method, any amount in excess of the higher of the reasonable and customary amounts.
3. If a person is covered by two plans that provide benefits or services on the basis of negotiated rates or fees, an amount in excess of the lower of the negotiated rates.
4. If a person is covered by one plan that calculates its benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method and another plan provides its benefits or services on the basis of negotiated rates or fees, any amount in excess of the negotiated rate.
5. The amount of any benefit reduction by the Principal Plan because you did not comply with the plan’s provisions is not an Allowable Expense. Examples of these types of provisions include second surgical opinions, utilization review requirements, and network provider arrangements.
6. If you advise us that all plans covering you are high deductible health plans as defined by Section 223 of the Internal Revenue Code, and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code, any amount that is subject to the primary high deductible health plan’s deductible.

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage;
2. Group service plan contract, group practice, group individual practice and other group prepayment coverages;
3. Group coverage under labor-management trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.
4. Medicare. This does not include Medicare when, by law, its benefits are secondary to those of any private insurance program or other non-governmental program, including a self-insured 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 first of the following rules which applies will determine the order in which benefits are payable:

1. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision. This would include Medicare in all cases, except when the law requires that This Plan pays before Medicare.
2. A plan which covers you as a *subscriber* pays before a plan which covers you as a dependent. But, if you are retired and eligible for Medicare, Medicare pays (a) after the plan which covers you as a dependent of an active employee, but (b) before the plan which covers you as a retired employee.

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

For Active Subscriber and Dependents. *Members* entitled to Medicare receive the full benefits of this *plan*, except for those *members* listed below who are eligible for Medicare Part A because they have worked the required amount of time under the Social Security System:

1. *Members* who are receiving treatment for end-stage renal disease following the first 30 months such *members* are entitled to end-stage renal disease benefits under Medicare; and

2. *Members* who are entitled to Medicare benefits as disabled persons; unless, the *members* 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 that duplicate any benefits to which you would be entitled under full Medicare coverage (Medicare Parts A and B), whether or not you are actually enrolled in Medicare Parts A or B, and whether or not the benefits to which you are entitled are actually paid by Medicare.

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

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

2. For services you receive that are covered both by Medicare and under this *plan*, coverage under this *plan* will apply only to Medicare deductibles, coinsurance, and other charges for covered services over and above what Medicare pays.

3. For any given claim, the combination of benefits provided by Medicare and the benefits provided under this *plan* will not exceed the *maximum allowed amounts* for the covered services.

4. For covered drugs, including drugs covered under the pharmacy plan. The *plan* will pay secondary to Medicare for Medicare Part B drugs.

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

REQUIRED MONTHLY CONTRIBUTIONS FOR MEDICARE ELIGIBLE MEMBERS

For Active Subscribers and Dependents Entitled to but not enrolled under Medicare Part A and/or Medicare Part B. The required monthly contribution for coverage under this *plan* will be the required monthly contribution due for *members* covered under this *plan* who are not entitled to Medicare.

For Retired Employees and Their Spouses Entitled to but not enrolled under Medicare Part A and/or Medicare Part B. The required monthly contribution for coverage under this *plan* will be increased by an amount necessary to provide the hospital and/or medical benefits of this *plan*.

Note: Any *member* that is on a retiree SISC *plan* is required to enroll in Medicare Part A and B when eligible to enroll and stay enrolled; otherwise a surcharge will apply.

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 the *claims administrator* has determined that services can be safely provided in an outpatient setting, or if an inpatient *stay* is recommended. Services that are *medically necessary* and appropriate are certified by the *claims administrator* and monitored so that you know when it is no longer *medically necessary* and appropriate to continue those services.

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

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

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

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

UTILIZATION REVIEW REQUIREMENTS AND EFFECT ON BENEFITS

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

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

The appropriate utilization reviews must be performed in accordance with this *plan*. When pre-service review is performed and the admission, procedure or service is determined to be *medically necessary* and appropriate, benefits will be provided for the services listed below.

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

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

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

- Specific non-emergency outpatient services, including diagnostic treatment and other services.
- Specific outpatient surgeries performed in an outpatient facility or a doctor's office.
- Transplant services, including transplant travel expense. The following criteria must be met for certain transplants, as follows:
  - For bone, skin or cornea transplants, the *physicians* on the surgical team and the facility in which the transplant is to take place must be approved for the transplant requested.
  - For transplantation of heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney or bone marrow/stem cell and similar procedures, the providers of the related preoperative and postoperative services must be approved and the transplant must be performed at a *Centers of Medical Excellence (CME)* facility or a *Blue Distinction* (*BD*) facility.
- Air ambulance in a non-medical *emergency*.
- Visits for physical therapy, physical medicine, occupational therapy and chiropractic care beyond those described under the "Physical Therapy, Physical Medicine, Occupational Therapy and Chiropractic Care" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED. While there is no limit on the number of covered visits for *medically necessary* physical therapy, physical medicine, and occupational therapy and chiropractic care, additional visits in excess of the stated number of visits must be authorized in advance.
- Specific durable medical equipment.
- Infusion therapy or home infusion therapy, if the attending physician has submitted both a prescription and a plan of treatment before services are rendered.
- Home health care. The following criteria must be met:
  - The services can be safely provided in your home, as certified by your attending *physician*;
  - Your attending *physician* manages and directs your medical care at home; and
  - Your attending *physician* has established a definitive treatment plan which must be consistent with your medical needs and lists the services to be provided by the *home health agency*.
- Admissions to a *skilled nursing facility,* if you require daily skilled nursing or rehabilitation, as certified by your attending *physician*.
- Hip, knee replacement or spine surgical services, including hip, knee replacement or spine surgery travel expense, if:
  - The services are to be performed for hip, knee replacement or spine surgery;
  - 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
  - The hip, knee replacement or spine surgical procedure will be performed at a *Blue Distinction+ (BD+)* facility.
- Bariatric surgical services, such as gastric bypass and other surgical procedures for weight loss, including bariatric travel expense, if:
  - The services are to be performed for the treatment of morbid obesity;

- 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
- The bariatric surgical procedure will be performed at a *Blue Distinction* (*BD*) or a *Blue Distinction+ (BD+)* facility.

- Advanced imaging procedures, including but not limited to: Magnetic Resonance Imaging (MRI), Computerized Tomography (CT scan), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography, and Nuclear Cardiac Imaging. You may call the toll-free customer service telephone number on your identification card to find out if an imaging procedure requires pre-service review.
- Behavioral health treatment for pervasive developmental disorder or autism, as specified in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.
- Transgender services, including transgender travel expense, as specified under the "Transgender Services" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED. You must be diagnosed with gender identity disorder or gender dysphoria by a *physician*.

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

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

Retrospective review for medical necessity is performed to review services that have already been provided. This applies in cases when pre-service or care coordination review was not completed, or in order to evaluate and audit medical documentation subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified. Services that are not reviewed prior to or during service delivery will be reviewed retrospectively when the bill is submitted for benefit payment. If that review results in the determination that part or all of the services were not *medically necessary* and appropriate, benefits will not be provided for those services.

HOW TO OBTAIN UTILIZATION REVIEWS

Remember, it is always your responsibility to confirm that the review has been performed.

Pre-service Reviews.

1. For all scheduled services that are subject to utilization review, you or your *physician* must initiate the pre-service review at least five working days prior to when you are scheduled to receive services.
2. You must tell your *physician* that this *plan* requires pre-service review. *Physicians* who are *participating providers* will initiate the review on your behalf. A *non-participating provider* may initiate the review for you, or you may call the *claims administrator* directly. The toll-free number for pre-service review is printed on your identification card.
3. If you do not receive the reviewed service within 60 days of the certification, or if the nature of the service changes, a new pre-service review must be obtained.
4. The *claims administrator* will determine if services are *medically necessary* and appropriate. For inpatient *hospital* and *residential treatment center* stays, the *claims administrator* will, if appropriate, specify a specific length of *stay* for services. You, your *physician* and the provider of the service will receive a written confirmation showing this information.

Care coordination Reviews

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

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

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

***Extraordinary Circumstances.** In determining "extraordinary circumstances", the *claims administrator* may take into account whether or not your condition was severe enough to prevent you from notifying the *claims administrator*, 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

- If a pre-service review or a care coordination review was not performed, a retrospective review will be done to review services that have already been provided to determine if they are *medically necessary*.

- Retrospective review is performed when the *claims administrator* is not notified of the service you received, and are therefore unable to perform the appropriate review. It is also performed when pre-service or care coordination review has been done, but services continue longer than originally certified.

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

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

THE MEDICAL NECESSITY REVIEW PROCESS

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

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

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

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

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

4. If 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 the *claims administrator* is unsuccessful, and a delay is anticipated, they will notify you and your *physician* of the delay and what they need 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, care coordination 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 change. Requests satisfying these criteria are certified as *medically necessary*. Review Coordinators are able to approve most requests.

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

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

8. Only the Peer Clinical Reviewer may determine that the proposed services are not *medically necessary* and appropriate. Your *physician* will be notified by telephone within 24 hours of a decision not to certify and will be informed at that time of how to request reconsideration. Written notice will be sent to you and the requesting provider within two business days of the decision. This written notice will include:

   - an explanation of the reason for the decision,
   - reference of the criteria used in the decision to modify or not certify the request,
   - the name and phone number of the Peer Clinical Reviewer making the decision to modify or not certify the request,
   - how to request reconsideration if you or your provider disagree with the decision.

9. Reviewers may be plan employees or an independent third party the *claims administrator* chooses at their sole and absolute discretion.

10. You or your *physician* may request copies of specific criteria and/or medical policy by writing to the address shown on your plan identification card. The *claims administrator* discloses their medical necessity review procedures to health care providers through provider manuals and newsletters.

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

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

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

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

HOW PERSONAL CASE MANAGEMENT WORKS

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

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

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. The 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 belong to you and your *physician*. The *plan administrator* will, in no way, compromise your freedom to make such decisions.

EFFECT ON BENEFITS

1. Benefits are provided for an alternative treatment plan on a case-by-case basis only. The *claims administrator* has absolute discretion in deciding whether or not to authorize services in lieu of benefits for any *member,* which alternatives may be offered and the terms of the offer.

2. The *claims administrator's* 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*.

3. 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. Please refer to YOUR RIGHT TO APPEALS – EXTERNAL REVIEW for information on how to obtain the proper review.

2. If the appeal decision is still unsatisfactory, your remedy may be binding arbitration. (See BINDING ARBITRATION.)

EXCEPTIONS TO THE UTILIZATION REVIEW PROGRAM

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

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

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

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

QUALITY ASSURANCE

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

HOW COVERAGE BEGINS AND ENDS

HOW COVERAGE BEGINS

PARTICIPATION REQUIREMENTS

Subscribers. Any *subscriber* who works at least 20 hours per week is eligible to enroll. Any *subscriber* who works an average of 30 hours per week as defined by federal law must be offered coverage. Any *subscriber* who works at least 90% of a 40 hour work week must enroll according to SISC III's eligibility policy.

ELIGIBLE STATUS

1. **Subscriber's**

   a. A classified non-temporary *subscriber* who works the minimum number of hours required by SISC III and the *participating employer*.

   b. A certificated *subscriber* under contract and who works a minimum of 50% of a certificated job.

   c. A *retired employee* who retired from active employment and was covered under a *plan* sponsored by SISC III immediately prior to retirement.

2. **Dependent's**

   The following persons are eligible to enroll as *dependents*: (a) Either the *subscribers spouse* or *domestic partner*; and (b) A child.

Definition of Dependent

1. **Spouse** is the *subscriber's* spouse as recognized under state or federal law. This includes same sex spouses when legally married in a state that recognizes same sex marriages. Spouse does not include any person who is in active service in the armed forces.

   Note: Legally separated spouses are eligible for coverage under this *plan*.

2. **Domestic partner** is the *subscriber's* domestic partner. Domestic partner does not include any person who is in active service in the armed forces. In order for the *subscriber* to include their domestic partner as a *dependent*, the *subscriber* and domestic partner must meet the following requirements:

   a. Both persons have a common residence.

   b. Both persons agree to be jointly responsible for each other's basic living expenses incurred during their domestic partnership.

   c. Neither person is married or a member of another domestic partnership.

   d. The two persons are not related by blood in a way that would prevent them from being married to each other in California.

   e. Both persons are at least 18 years of age.

   f. 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 members. 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.

   g. Both persons are capable of consenting to the domestic partnership.

h. Neither person has previously filed: (1) a Declaration of Domestic Partnership with the California Secretary of State, or a similar form with another governing jurisdiction, that has not been terminated pursuant to the laws of California, or of that other jurisdiction; or, if (1) does not apply, (2) an affidavit with SISC III declaring they are part of a domestic partnership that they have not been terminated by giving SISC III written notice that it has.

i. It has been at least six months since: (1) the date that the Notice of Termination of Domestic Partnership was filed with the California Secretary of State, or similar form was filed with another governing authority; or, if (1) does not apply, (2) either person has given written notice to SISC III that the domestic partnership they declared in an affidavit, given to SISC III, has terminated. This item does not apply if the previous domestic partnership ended because one of the partners died or married.

j. Both partners:

   i. If they reside in the State of California, must file a Declaration of Domestic Partnership with the California Secretary of State pursuant to Division 2.5 of the California Family Code to establish their domestic partnership. The *subscriber* must provide SISC III with a certified copy of the Declaration of Domestic Partnership that was filed with the California Secretary of State;

   ii. If they reside in another state or governing jurisdiction that registers domestic partnerships, they must register their domestic partnership with that state or governing jurisdiction. The *subscriber* must provide SISC III with a certified copy of the document that was filed with the governing jurisdiction registering their domestic partnership; or

   iii. If the *subscriber* and their domestic partner do not reside in a city, county or state that allows them to register as domestic partners, they must provide SISC III with a signed, notarized, affidavit certifying they meet all of the requirements set forth in 2.a through 2.i above, inclusive.

   Note: For the purposes of 2.j.i above, if the *subscriber* and their domestic partner registered their relationship prior to July 1, 2000, with a local governing jurisdiction in California, in lieu of supplying SISC III with a certified copy of the Declaration of Domestic Partnership (a State of California form), the *subscriber* may provide SISC III with a certified copy of the form filed with the local governing jurisdiction.

For the purposes of this provision, the following definitions apply:

"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.

"Basic living expenses" means shelter, utilities, and all other costs directly related to the maintenance of the common household of the common residence of the domestic partners. It also means any other cost, such as medical care, if some or all of the cost is paid as a benefit because a person is another person's domestic partner.

"Joint responsibility" means that each partner agrees to provide for the other partner's basic living expenses if the partner is unable to provide for herself or himself. Persons to whom these expenses are owed may enforce this responsibility if, in extending credit or providing goods or services, they relied on the existence of the domestic partnership and the agreement of both partners to be jointly responsible for those specific expenses.

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

   a. The child is under 26 years of age.

   b. The unmarried child is 26 years of age, or older and: (i) was covered under the *prior plan*, was covered as a *dependent* of the *subscriber* under another plan or health insurer, or has six or more

months of other *creditable coverage*; (ii) continues to be dependent on the *subscriber, spouse or domestic partner* for financial support and maintenance as defined by IRS rules; or (iii) is incapable of self-sustaining employment due to a physical or mental condition. A *physician* must certify in writing that the child is incapable of self-sustaining employment due to a physical or mental condition. SISC III must receive the certification, at no expense to itself, within 60-days of the date the *subscriber* receives the request from SISC III. SISC III may request proof of continuing dependency and that a physical or mental condition still exists, but not more often than once each year after the initial certification. This exception will last until the child is no longer chiefly dependent *on the subscriber, spouse or domestic partner* for financial support as defined by IRS rules and maintenance due to a continuing physical or mental condition. A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

c. A child who is in the process of being adopted is considered a legally adopted child if SISC III receives legal evidence of both: (i) the intent to adopt; and (ii) that the *subscriber*, *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 *subscriber's*, the *spouse's* or *domestic partner's* right to control the health care of the child.

d. A Child for whom the *subscriber*, *spouse* or *domestic partner* is a legal guardian is considered eligible on the date of the court decree. SISC III must receive legal evidence of the decree. Such Child must be enrolled as set forth in the ENROLLMENT and EFFECTIVE DATE provisions below.

Important Note: Before a *dependent's* enrollment is processed, SISC III reserves the right to request documentation or proof of his or her eligibility (that is a marriage certificate, a birth certificate, a court decree, adoption papers or any other documentation that SISC deems relevant and appropriate). SISC also reserves the right to request any relevant and appropriate documentation at any time to confirm a *dependent's* continued eligibility. In addition, before you can enroll your domestic partner, SISC III reserves the right to request documentation or proof to support the domestic partnership (that is a Declaration of Domestic Partnership or properly executed affidavit as noted above under **Domestic Partner**).

ELIGIBILITY DATE

1. For *subscribers,* you become eligible for coverage in accordance with rules established by your employer, but the effective date must be the first of the month. For specific information about your employer's eligibility rules for coverage, please contact your Human Resources or Benefits Department.

2. For *dependents,* you become eligible for coverage on the later of: (a) the date the *subscriber* becomes eligible for coverage; or, (b) the date you meet the *dependent* definition.

ENROLLMENT

To enroll as a *subscriber,* or to enroll *dependents,* the *subscriber* must properly file an application with SISC III. An application is considered properly filed, only if it is personally signed, dated, and given to SISC III within 31 days from your eligibility date. If any of these steps are not followed, your coverage may be denied or you may have to wait until the next Open Enrollment Period to enroll.

EFFECTIVE DATE

Your effective date of coverage is subject to the timely payment of required monthly contributions as stated in the *participation agreement*. 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 *subscribers,* on the first day of the month following your date of hire or the first day of your hire month if your hire date is the first working day of the month; and (b) for *dependents,* on the later of (i) the date the *subscriber'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 a *dependent* from coverage under this *plan* during the open enrollment period, 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).

Note: Disenrollment is not allowed for qualified *subscribers.* Disenrollment of *dependents* outside of the open enrollment period is only allowed due to a qualifying event.

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 *subscriber* (or *spouse* or *domestic partner*, if the *spouse* or *domestic partner* is enrolled) is already covered: (1) any *child* born to the *subscriber*, *spouse* or *domestic partner* will be covered from the moment of birth; and (2) any *child* being adopted by the *subscriber*, *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 *subscriber*, *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 *subscriber's*, *spouse's* or *domestic partner's* right to control the health care of the *child* may be used)*;* or (b) the *subscriber*, *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 *subscriber* must enroll the *child* within the 31-day period by submitting a membership change form to SISC III. Any membership change form not filed within the 31-day period must be submitted to SISC III during the Open Enrollment Period generally held during September of each year for an effective date of October 1.

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. For less than full-time *subscribers* or *subscribers* who receive less than the amount contributed toward the cost of a full-time *subscriber:*

    a. If you declined coverage you must file an application with SISC III to enroll within a time period ending 31 days after: (a) the date of an increase in the number of hours worked; or (b) the date of an increase in amount contributed by the *participating employer.* Coverage will become effective on the first day of the month following the date of the event.

    b. If you declined coverage because you were covered elsewhere, you must file an application with SISC III to enroll within a time period ending 31 days after the date you lose coverage. You must have signed a declination of coverage form when first eligible or during the Open Enrollment Period stating you declined coverage because you were covered elsewhere and evidence of loss of coverage must be submitted to SISC III with your application for enrollment. Coverage will become effective on the first day of the month following the date you lost coverage.

2. For all other *subscribers* and eligible *dependents:*

   You have met all of the following requirements:

   a. You were covered as a member or dependent under either:

      i. Another employer group health plan or health insurance coverage, including coverage under a COBRA or CalCOBRA continuation; or

      ii. A state Medicaid plan or under a state child health insurance program (SCHIP), including the Healthy Families Program or the Access for Infants and Mothers (AIM) Program.

      iii. You certified in writing at the time you became eligible for coverage under this *plan* that you were declining coverage under this *plan* or disenrolling because you were covered under another health plan as stated above and you were given written notice that if you choose to enroll later, you may be required to wait until the next open enrollment period to do so.

      iv. Your coverage under the other health plan wherein you were covered as a member or dependent ended as follows:

         a. If the other health plan was another employer group health plan or health insurance coverage, including coverage under a COBRA or CalCOBRA continuation, coverage ended because you lost eligibility under the other plan, your coverage under a COBRA or CalCOBRA continuation was exhausted, or employer contributions toward coverage under the other plan terminated.

            Loss of eligibility for coverage under an employer group health plan or health insurance includes loss of eligibility due to termination of employment or change in employment status, reduction in the number of hours worked, loss of dependent status under the terms of the *plan*, termination of the other plan, legal separation, divorce, death of the person through whom you were covered, and any loss of eligibility for coverage after a period of time that is measured by reference to any of the foregoing.

         b. If the other health plan was a state Medicaid plan or a state child health insurance program (SCHIP), including the Healthy Families Program or the Access for Infants and Mothers (AIM) Program, coverage ended because you lost eligibility under the program. You must properly file an application with SISC III within 60 days after the date your coverage ended.

      v. You properly file an application with SISC III within 31 days from the date on which you lose coverage.

   b. A court has ordered coverage be provided under your employee health plan for: (i) a *spouse*; (ii) a *domestic partner*; or (iii) a dependent *child*, but only if the *spouse*, *domestic partner* and/or dependent *child* meets the eligibility requirements of the *plan.* Application must be filed within 31 days from the date the court order is issued.

   c. You have a change in family status through either marriage or domestic partnership, or the birth, adoption, or placement for adoption of a *child*:

      i. 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.

      ii. 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 on the first day of the month following the date of birth. For adoption, or placement for adoption coverage will be effective as of the date of the court decree.

3. 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.

4. You become eligible for assistance, with respect to the cost of coverage under the employer's group *plan*, under a state Medicaid or SCHIP health plan, including any waiver or demonstration project conducted under or in relation to these plans. You must properly file an application with SISC III within 60 days after the date you are determined to be eligible for this assistance.

5. You are an employee who is a reservist as defined by state or federal law, who terminated coverage as a result of being ordered to military service as defined under state or federal law, and apply for reinstatement of coverage following reemployment with your employer. Your coverage will be reinstated without any waiting period. The coverage of any dependents whose coverage was also terminated will also be reinstated. For dependents, this applies only to dependents who were covered under the plan and whose coverage terminated when the employee's coverage terminated. Other dependents who were not covered may not enroll at this time unless they qualify under another of the circumstances listed above.

Effective date of coverage. For enrollments during a special enrollment period as described above, coverage will be effective on the first day of the month following the date you file the enrollment application, except as specified below:

1. If a court has ordered that coverage be provided for a dependent *child*, coverage will become effective for that *child* on the earlier of (a) the first day of the month following the date you file the enrollment application or (b) within 30 days after a copy of the court order is received or of a request from the district attorney, either parent or the person having custody of the *child*, or the employer.

2. For reservists and their dependents applying for reinstatement of coverage following reemployment with the employer, coverage will be effective as of the date of reemployment.

OPEN ENROLLMENT PERIOD

There is an open enrollment period once each *year*. This period of time is generally held during the month of September. During that time, a member who meets the eligibility requirements as a *subscriber* under this *plan* may enroll. A *subscriber* may also enroll any eligible *dependents* at that time. Persons eligible to enroll as *dependents* may enroll only under the *subscriber's plan*.

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

HOW COVERAGE ENDS

Coverage may be cancelled without notice from SISC III for any of the reasons listed below. SISC III does not provide notice of cancellation to members, but will notify the *participating employer*.

1. **Subscriber**

   a. If the *participation agreement* between the *participating employer* and SISC III terminates, the *subscriber's* coverage ends at the same time. Either the *participating employer* or SISC III may cancel or change the *participation agreement* without notice to *subscribers*.

   b. If the *participating employer* no longer provides coverage for the class of a members to which the *subscriber* belongs, the *subscriber's* coverage ends when coverage for that class ends.

   c. If the *subscriber* no longer meets the eligibility requirements established by SISC III in the *participation agreement*, the *subscriber's* coverage ends as of the next required monthly contribution due date. This is usually the first of the month.

   d. If required monthly contributions are not paid on the *subscriber's* behalf, the *subscriber's* coverage will end on the first day of the period for which required monthly contributions are not paid.

e. If less than full-time *subscribers* or *subscribers* who receive less than the amount contributed toward the cost of a full-time *subscriber* voluntarily cancel coverage, coverage ends on the first day of the month following a 30-day notice.

f. If a *retired employee* does not elect coverage upon his or her retirement, coverage ends on the first day of the month immediately following his or her retirement date. If a *retired employee* declines district coverage, the *retired employee* may not elect coverage at a future date.

Exception to item c.:

If required monthly contributions are paid, coverage may continue for a *subscriber* who is granted a temporary leave of absence up to six months, a sabbatical year's leave of absence of up to 12 months, or an extended leave of absence due to illness certified annually by the *participating employer*.

2. **Dependents**

a. If coverage for the *subscriber* ends, coverage for *dependents* ends at the same time.

b. If coverage for *dependents* ceases to be available to the *subscriber*, *dependent's* coverage ends on that date.

c. If the *participating employer* fails to pay the required monthly contributions on behalf of a *dependent*, coverage ends on the last date for which the *participating employer* made this payment.

d. If a *dependent's* coverage is canceled, coverage ends on the first day of the month following a written notice within 31 days of a qualifying event.

e. If a *dependent* no longer meets the requirements set forth in the "Eligible Status" provision of HOW COVERAGE BEGINS, coverage ends on the first day of the month following that date.

Exceptions to item e.:

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 chiefly dependent on the *subscriber*, *spouse* or *domestic partner* for support and maintenance as defined by IRS rules, and (iii) incapable of self-sustaining employment due to a physical or mental condition. A *physician* must certify in writing that the *child* has a physical or mental condition that makes the child incapable of obtaining self-sustaining employment. Anthem will notify the *subscriber* that the *child's* coverage will end when the *child* reaches the *plan's* upper age limit at least 90-days prior to the date the *child* reaches that age. The *subscriber* must send SISC III proof of the *child's* physical or mental condition within 60-days of the date the *subscriber* receives Anthem's request. If SISC III does not complete their determination of the *child's* continuing eligibility by the date the *child* reaches the *plan's* upper age limit, the *child* will remain covered pending determination by SISC III. When a period of two years has passed, SISC III may request proof of continuing dependency due to a continuing physical or mental condition, but not more often than once each year. This exception will last until the *child* is no longer chiefly dependent on the *subscriber*, *spouse* or *domestic partner* for support and maintenance or a physical or mental condition no longer exists. A *child* is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

All conditions of eligibility shall be in accordance with the eligibility rules adopted by SISC III.

Note: If a marriage or domestic partnership terminates, the *subscriber* must give or send to SISC III written notice of the termination. Coverage for a former *spouse* or *domestic partner*, if any, ends according to the "Eligible Status" provisions. If SISC III suffers a loss as a result of the *subscriber* failing to notify them of the termination of their marriage or domestic partnership, SISC III may seek recovery from the *subscriber* for any actual loss resulting thereby. Failure to provide written notice to SISC III will not delay or prevent termination of the marriage or domestic partnership. If the *subscriber* 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 *subscriber'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 CONTINUATION OF COVERAGE, CALCOBRA CONTINUATION OF COVERAGE, CONTINUATION FOR DISABLED DISTRICT MEMBERS, COVERAGE FOR SURVIVING SPOUSES OF CERTIFICATED MEMBERS, CONTINUATION DURING LABOR DISPUTE, and EXTENSION OF BENEFITS.

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 a *subscriber* or *dependent;* and (b) a *child* who is born to or placed for adoption with the *subscriber* during the COBRA continuation period. Qualified Beneficiary does not include any person who was not enrolled during the Initial Enrollment Period, including any *dependents* acquired during the COBRA continuation period, with the exception of newborns and adoptees as specified above.

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

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

ELIGIBILITY FOR COBRA CONTINUATION

A *subscriber* or *dependent* 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 *participating employer* or its administrator (we are not the administrator) will notify either the *subscriber* or *dependent* of the right to continue coverage under COBRA, as provided below:

1. For Qualifying Events 1, or 2, the *participating employer* or its administrator will notify the *subscriber* of the right to continue coverage.

2. For Qualifying Events 3(a) or 3(e) above, a *dependent* will be notified of the COBRA continuation right.

3. You must inform the *participating employer* within 60 days of Qualifying Events 3(b), 3(c) or 3(d) above if you wish to continue coverage. The *participating employer* in turn will promptly give you official notice of the COBRA continuation right.

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

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

Notice of continued coverage, along with the initial required monthly contribution, must be delivered to the *participating employer* within 45 days after you elect COBRA continuation coverage.

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

Cost of Coverage. The *participating employer* 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 *participating employer* each month during the COBRA continuation period. SISC III must receive payment of the required monthly contribution each month from the *participating employer* in order to maintain the coverage in force.

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

1. A *spouse* whose COBRA continuation began due to divorce, separation or death of the *subscriber;*

2. A *domestic partner* whose COBRA continuation began due to the end of the domestic partnership or death of the *subscriber;*

3. A *child* if neither the *subscriber* nor the *spouse* has enrolled for this COBRA continuation coverage (if more than one *child* is so enrolled, the required monthly contribution will be the two-party or three-party rate depending on the number of *children* enrolled); and

4. A *child* whose COBRA continuation began due to the person no longer meeting the dependent *child* definition.

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

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

When COBRA Continuation Coverage Begins. When COBRA continuation coverage is elected during the Initial Enrollment Period and the 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 Qualifying Event, if the Qualifying Event was termination of employment or reduction in work hours;*
2. The end of 36 months from the Qualifying Event, if the Qualifying Event was the death of the *subscriber,* divorce or legal separation, the end of a domestic partnership, or the end of dependent *child* status;*
3. The end of 36 months from the date the *subscriber* became entitled to Medicare, if the Qualifying Event was the *subscriber's* entitlement to Medicare. If entitlement to Medicare does not result in coverage terminating and Qualifying Event 1 occurs within 18 months after Medicare entitlement, coverage for Qualified Beneficiaries other than the *subscriber* will end 36 months from the date the *subscriber* became entitled to Medicare;
4. The date the *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 *member* first becomes covered under any other group health plan; or
7. The date, following the election of COBRA, the *member* first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

*For a *member* whose COBRA continuation coverage began under a *prior plan,* this term will be dated from the time of the Qualifying Event under that *prior plan*. Additional note: If COBRA continuation under this *plan* began on or after January 1, 2003 and ends in accordance with item 1, the *member* 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 *member* is eligible to further continue coverage under CalCOBRA. Please see CALCOBRA CONTINUATION OF COVERAGE in this *benefit 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 *subscriber's* death. But coverage could terminate prior to such time for either the *subscriber* or *dependent* in accordance with items 4, 5 or 6 above.

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

EXTENSION OF CONTINUATION DURING TOTAL DISABILITY

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

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

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

Notice. The *member* must furnish the *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. For the 19th through 29th months that the total disability continues, the *participating employer* must remit the cost for the extended continuation coverage to SISC III. This cost (called the "required monthly contribution") shall be subject to the following conditions:

1. If the disabled *member* continues coverage during this extension, this charge shall be **150%** of the applicable rate for the length of time the disabled *member* remains covered, depending upon the number of covered dependents. If the disabled *member* does not continue coverage during this extension, this charge shall remain at **102%** of the applicable rate.
2. The cost for extended continuation coverage must be remitted to SISC III by the *participating employer* each month during the period of extended continuation coverage. SISC III must receive timely payment of the required monthly contribution each month from the *participating employer* in order to maintain the extended continuation coverage in force.
3. The *participating employer* 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 *member* remains covered. The charge will be **102%** of the applicable rate for any periods of time the disabled *member* is not covered following the 18th month.

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

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

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

*Note: If your COBRA continuation under this *plan* began on or after January 1, 2003 and ends in accordance with item 2, you may further elect to continue coverage for medical benefits only under CalCOBRA for the balance of 36 months (COBRA and CalCOBRA combined). All COBRA eligibility must be exhausted before you are eligible to further continue coverage under CalCOBRA. Please see CALCOBRA CONTINUATION OF COVERAGE in this *benefit booklet* 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; 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, your *participating employer* will notify you of your right to further elect coverage under CalCOBRA. If you choose to elect CalCOBRA coverage, you must notify your *participating employer* in writing within 60 days of the date your coverage under federal COBRA ends or when you are notified of your right to continue coverage under CalCOBRA, whichever is later.

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

Cost of Coverage. You may 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 *participating employer* each month during the CalCOBRA continuation period. This cost will be:

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 will be:

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

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

You must make payment to your *participating employer* within the timeframes specified below. Your *participating employer* must receive payment of your required monthly contribution each month to maintain your coverage in force.

Payment Dates. The first payment is due along with your enrollment form within 45 days after you elect continuation coverage. You must make this payment by first-class mail or other reliable means of delivery, in an amount sufficient to pay any required monthly contribution and monthly contributions due. Failure to submit the correct amount within this 45-day period will disqualify you from receiving continuation coverage under CalCOBRA. Succeeding monthly contributions are due on the first day of each following month.

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

Change of the Monthly Contribution. The amounts of the required monthly contribution may be changed by the *participating employer* as of any monthly contribution due date. The *participating employer* will provide you with written notice at least 60 days prior to the date any monthly contribution increase goes into effect.

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 end of the period for which required monthly contributions are last paid;
4. The date you become covered under any other health plan;
5. The date you become entitled to Medicare; or
6. 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*.

CONTINUATION FOR DISABLED DISTRICT MEMBERS

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 member, your benefits under this *plan* may be continued.

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

Cost of Coverage. The *participating 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 *participating employer* each month during your continuation. SISC III must receive payment of the required monthly contribution each month from the *participating employer* in order to maintain the coverage in force. SISC III will accept required monthly contributions only from the *participating employer*. Payment made by you directly to SISC III will not continue coverage.

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 the *participation agreement*.

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

1. The date the *participation agreement* 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 MEMBERS

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

1. The *spouse* becomes covered under another group health plan, or
2. The *spouse's* coverage ends as described under HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE ENDS.

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

CONTINUATION DURING LABOR DISPUTE

If you are an eligible *subscriber* who stops working because of a labor dispute, the *participating employer* may arrange for coverage to continue as follows:

1. **Required Monthly Contributions**: Required monthly contributions are determined by SISC III as stated in the *participation agreement*. These required monthly contributions become effective on the required monthly contribution due date after work stops.

2. **Collection of Required Monthly Contributions:** The *participating employer* is responsible for collecting required monthly contributions from those *subscribers* who choose to continue coverage. The *participating employer* is also responsible for submitting required monthly contributions to SISC III on or before each required monthly contribution due date.

3. **Cancellation if participation falls below 75%:** SISC III must receive premium for at least **75%** of the *subscribers* who stop work because of the labor dispute. If at any time participation falls below **75%**, coverage may be cancelled. This cancellation is effective 10 days after written notice to the *participating employer*. The *participating employer* is responsible for notifying the *subscribers*.

4. **Length of coverage:** Coverage during a labor dispute may continue up to six months. After six months, coverage is cancelled automatically without notice from SISC III.

EXTENSION OF BENEFITS

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

1. If you are confined as an inpatient in a *hospital* or *skilled nursing facility*, you are considered totally disabled as long as the inpatient *stay* is *medically necessary*, and no written certification of the total disability is required. If you are discharged from the *hospital* or *skilled nursing facility*, you may continue your total disability benefits by submitting written certification by your *physician* of the total disability within 90 days of the date of your discharge. Thereafter, the *claims administrator* must receive proof of your continuing total disability at least once every 90 days while benefits are extended.

2. If you are not confined as an inpatient but wish to apply for total disability benefits, you must do so by submitting written certification by your *physician* of the total disability. The *claims administrator* must receive this certification within 90 days of the date coverage ends under the *participation agreement*. At least once every 90 days while benefits are extended, the *claims administrator* must receive proof that your total disability is continuing.

3. Your extension of benefits will end when any one of the following circumstances occurs:

    a. You are no longer totally disabled.

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

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

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

GENERAL PROVISIONS

Description of Coverage. This *benefit booklet* is not a *participation agreement*. It does not change the coverage under the *participation agreement* in any way. This *benefit booklet*, which is evidence of coverage under the *participation agreement*, is subject to all of the terms and conditions of that *participation agreement***.**

Providing of Care. SISC III is not responsible for providing any type of *hospital,* medical or similar care, nor is SISC III 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 the *claims administrator*, or any of the employees of the *claims administrator*, an employee or agent of any *hospital,* medical group or medical care provider of any type.

Non-Regulation of Providers. The benefits of this *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*.

Inter-Plan Programs

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

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

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

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

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

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

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

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

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

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

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

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

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

Terms of Coverage

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

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

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

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

Protection of Coverage. SISC III does not have the right to cancel your coverage under this *plan* while: (1) this *plan* is in effect; (2) you are eligible; and (3) your required monthly contributions are paid according to the terms of the *plan*; and (4) the *participation agreement* is still in effect.

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

Provider Reimbursement. *Physicians* and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. A participating *physician* may, after notice from 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.

Availability of Care. If there is an epidemic or public disaster and you cannot obtain care for covered services, SISC III refunds the unearned part of the required monthly contribution paid. A written request for that refund and satisfactory proof of the need for care must be sent to us within 31 days. This payment fulfills the obligations of SISC III under the *participation agreement*.

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. SISC III is not liable for any expense you incur in excess of the benefits of this *plan*.

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

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

Payment to Providers. The benefits of this *plan* will be paid directly to *contracting hospitals*, *participating providers* and medical transportation providers. If you or one of your *dependents* receives services from *non-contracting hospitals* or *non-participating providers,* payment will be made directly to the *subscriber* and you will be responsible for payment to the provider. The *plan* will pay *non-contracting hospitals* and other providers of service directly when *emergency services* and care are provided to you or one of your *dependents.* The *plan* will continue such direct payment until the emergency care results in stabilization. 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. Whenever payment has been made in error, SISC III will have the right to recover such payment from you or, if applicable, the provider, in accordance with applicable laws and regulations. In the event SISC III recovers a payment made in error from the provider, except in cases of fraud or misrepresentation on the part of the provider, SISC III will only recover such payment from the provider within 365 days of the date the payment was made on a claim submitted by the provider. SISC III reserves the right to deduct or offset any amounts paid in error from any pending or future claim.

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

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

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

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

Prepayment Fees. Your *participating employer* is responsible for paying required monthly contributions to SISC III for all coverage provided to you and your *dependents*. Your *participating employer* may require that you contribute all or part of the costs of these required monthly contributions. Please consult your *participating employer* for details.

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

Financial Arrangements with Providers. The *claims administrator* or an affiliate has contracts with certain health care providers and suppliers (hereafter referred to together as "Providers") for the provision of and payment for health care services rendered to its members and *subscribers* 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, *subscribers* 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*.

Transition Assistance for New *Members*: Transition Assistance is a process that allows for completion of covered services for new *members* receiving services from a *non-participating provider*. If you are a new *member*, you may request Transition Assistance if any one of the following conditions applies:

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

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

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

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

5. The care of a newborn *child* between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the time the *child* enrolls in this *plan*.

6. Performance of a surgery or other procedure that the *claims administrator* have authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the time you enroll in this *plan*.

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

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

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

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

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

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

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

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

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

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

6. Performance of a surgery or other procedure that the *claims administrator* has authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the date the provider's contract terminates.

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

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

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

Voluntary Clinical Quality Programs. The claims administrator may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) within a specific timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from covered services under your plan. These programs are not guaranteed and could be discontinued at any time. The claims administrator will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. If you receive a gift card and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.

Voluntary Wellness Incentive Programs. The claims administrator may offer health or fitness related program options for purchase by the plan administrator to help you achieve your best health. These programs are not covered services under your plan, but are separate components, which are not guaranteed under this plan and could be discontinued at any time. If the plan administrator has selected one of these options to make available to all employees, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.

YOUR RIGHT TO APPEALS

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

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

If your claim is denied:

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

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

Notice of Adverse Benefit Determination

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

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

For claims involving urgent/concurrent care:

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

Appeals

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

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

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

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

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

Anthem Blue Cross Life and Health Insurance Company
ATTN: Appeals
P.O. Box 60007, Los Angeles, CA 90060

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

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

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

The *claims administrator* will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an adverse benefit determination on review based on a new or additional rationale, the *claims administrator* will provide you, free of charge, with the rationale.

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

How Your Appeal will be Decided

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

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

Notification of the Outcome of the Appeal

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

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

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

Appeal Denial

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

External Review

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

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

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

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

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

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

Anthem Blue Cross Life and Health Insurance Company
ATTN: Appeals
P.O. Box 60007, Los Angeles, CA 90060

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

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

Requirement to file an Appeal before filing a lawsuit

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

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

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 regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

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

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

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

The arbitration is begun by the *member* making written demand on the *plan administrator*. Any demand for arbitration must be made within one (1) year from the issuance by the *claims administrator* of its decision following appeal. In cases where the amount in controversy is within the jurisdiction of small claims court, suit must be filed within one (1) year from the issuance by the *claims administrator* of its decision following appeal. Failure to demand arbitration or file in small claims court within one (1) year of the issuance by the *claims administrator* of its decision following appeal shall result in the forfeiture of any right to arbitration or to take any other legal action. Any written demand should be sent to the *plan administrator* at the address shown below:

SISC III
P.O. Box 1847
Bakersfield, CA 93303-1847

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 *member* and the *plan administrator*, or by order of the court, if the *member* and the *plan administrator* cannot agree. The arbitration will be held at a time and location mutually agreeable to the member and the *plan administrator*.

DEFINITIONS

The meanings of key terms used in this *benefit 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 *benefit 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.

Agreement Date. The Agreement Date is the date the Participation Agreement between SISC III and the Participating Employer comes into effect.

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 50-mile radius of your residence;
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 for transplant and bariatric surgical services. These services are only covered when performed at a designated bariatric *Blue Distinction* (*BD*) or a *Blue Distinction+ (BD+)*.

Bariatric Blue Distinction (BD) and Blue Distinction+ (BD+) Coverage Area is the area within the 50-mile radius surrounding a designated bariatric *Blue Distinction* (*BD*) or a *Blue Distinction+ (BD+)*.

Benefit Booklet (benefit booklet) is this written description of the benefits provided under the *plan*.

Blue Distinction (BD) are health care providers designated by the *claims administrator* as a selected facility for specified medical services. A provider participating in a Blue Distinction (BD) network has an agreement in effect with the *claims administrator* at the time services are rendered or is available through their affiliate companies or their relationship with the Blue Cross and Blue Shield Association. Blue Distinction (BD) agree to accept the *maximum allowed amount* as payment in full for covered services. A *participating provider* is not necessarily a Blue Distinction (BD).

Blue Distinction+ (BDC+) Facility: Blue Distinction+ facilities have met or exceeded national quality standards for care delivery AND have demonstrated that they operate more efficiently (quality and cost).

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

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

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*. The *claims administrator* is in no event the administrator for coverage as stated under CONTINUATION OF COVERAGE**,** nor is Anthem Blue Cross Life and Health Insurance Company the *plan* fiduciary or financially responsible for benefits. SISC III assumes full liability for payment of benefits described in the *plan* and thereby acts as *plan* fiduciary, and benefits are payable solely from the assets of SISC III.

Confinement period is one continuous *stay* or successive *stays* that are separated by fewer than 28 consecutive days during which the *member* is not confined as an inpatient in a *hospital*, *skilled nursing facility* or any other place of residence for ill or disabled persons, other than the *member's* home.

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

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

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 by utensil, tube or gastrostomy; suctioning and administration of medicine which is usually self-administered or any other care which does not require continuing services of medical personnel.

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

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

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

Designated Orthopedic Provider is a provider who has achieved designation as a Blue Distinction+ hospital for Knee/Hip Replacement or Spine Surgery.

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

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), or a *psychiatric emergency medical condition*, which the *member* reasonably perceives, could permanently endanger health if medical treatment is not received immediately. Final determination as to whether services were rendered in connection with an emergency will rest solely with the *claims administrator*.

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

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

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.

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

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

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

Infertility is: (1) the presence of a condition recognized by a *physician* as a cause of infertility; or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception or after 3 cycles of artificial insemination.

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.

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

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

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Provided for the diagnosis or direct care and treatment of the medical condition;
3. Within standards of good medical practice within the organized medical community;

4. Not primarily for your convenience, or for the convenience of your *physician* or another provider;
5. Not more costly than an equivalent service or sequence of services that is medically appropriate and is likely to produce equivalent therapeutic or diagnostic results in regard to the diagnosis or treatment of the patient's illness, injury, or condition; and
6. The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:
    a. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and
    b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
    c. For *hospital stays*, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received by you as an outpatient or in a less intensified medical setting.

Member is the *subscriber* or *dependent*.

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

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

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

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

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

Other health care provider is one of the following providers:

- A certified registered nurse anesthetist
- A blood bank

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

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

Participation Agreement is the agreement between Self-Insured Schools of California and the *participating employer* providing for the participation of specified employees in this *plan*.

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

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

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

Physician means:

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

2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, and such license is required to render that service, and is providing a service for which benefits are specified in this *benefit booklet*:

    - A dentist (D.D.S. or D.M.D.)
    - An optometrist (O.D.)
    - A dispensing optician
    - A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
    - A licensed clinical psychologist
    - A licensed educational psychologist for the provision of behavioral health treatment services for the treatment of pervasive developmental disorder or autism only
    - A chiropractor (D.C.)
    - An acupuncturist (but only for acupuncture and for no other services) (A.C.)
    - A licensed clinical social worker (L.C.S.W.)
    - A marriage and family therapist (M.F.T.)

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

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

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

Plan is the set of benefits described in this *benefit booklet* or as amended hereafter and adopted by the *participating employer* through its *participation agreement* with Self-Insured Schools of California. These benefits are subject to the terms and conditions of the *plan.* If changes are made to the plan, an amendment or revised *benefit booklet* will be issued to each *participating employer* affected by the change.

Plan administrator refers to Self-Insured Schools of California (SISC III), the entity which is responsible for the administration of the *plan.*

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

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

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

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

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

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

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

http://www.ahrq.gov

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

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

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

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

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

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

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

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

Retail Health Clinic - A facility that provides limited basic medical care services to *members* on a "walk-in" basis. These clinics normally operate in major pharmacies or retail stores.

Retired employee meets the *plan's* eligibility requirements for retired employees as outlined under HOW COVERAGE BEGINS AND ENDS.

Scheduled amount is determined according to the SCHEDULES FOR NON-PARTICIPATING PROVIDERS. Any amount by which a *non-participating provider's* charge exceeds this schedule, exceeds the *maximum allowed amount* and is not covered under this plan. **You are responsible for paying any such excess amount.**

Service area is the area in which the provider's principal place of business is located. The counties encompassed by each service area are listed in the SCHEDULES FOR NON-PARTICIPATING PROVIDERS.

SISC is Self-Insured Schools of California joint powers authority.

SISC III means the medical benefit plans developed by SISC.

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

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

Specialty drugs are typically 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. Certain specified

specialty drugs may require special handling, such as temperature controlled packaging and overnight delivery, and therefore, certain specified *specialty drugs* will be required to be obtained through the specialty pharmacy program, unless you qualify for an exception.

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.

Subscriber 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.

Telemedicine is the diagnosis, consultation, treatment, transfer of medical data and medical education through the use of advanced electronic communication technologies such as interactive audio, video or other electronic media that facilitates access to health care services or medical specialty expertise. Standard telephone, facsimile or electronic mail transmissions, or any combination therein, in the absence of other integrated information or data adequate for rendering a diagnosis or treatment, do not constitute telemedicine services.

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

Totally disabled subscriber is a *subscriber* who, because of illness or injury, is unable to work for income in any job for which he/she is qualified or for which he/she becomes qualified by training or experience, and who is in fact unemployed.

Unit Value Schedule lists the unit values of medical services. For any procedure not listed in the schedule, the *claims administrator* provides a benefit on the basis of comparable service. Benefits are determined based on the schedule in effect at the time the claim is paid. The unit value schedule listed in this Benefit Booklet is only a partial listing.

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

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

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

We (us, our) refers to Self-Insured Schools of California.

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

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

SCHEDULES FOR NON-PARTICIPATING PROVIDERS

This section explains how the *claims administrator* determines the *scheduled amount* (the *maximum allowed amount* for *non-participating providers*), and is subject to the maximums, conditions, exclusions and limitations of this *plan*.

SERVICE AREAS

A provider's *service area* is determined by the area in which the provider's principal place of business is located.

- **Service Area 1:** Counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Merced, Modoc, Mono, Nevada, Placer, Plumas, Sacramento, San Benito, Shasta, Sierra, Siskiyou, Solano, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo and Yuba.
- **Service Area 2:** Counties of Alameda, Contra Costa, Monterey, Napa and Santa Cruz.
- **Service Area 3:** Counties of Marin, San Francisco, San Mateo and Santa Clara.
- **Service Area 4:** Counties of Los Angeles and Riverside (City of Palm Springs only).
- **Service Area 5:** Orange County.
- **Service Area 6:** Counties of Kern, Riverside (except City of Palm Springs), San Bernardino, San Luis Obispo, Santa Barbara and Ventura.
- **Service Area 7:** San Diego County.
- **Service Area 8:** Counties of Fresno, San Joaquin, Sonoma and Stanislaus.
- **Service Area 9:** Imperial County.
- **Service Area 10:** Outside California.

Important Note: The *claims administrator* has the right to adjust, without notice, all schedules found in this section in order to maintain the relationship between these *scheduled amounts* for *non-participating providers* and the fee schedule negotiated by the *claims administrator* with *participating providers*. Benefits are determined based on the schedule in effect at the time services are rendered.

CHARGES BY A PHYSICIAN WHO IS A NON-PARTICIPATING PROVIDER

1. Charges for services of a *physician* who is a *non-participating provider* are determined by multiplying the "Unit Value" of the service (listed in the Unit Value Schedule) by the appropriate "Unit Allowance" listed in the Unit Allowance Schedule. The "Unit Allowance" varies according to the *service area* of the provider.
2. For any procedure not listed in the Unit Value Schedule, the *claims administrator* will provide a benefit on the basis of comparable service.
3. The Unit Value Schedule listed in this *benefit booklet* is only a partial listing.

For services provided by a *physician* who is a *non-participating provider,* the *maximum allowed amount* will not exceed the amount determined by the following process. First, the *claims administrator* determines the appropriate "Unit Allowance" for the service by determining in which *service area* the *physician* performed the service. Then, the *claims administrator* multiplies the "Unit Value" of that service by the appropriate "Unit Allowance". The resulting amount is the *maximum allowed amount* the *claims administrator* will allow for that service under the *plan*.

The *claims administrator* has developed a Unit Value Schedule for covered services. An excerpt of this Schedule is set forth in this section. Notice that for each service listed in the Schedule, there is a "Procedure

Code" and a "Unit Value". *Physicians* use these Procedure Codes to identify their services for billing purposes. These codes are published by the American Medical Association and are widely used throughout the medical profession.

Your *physician* should be able to identify for you which "Procedure Code(s)" applies to the service(s) to be performed. Remember, the *maximum allowed amount* may be less than the *physician's* charge for such services. You are responsible for paying any amount by which this charge exceeds the *maximum allowed amount,* in addition to any Deductible and Co-Payment required under this *plan*.

If you want assistance in determining the *maximum allowed amount* for services provided by a *physician* who is a *non-participating provider,* you may telephone the *claims administrator* at the number shown on your identification card.

Remember, if you obtain your health care services from a *participating provider,* you will be able to determine the amount of your financial responsibility more simply. *Participating providers* have agreed to accept the *maximum allowed amount* as payment in full for covered services, They should not send you a bill or collect for amounts above the *maximum allowed amount,* leaving you only the amount of your Calendar Year Deductible and Co-Payment described in the SUMMARY OF BENEFITS.

UNIT ALLOWANCE SCHEDULE

Service Area	Surgery	Anesthesia	Medicine	Radiology	Pathology
1	$110.00	$25.00	$4.80	$9.50	$1.05
2	110.00	25.00	4.80	9.50	1.05
3	120.00	26.00	5.10	10.50	1.15
4	120.00	26.00	5.10	10.50	1.15
5	120.00	26.00	5.10	10.50	1.15
6	110.00	25.00	4.80	9.50	1.05
7	110.00	25.00	4.80	9.50	1.05
8	110.00	25.00	4.80	9.50	1.05
9	110.00	25.00	4.80	9.50	1.05
10	120.00	26.00	5.10	10.50	1.15

UNIT VALUE SCHEDULE
(Partial Listing)

PROCEDURAL CODE	SURGICAL PROCEDURE (for each single procedure)	UNIT VALUE
Skin		
10060	Incision and drainage of abscess	0.58
11100	Biopsy of skin, including closure	0.43
11770	Excision of pilonidal cyst or sinus	1.59
Breast		
19120	Excision of breast tumor, unilateral	2.80
19200	Radical mastectomy, including pectoral muscles and axillary nodes	7.25

UNIT VALUE SCHEDULE - Continued
(Partial Listing)

PROCEDURAL CODE	SURGICAL PROCEDURE (for each single procedure)	UNIT VALUE
Fractures		
21315	Nasal, simple, closed reduction	1.16
25565	Closed radial and ulnar shafts, manipulative reduction	3.71
27232	Femur and neck, manipulative reduction, including traction	5.63
Heart		
33400	Aortic valvuloplasty, with bypass	14.79
33420	Valvotomy, mitral valve, closed	11.04
Throat		
42650	Dilation, salivary duct	0.42
42820	Tonsillectomy and adenoidectomy, under 12 years	2.64
Digestive		
43620	Total gastrectomy	10.25
44950	Appendectomy	3.96
47600	Cholecystectomy	5.67
Rectum		
46200	Fissurectomy	2.01
46250	Hemorrhoidectomy,external complete	2.48
Male		
55801	Prostatectomy, perineal (sub-total)	8.16
Female		
58180	Supracervical (sub-total) hysterectomy with or without tubes or ovaries	7.15
Maternity		
59510	Cesarean section, including antepartum and postpartum care	11.98
Thyroid		
60200	Local excision of cyst of thyroid	4.54
60240	Thyroidectomy, total or complete	7.89
Ear		
69420	Myringotomy	0.75
69501	Transmastoid antrotomy	5.17

SURGERY (two or more surgical procedures). When two or more surgical procedures are performed during the same operative session, the *claims administrator* will calculate the *maximum allowed amount* for all of the services combined by adding:

- The *maximum allowed amount* for the primary procedure plus
- A reduced percentage of what the *scheduled amount* would have been for each of the additional procedures if these services had been performed alone.

SURGERY (assistant surgeon). The Unit Value for the services of an assistant surgeon will be a reduced percentage of the *scheduled amount* for the primary surgeon.

ANESTHESIA (anesthesiologist or anesthetist). The total Unit Value for the services of an anesthesiologist or anesthetist is the basic anesthesia value for that procedure and a Unit Value for the actual time spent administering anesthesia.

PROCEDURAL CODE	BASIC ANESTHESIA	UNIT VALUE
01400	Knee Joint	3.0
01462	Lower leg, ankle, or foot	3.0
00566	Direct coronary artery bypass grafting without pump oxygenator	12.0
00740	Upper gastrointestinal endoscopic	4.0
00940	Vaginal	3.0
01961	Cesarean delivery	5.6

UNIT VALUE SCHEDULE

MEDICINE		UNIT VALUE
99205	Office Visit -- initial comprehensive exam	19.44
99212	Office Visit -- problem-focused examination evaluation, and/or treatment	4.61
99231	Hospital Visit -- problem-focused examination, evaluation, and/or treatment, same illness	5.27
99241	Consultation -- problem-focused examination and/or evaluation	10.59
RADIOLOGY		
Diagnostic		
70210	Sinuses and paranasal, limited	2.75
70250	Skull, limited	3.03
74241	Upper gastrointestinal tract	7.71
74415	Nephrotomography	8.95
Therapeutic		
77261	Therapeutic radiology treatment planning, simple	6.55
Nuclear Medicine		
78000	Thyroid uptake	4.00
79000	Hyperthyroidism, initial evaluation	15.88
PATHOLOGY		
81000	Urinalysis, routine, complete	4.32
87081	Microbiology - culture, bacterial screening	10.58

CHARGES BY A HOSPITAL WHICH IS A NON-PARTICIPATING PROVIDER

1. The *maximum allowed amount* for outpatient care provided by a *hospital* which is a *non-participating provider* is the amount determined under YOUR MEDICAL BENEFITS: MAXIMUM ALLOWED AMOUNT.

2. The *maximum allowed amount* for inpatient care provided by a *hospital* which is a *non-participating provider* is **$600** per day.

FOR YOUR INFORMATION

Your Rights and Responsibilities as a SISC III Member

As a SISC III *member* you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, we're committed to making sure your rights are respected while providing your health benefits. That also means giving you access to our network providers and the information you need to make the best decisions for your health and welfare.

These are your rights and responsibilities:

You have the right to:

- Speak freely and privately with your doctors and other health providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it's covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect us to keep your personal health information private. This is as long as it follows state and Federal laws, and our privacy policies.
- Get the information you need to help make sure you get the most from your health plan, and share your feedback. This includes information on:
    - Our company and services
    - Our network of doctors and other health care providers
    - Your rights and responsibilities
    - The rules of your health care plan
    - The way your health plan works
- Make a complaint or file an appeal about:
    - Your health care plan
    - Any care you get
    - Any covered service or benefit ruling that your health care plan makes
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a doctor or other health care professional about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose another person to be with you to help you to understand.

You have the responsibility to:

- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- Follow all health care plan rules and policies.
- Choose any primary care physician (doctor), also called a PCP, who is in our network if your health care plan requires it.
- Treat all doctors, health care providers, and staff with courtesy and respect.

- Keep all scheduled appointments with your health care providers and call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your doctors or other health care providers to make a treatment plan that you all agree on.
- Follow the care plan that you have agreed on with your doctors or health care providers.
- Give us, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health care plans and insurance benefits you have in addition to your coverage with us.
- Let us know if you have any changes to your name, address or family members covered under your plan. Please call your District for any changes to your plan.

For details about your coverage and benefits, please read your Benefit Booklet.

We are committed to providing quality benefits and customer service to our *members*. Benefits and coverage for services provided under the benefit program are governed by the Benefit Booklet and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact us, please go to www.anthem.com/ca and select "Customer Support>Contact Us", or you may call the customer service number on your ID card.

ORGAN DONATION

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

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

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

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

www.donatelifecalifornia.org/

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

ANTHEM BLUE CROSS WEB SITE

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

LANGUAGE ASSISTANCE PROGRAM

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

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

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

- Spanish
- Chinese
- Vietnamese
- Korean
- Tagalog

Oral interpretation services are available in additional languages.

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

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

STATEMENT OF RIGHTS UNDER THE NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

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

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

In addition, a plan or issuer may not, under federal law, require that a *physician* or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, please call the customer service telephone number listed on your ID card.

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

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

NOTICE OF PROTECTION PROVIDED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

Effective April 14, 2003, a Federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires that health plans like the Self-Insured Schools of California (SISC) group health plan (hereafter referred to as the "Plan"), maintain the privacy of your personally identifiable health information (called **Protected Health Information or PHI**).

- The term **"Protected Health Information" (PHI)** includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.
- **PHI does not include** health information contained in employment records held by your employer in its role as an employer, including but not limited to health information on disability, work-related illness/injury, sick leave, Family and Medical leave (FMLA), life insurance, dependent care FSA, drug testing, etc.

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was distributed to you upon enrollment in the Plan and is available from the SISC website at www.sisc.kern.org. Information about HIPAA in this document is not intended and cannot be construed as the Plan's Notice of Privacy Practices.

The Plan, and the Plan Sponsor (the SISC Board of Directors), will not use or further disclose information that is protected by HIPAA ("protected health information or PHI") except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law. **In particular, the Plan will not, without your written 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**.

Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim or for other reasons related to the administration of the Plan.

A. **The Plan's Use and Disclosure of PHI:** The Plan will use protected health information (PHI), without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.

   - **Treatment** is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your health care providers. The Plan rarely, if ever, uses or discloses PHI for treatment purposes.
   - **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following:

     a. Determination of eligibility, coverage, cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copayments as determined for an individual's claim), and establishing employee contributions for coverage;

     b. Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of benefits, subrogation of health benefit claims, billing, collection activities and related health care data processing, and claims auditing;

     c. Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization review, including precertification, concurrent review and/or retrospective review.

- **Health Care Operations** includes, but is not limited to:

  a. Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies, quality assessment, patient safety activities;

  b. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;

  c. Underwriting (the Plan does not use or disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), enrollment, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;

  d. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

  e. Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, Plan sponsors, or other customers.

B. **When an Authorization Form is Needed:** Generally the Plan will require that you sign a valid authorization form (available from the SISC Privacy Officer) in order for the Plan to use or disclosure your PHI **other than** when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations or other instance in which HIPAA explicitly permits the use or disclosure without authorization. The Plan's Notice of Privacy Practices also discusses times when you will be given the opportunity to agree or disagree before the Plan uses and discloses your PHI. The Notice is available on the SISC website at www.sisc.kern.org or from the SISC Privacy Officer.

C. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agrees to:

  1. Not use or disclose the information other than as permitted or required by the Plan Document or as required by law,

  2. Ensure that any agents, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules.

  3. Not use or disclose the information for employment-related actions and decisions,

  4. Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor, (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices).

  5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware,

  6. Make PHI available to the individual in accordance with the access requirements of HIPAA,

  7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA,

  8. Make available the information required to provide an accounting of PHI disclosures,

  9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of the Dept. of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA, and

10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction if feasible.

D. In order to ensure that adequate separation between the Plan and the Plan Sponsor is maintained in accordance with HIPAA, only the following employees or classes of employees may be given access to use and disclose PHI:

1. The Plan's Privacy Officer;

2. SISC Health Benefits staff involved in the administration of this Plan*;*

3. Business Associates under contract to the Plan including but not limited to the PPO medical, dental and vision plan claims administrator, preferred provider organization (PPO) networks, retail prescription drug benefit plan administrator, the Wellness program, the telemedicine program, the Medicare supplement administrator, the COBRA administrator, Health Flexible Spending Account (FSA) administrator, the Plan's attorneys, accountants, consultants and actuaries;

E. The persons described in the section may only have access to and use and disclose PHI for Plan administration functions for the Plan. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution of noncompliance. Issues of noncompliance (including disciplinary sanctions as appropriate) will be investigated and managed by the Plan's Privacy Officer (the Coordinator Health Benefits) at the address noted here:

Self-Insured Schools of California (SISC)
2000 "K" Street P.O. Box 1847 - Bakersfield, CA 93303-1847
Phone: 661-636-4410

F. Effective April 21, 2005 in compliance with **HIPAA Security** regulations, the Plan Sponsor will:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,

2. Ensure that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures,

3. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and

4. Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

G. **Hybrid Entity**: For purposes of complying with the HIPAA Privacy rules, this Plan is a "hybrid entity" because it has both group health plan functions (a health care component of the entity) and non-group health plan functions. The Plan designates that its health care group health plan functions are covered by the privacy rules. The health care group health plan functions include the services related to the "Plan."

Claims Administered by:

ANTHEM BLUE CROSS

on behalf of

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY