Anthem Blue Cross Traditional

Health Maintenance Organization (HMO)

Evidence of Coverage and Disclosure Form
for the Basic Plan

Effective January 1, 2016

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

CalPERS

Combined Evidence of Coverage and Disclosure Form

Anthem Blue Cross
21555 Oxnard Street
Woodland Hills, California 91367
Phone Number: 1-855-839-4524
www.anthem.com/ca/calpers/hmo

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

Many words used in this booklet are explained in the "Important Words to Know" section starting on page 82. When reading through this booklet, check that section to be sure that you understand what these words mean. Each time these words are used they are *italicized*.

Table of Contents

Welcome to Anthem Blue Cross Traditional HMO **1**

A Summary of Common Services **2**

How Coverage Begins and Ends **3**

Eligibility and Enrollment 3
Live/Work 3
A Medical Group Can End its Services to You 3
Physician/Patient Relations 4

Your Monthly Subscription Charges **5**

Getting Started **7**

Choosing Your Primary Care Doctor 7
If You Need Help Choosing 7
Changing Your Medical Group 8

When You Need Care **10**

When You Need Routine Care 10
When You Need a Referral 10
Ready Access 11
Obstetrical and Gynecological Care 12
Care for Mental or Nervous Disorders or Substance Abuse and Pervasive Developmental Disorder or Autism 12
Transgender Services 13
When You Want a Second Opinion 13
When You Need a Hospital Stay 15
When There is an Emergency 15
You Need Urgent Care 16
Triage and Screening Services 17
Telehealth 17
Getting Care When You Are Outside of California 17
Care Outside the United States-BlueCard Worldwide 18
Revoking or Modifying a Referral or Authorization 19
If You and Your Doctor Do Not Agree 20
We Want You to Have Good Health 20

Your Benefits at Anthem Blue Cross Traditional HMO **21**

What are Copays? 21
Here are the Copay Limits 21
What We Cover 22

Medical Management Programs **40**

Utilization Review Program 40
Authorization Program 41
Disagreements with Medical Management Program Decisions 42
Exceptions to the Medical Management Program 43
Revoking or Modifying an Authorization 43

Exclusions **44**

Kinds of Services You Cannot Get with this Plan 44

How to File a Complaint **49**

Independent Medical Review of Denials of Experimental or Investigative Treatment 51
Independent Medical Review of Complaints Involving a Disputed Health Care Service 53
Department of Managed Health Care 54
Appeal Procedure Following Grievance Procedure 54
Arbitration 55
CalPERS Administrative Review and Hearing Process 56

Keeping Anthem Blue Cross Traditional HMO After Your Coverage Status Changes **62**

You or Your Family Members May Choose *COBRA* 62
If You Want to Keep Your Health Plan 63
How Long You Can Be Covered 63
Other Coverage Options Besides COBRA Continuation Coverage 64
Retirement and COBRA 64
If You or a Family Member is Disabled 65
What About After COBRA? 66
CalCOBRA 66
Extension 68
Continuation of Group Coverage for Members on Military Leave 68

Other Things You Should Know **69**

Using a Claim Form to Get Benefits 69
Getting Repaid by a Third Party 69
Coordination of Benefits 70
If You Qualify for Medicare 72
Other Things You Should Know 73

Important Words to Know **82**

For Your Information **89**

Chiropractic and Acupuncture Care Amendment **93**

Your Prescription Drug Plan **100**

Welcome to Anthem Blue Cross Traditional HMO

Thank you for choosing our health plan.

Anthem Blue Cross Traditional HMO is here to serve you. This booklet tells you all about your health care plan and its benefits.

- It tells you about what kinds of care this *plan* covers and does not cover.
- It tells you what you have to do, or what has to happen so you can get benefits.
- It tells you what kinds of *doctors* and other *health care providers* you can go to for care.
- It tells you about options you may have if your coverage ends.

Take some time to read it now.

- Keep this booklet handy for any questions you may have later on.

We are here to help you!!

We want to give you the help you need. If you have any questions,

- Please call Anthem Blue Cross Traditional HMO Customer Service at 1-855-839-4524.
- Or write us at:

Anthem Blue Cross

Attn.: Anthem Blue Cross Traditional HMO

P.O. Box 60007

Los Angeles, CA 90060-0007

website: www.anthem.com/ca/calpers/hmo

We can help you get the health care you need.

A Summary of Common Services

This is only a brief summary. Refer to the section "Your Benefits at Anthem Blue Cross Traditional HMO" starting on page 21 in this booklet for more information.

REMEMBER

Your primary care doctor and your medical group must give or approve all of your care.

What We Cover	**Member Copay**
Doctor Care	
– Office or Home visits	$15
– *Doctor* visit during a *hospital stay*	No charge
– Visit to a *specialist*	$15
– *Urgent care*	$15
Hospital Care	
– *Inpatient*	No charge
– Outpatient	No charge
– Emergency	$50 (waived if admitted)
Preventive Care Services	
– Preventive services	No charge
– Diagnostic X-ray/lab	No charge
Member *Copay Limits*	
Member's maximum *calendar year copay* for all covered services	$1,500 per *member* $3,000 per family

How Coverage Begins and Ends

Eligibility and Enrollment

Information about your eligibility, enrollment termination of coverage, and conversion rights can be obtained through the CalPERS website at www.calpers.ca.gov, or by calling CalPERS. Also, please refer to the CalPERS Health Program Guide for additional information about eligibility. Your coverage begins on the date established by CalPERS.

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

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

Live/Work

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

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

A Medical Group Can End its Services to You

- **If you move away from the area it serves.** You will need to ask to transfer to another *medical group*. If you move outside the Anthem Blue Cross Traditional HMO service area, you will not be eligible for Anthem Blue Cross Traditional HMO.
  - Call the *Customer service number* at 1-855-839-4524, or ask your *employer* for a *membership change form*.
  - The change in your *medical group* will happen on the first day of the month after we get your request.
- **If you refuse to follow a treatment** your *doctor* recommends when there is no other better choice, your coverage may end with that *doctor* and/or *medical group*. We will help you get coverage with another *doctor* and/or *medical group*.

- **If your conduct threatens others.** If you act in a way that threatens the safety of Anthem employees, providers, other plan members, or other patients, or repeatedly behave in a manner that substantially impairs Anthem's ability to furnish or arrange services for you or other *members* or substantially impairs a provider's ability to provide services to other patients, your *medical group* may ask us to move you to another *medical group*. You will have the opportunity to respond to any allegations that any such behavior has occurred.

Physician/Patient Relations

If you are not satisfied with your relationship with your *doctor* please contact the *Customer Service number* at 1-855-839-4524 and ask to transfer to another *medical group*. If you are not satisfied with your relationship with Anthem, then you may submit the matter to CalPERS under the change of enrollment procedure in Section 22841 of the Government Code.

Your Monthly Subscription Charges

State Employees and Annuitants

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

Cost of the Plan:

Type of Enrollment	Monthly Rate
Employee	$ 752.48
Employee and one family member	$ 1,504.96
Employee and two or more family members	$ 1,956.45

Contracting Agency Employees and Annuitants

The subscription charges are based on the pricing region in which the employee/annuitant lives. See below for the pricing for each region. If the employee/annuitant lives outside of the Anthem Blue Cross Traditional HMO's service area and is enrolled based on place of employment, then the pricing region for the place of employment will apply. If the employee/annuitant moves from one pricing region to another, rates will change on the first of the month following the change of residence. The rates shown below are effective January 1, 2016, and will be reduced by the amount your contracting agency contributes toward the cost of your health benefit plan. For help on calculating your net contributions, contact your agency or retirement system health benefits officer.

Cost of the Plan:

Type of Enrollment	Monthly Rate
Employee only	
Region 1	$ 855.42
Region 1A	$ 1,112.54
Region 2	$ 964.91
Region 3	$ 610.64
Region 4	$ 710.79
Employee and one family member	
Region 1	$ 1,710.84
Region 1A	$ 2,225.08
Region 2	$ 1,929.82
Region 3	$ 1,221.28
Region 4	$ 1,421.58

Employee and two or more family members

Region 1	**$** 2,224.09
Region 1A	**$** 2,892.60
Region 2	**$** 2,508.77
Region 3	**$** 1,587.66
Region 4	**$** 1,848.05

Pricing Regions for Contracting Agency Employees and Annuitants

1 – San Francisco Bay Area

1A – Sacramento Counties

2 – Other Northern California Counties

3 – Los Angeles/Ventura/San Bernardino Counties

4 – Other Southern California Counties

Subscription Charge Change

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

Subscription Charge Payment

For direct payment of subscription charges, contact:

CalPERS HMO Membership Department
Anthem Blue Cross
P.O. Box 629
Woodland Hills, CA 91365-0629
1-855-839-4524

Getting Started

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

Choosing Your Primary Care Doctor

When you enroll you should choose a *primary care doctor*. Your *primary care doctor* will be the first *doctor* you see for all your health care needs. If you need special kinds of care, this *doctor* will refer you to other kinds of *health care providers*.

Your *primary care doctor* will be part of an Anthem Blue Cross Traditional HMO contracting *medical group*. There are two types of Anthem Blue Cross Traditional HMO *medical groups*.

- A *primary medical group (PMG)* is a group practice staffed by a team of *doctors*, nurses, and other *health care providers*.
- An *independent practice association (IPA)* is a group of *doctors* in private offices who usually have ties to the same *hospital*.

You and your family members can enroll in whatever *medical group* is best for you, that is accepting new patients.

- You must live or work within fifteen (15) miles or thirty minutes (30) of the *medical group.*
- You and your family members do not have to enroll in the same *medical group*.
- For a child, you may choose a *primary care doctor* who is a pediatrician.

We publish a directory of *Anthem Blue Cross Traditional HMO providers*. The directory lists all *medical groups*, *IPAs*, and the *primary care doctors* and *hospitals* that are affiliated with each *medical group* or *IPA*. You can get a directory calling the *Customer Service number* at 1-855-839-4524. You may also search for an *Anthem Blue Cross Traditional HMO provider* using the "Find a Doctor" function on our website at www.anthem.com/ca/calpers/hmo. The listings include the credentials of our *primary care doctors* such as specialty designations and board certification.

If You Need Help Choosing

We can help you choose a *doctor* who will meet your needs.

- Call our *Customer Service number* at 1-855-839-4524.
- Talk to the *Anthem Blue Cross Traditional HMO coordinator* at your *medical group*. Your *Anthem Blue Cross Traditional HMO coordinator* can also help you:
  - Understand the services and benefits you can get through Anthem Blue Cross Traditional HMO.
  - Get answers to any questions you may have about your *medical group*.

Changing Your Medical Group

You may find out later on that you need to change your *medical group*. You may move or you may have some other reason. Call our *Customer service number* at 1-855-839-4524 to request a change in *medical group*. We will need to know why you want to change your *medical group*.

If you let us know you want to change your *medical group* by the fifteenth of the month, the change will take place on the first day of the next month as long as you are not still getting treatment from your *doctor* or specialist within the *medical group*. If you let us know you want to change your *medical group* after the fifteenth of the month, the change will take place on the first day of the month following the next month as long as you are not still getting medical treatment from your *doctor* or *specialist* within the *medical group*.

We will approve your request for a change if the *primary care doctor* within the new *medical group* you have picked is accepting new patients. As when you first enroll, you must live or work within fifteen (15) miles or thirty minutes (30) of the new *medical group.*

Please Note: We will not change your *medical group* if you:

- Are an *inpatient* in a *hospital*, a *skilled nursing facility* or other medical institution;
- Are undergoing radiation, chemotherapy, or some other course of treatment for an illness or injury; or
- If you are pregnant and your pregnancy has reached the third trimester;

until the first day of the month following the month in which you have been discharged from an institution, your pregnancy has ended, or you have completed your course of treatment.

If you change your *medical group*, any referrals given to you by your previous *medical group* will not be accepted by your new *medical group*. If you still require a referral for care, you will need to request a referral from your new *primary care doctor* within your new *medical group*. This means your referral may require evaluation by your new *medical group* or us.

Please note that we or your new *medical group* may refer you to a different provider than the one approved by your prior *medical group*.

If you are changing *medical groups*, Customer Service may be able to help smooth the change. When Case Management is involved, the RN Case Manager will also be consulted about the effective date of your *medical group* change request. At the time of your request, please let us know if you are currently under the care of a *specialist*, receiving home health services or using *durable medical equipment* such as a wheelchair, walker, hospital bed or an oxygen delivery system.

If you move to an area not served by Anthem Blue Cross Traditional HMO, we will not be able to cover your medical care. If you move, let your *employer* know within 30 days. That way you can enroll in a different health care plan right away, and still get the health care you need.

Reproductive Health Care Services

Some *hospitals* and other providers do not provide one or more of the following services that may be covered under your *plan* contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective *doctor*, *medical group*, *independent practice association*, or clinic, or call us at the *Customer Service number* at 1-855-839-4524 to ensure that you can obtain the health care services that you need.

When You Need Care

When You Need Routine Care

- **Call your *primary care doctor's* office.**
- **Make an appointment.**

  When you call:

  - Tell them you are an Anthem Blue Cross Traditional HMO *member*.
  - Have your Member ID card handy. They may ask you for:
    - Your group number
    - Member I.D. number
    - Office visit *copay*
  - Tell them the reason for your visit.
- **When you go for your appointment, bring your Member ID card.**
- **Please call your *doctor's* office if you cannot come for your appointment, or if you will be late.**
- **If you need care after normal office hours, call your *primary care doctor's* office for instructions.**

When You Need a Referral

Your *doctor* may refer you to another *doctor* or *health care provider* if you need special care. Your *primary care doctor* must authorize all the care you get except for *emergency services.*

Your *doctor's medical group,* or your *primary care doctor* if they are not part of a *medical group*, has to agree that the service or care you will be getting from the other *health care provider* is *medically necessary***.** Otherwise it will not be covered.

- You will need to make the appointment at the other *doctor's* or *health care provider's office*.
- Your *primary care doctor* will give you a referral form to take with you to your appointment. This form gives you the authorization to get this care. If you do not get this form, ask for it or talk to your *Anthem Blue Cross Traditional HMO coordinator*.
- You may have to pay a *copay*. If your *primary care doctor* refers you to a non-*Anthem Blue Cross Traditional HMO provider*, and you have to pay a *copay*, any fixed dollar *copay* will be the same as if you had the same service provided by an *Anthem Blue Cross Traditional HMO provider*. But, if your *copay* is other than a fixed dollar *copay*, while your benefits levels will not change, your out-of-pocket cost may be greater if the services are provided by a non-*Anthem Blue Cross Traditional HMO provider*. You should not get a bill, unless it is for a *copay*, for this service. If you do, send it to your *Anthem Blue Cross Traditional HMO*

coordinator right away. The *medical group*, or *primary care doctor* if they are not part of a *medical group*, will see that the bill is paid.

Standing Referrals. If you have a condition or disease that requires continuing care from a specialist or is life-threatening, degenerative, or disabling (including HIV or AIDS), your *primary care doctor* may give you a *standing referral* to a *specialist* or *specialty care center*. The referral will be made if your *primary care doctor*, in consultation with you, and a *specialist* or *specialty care center*, if any, determine that continuing specialized care is *medically necessary* for your condition or disease.

If it is determined that you need a *standing referral* for your condition or disease, a treatment plan will be set up for you. The treatment plan:

- Will describe the specialized care you will receive;
- May limit the number of visits to the *specialist*; or
- May limit the period of time that visits may be made to the *specialist*.

If a *standing referral* is authorized, your *primary care doctor* will determine which *specialist* or *specialty care* center to send you to in the following order:

- First, an Anthem Blue Cross Traditional HMO contracting *specialist* or *specialty care center* which is associated with your *medical group*;
- Second, any Anthem Blue Cross Traditional HMO contracting *specialist* or *specialty care center*; and
- Last, any *specialist* or *specialty care center*;

that has the expertise to provide the care you need for your condition or disease.

After the referral is made, the *specialist* or *specialty care center* will be authorized to provide you health care services that are within the *specialist's* area of expertise and training in the same manner as your *primary care doctor*, subject to the terms of the treatment plan.

Remember: We only pay for the number of visits and the type of special care that your *primary care doctor* authorizes. Call your *doctor* if you need more care. **If your care is not approved ahead of time, you will have to pay for it (except for *emergency services.)***

Ready Access

There are two ways you may get special care without getting an authorization from your *medical group*. These two ways are the "Direct Access" and "Speedy Referral." programs. **Not all medical groups take part in the Ready Access program. See your Anthem Blue Cross Traditional HMO Directory for those that do.**

Direct Access. You may be able to get some special care without an authorization from your *primary care doctor*. We have a program called "Direct Access", which lets you get special care, without an authorization from your *primary care doctor* for:

- Allergy
- Dermatology
- Ear/Nose/Throat

Ask your *Anthem Blue Cross Traditional HMO coordinator* if your *medical group* takes part in the "Direct Access" program. If your *medical group* participates in the Direct Access program, you must still get your care from a *doctor* who works with your *medical group*. The *Anthem Blue Cross Traditional HMO coordinator* will give you a list of those *doctors*.

Speedy Referral. If you need special care, your *primary care doctor* may be able to refer you for it without getting an authorization from your *medical group* first. The types of special care you can get through Speedy Referral depend on your *medical group*.

Obstetrical and Gynecological Care

Obstetrical and gynecological services may be received directly, without obtaining referral from your *primary care doctor*, from an obstetrician and gynecologist or family practice physician who is a member of your *medical group*, or who has an arrangement with your *medical group* to provide care for its patients, and who has been identified by your *medical group* as available for providing obstetrical and gynecological care.

- A *doctor* specializing in obstetrical or gynecological care may refer you to another *doctor* or *health care provider* and order related obstetrical and gynecological items and services if you need additional *medically necessary* care.
- The conditions for a referral from a *doctor* specializing in obstetrical or gynecological care are the same conditions for a referral from your *participating care doctor*. See **When You Need a Referral on pages 10-11**.
- Ask your *Anthem Blue Cross Traditional HMO coordinator* for the list of OB-GYN health care providers you must choose from.

Care for Mental or Nervous Disorders or Substance Abuse and Pervasive Developmental Disorder or Autism

You may get care for the treatment of *mental or nervous disorders* or substance abuse and pervasive developmental disorder or autism without getting an authorization from your *medical group*. In order for this care to be covered, you must go to an *Anthem Blue Cross Traditional HMO provider*. Some services require that we review and approve care in advance. Please see "Mental or Nervous Disorders/Substance Abuse" on pages 32, in the section called "Your Benefits At Anthem Blue Cross Traditional HMO" starting on page 21 for complete information.

You can get an Anthem Blue Cross Behavioral Health Network directory listing these providers from us as follows:

- You can call our *Customer Service number* at 1-855-839-4524 or you may write to us and ask us to send you a directory. Ask for the Behavioral Health Network directory.
- You can also search for an *Anthem Blue Cross Traditional HMO provider* using the "Find a Doctor" function on our website at www.anthem.com/ca/calpers/hmo. Be sure to select the "Behavioral Health Professionals" option on the next screen following your selection of plan category.

In addition, if you are a new *member* and you enrolled in this *plan* because the employer changed health plans, and you are getting care for an acute, serious, or chronic *mental or nervous disorder* or for substance abuse from a *doctor* or other *health care provider* who is not part of the Anthem Blue Cross Traditional HMO network, you may be able to continue your course of treatment with that *doctor* or *health care provider* for a reasonable period of time before transferring to an *Anthem Blue Cross Traditional HMO provider*. To ask for this continued care or to get a copy of our written policy for this continued care, please call our *Customer Service number* at 1-855-839-4524.

Transgender Services

You may get coverage for services and supplies provided in connection with gender transition without getting an approval from your *medical group*. You must obtain our approval in advance for all transgender services in order for these services to be covered by this *plan* (see "Medical Management Programs" starting on page 40 for details). No benefits are payable for these services if our approval is not obtained. Please see "Transgender Services" in the section called "Your Benefits At Anthem Blue Cross Traditional HMO" starting on page 21 for complete information.

When You Want a Second Opinion

You may receive a second opinion about care you receive from:

- Your *primary care doctor*, or
- A *specialist* to whom you were referred by your *primary care doctor*.

Reasons for asking for a second opinion include, but are not limited to:

- Questions about whether recommended surgical procedures are reasonable or necessary.
- Questions about the diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including but not limited to a serious chronic condition.
- The clinical indications are not clear or are complex and confusing.
- A diagnosis is in doubt because of test results that do not agree.
- The first *doctor* or *health care provider* is unable to diagnose the condition.

- The treatment plan in progress is not improving your medical condition within an appropriate period of time.
- You have tried to follow the treatment plan or you have talked with the *doctor* or *health care provider* about serious concerns you have about your diagnosis or plan of care.

To ask for a second opinion about care you received from your *primary care doctor* if your *primary care doctor* is part of a *medical group*, call your *primary care doctor* or your *Anthem Blue Cross Traditional HMO coordinator* at your *medical group*. The second opinion will be provided by a qualified *doctor* or *health care provider* of your choice who is part of your *medical group*.

To ask for a second opinion about care you received from:

- Your *primary care doctor* if he or she is an independently contracting *primary care doctor* (not part of a *medical group*), or
- Any *specialist*,

please call the *Customer Service number* at 1-855-839-4524. The Customer Service Representative will verify your Anthem Blue Cross Traditional HMO membership, get preliminary information, and give your request to an RN Case Manager. The second opinion will be provided by a qualified *doctor* or *health care provider* of your choice who is part of the Anthem Blue Cross network. Please note that if your *primary care doctor* is part of a *medical group*, the *doctor* or *health care provider* who provides the second opinion may not necessarily be part of your *medical group*.

For any second opinion, if there is no appropriately qualified *doctor* or *health care provider* in the Anthem Blue Cross network, we will authorize a second opinion by another appropriately qualified *doctor* or *health care provider*, taking into account your ability to travel.

For all second opinions, a decision will be made promptly after your request and any necessary information are received. Decisions on urgent requests are made within a time frame appropriate to your medical condition but no later than 72 hours after you make your request. For non-urgent requests, a decision will be made within two business days after any necessary information is received.

When approved, your *primary care doctor* or Case Manager helps you with selecting a *doctor* or *health care provider* who will provide the second opinion within a reasonable travel distance and makes arrangements for your appointment at a time convenient for you and appropriate to your medical condition. If your medical condition is serious, your appointment will be scheduled within no more than seventy-two (72) hours. You must pay only your usual *copay* for the second opinion.

An approval letter is sent to you and the *doctor* or *health care provider* who will provide the second opinion. The letter includes the services approved and the date of your scheduled appointment. It also includes a telephone number to call if you have questions or need additional help. Approval is for the second opinion consultation only. It does not include any other services such as lab, x-ray, or additional treatment. You and your *primary care doctor* or *specialist* will get a copy of the second opinion report, which includes any recommended diagnostic testing or procedures. When you get the report, you and your *primary care doctor* or

specialist should work together to determine your treatment options and develop a treatment plan. Your *medical group* (or your *primary care doctor*, if he or she is an independently contracting *primary care doctor*) must authorize all follow-up care.

You may appeal a disapproval decision by following our complaint process. Procedures for filing a complaint are described later in this booklet (see "How to File a Complaint" starting on page 49) and in your denial letter.

If you have questions or need more information about this program, please contact your *Anthem Blue Cross Traditional HMO coordinator* at your *medical group* or call the *Customer Service number* at 1-855-839-4524.

When You Need a Hospital Stay

There may be a time when your *primary care doctor* says you need to go to the *hospital*. If it is not an *emergency*, the *medical group* will look into whether or not it is *medically necessary*. If the *medical group* authorizes your *hospital stay*, you will need to go to a *hospital* that works with your *medical group*.

When There is an Emergency

If you need *emergency services*, get the medical care you need right away. In some areas, there is a 9-1-1 emergency response system that you may call for *emergency services* (this system is to be used only when there is an *emergency* that requires an emergency response).

Once you are stabilized, your *primary care doctor* must authorize any care you need after that.

- Ask the *hospital* or emergency room *doctor* to call your *primary care doctor*.
- Your *primary care doctor* will authorize any other *medically necessary* care or will take over your care.

You may need to pay a *copay* for emergency room services. A *copay* is a set amount you must pay for services. We cover the rest.

If You Are In-Area. You are in-area if you are 15-miles or 30-minutes or less from your *medical group* (or 15-miles or 30-minutes or less from your *medical group's hospital*, if your *medical group* is an *independent practice association*).

If you need *emergency services*, get the medical care you need right away. If you want, you may also call your *primary care doctor* and follow his or her instructions.

Your *primary care doctor* or *medical group* may:

- Ask you to come into their office;
- Give you the name of a *hospital* or emergency room and tell you to go there;
- Order an ambulance for you;
- Give you the name of another doctor or medical group and tell you to go there; or
- Tell you to call the 9-1-1 emergency response system.

If You Are Out of Area. You can still get *emergency services* if you are more than 15-miles or 30-minutes away from your *primary care doctor* or *medical group.*

If you need *emergency services*, get the medical care you need right away (follow the instructions above for When There is an Emergency). In some areas, there is a 9-1-1 emergency response system that you may call for *emergency services* (this system is to be used only when there is an *emergency* that requires an emergency response). You must call us within 48 hours if you are admitted to a *hospital*.

Remember:

- We will not cover services that do not fit what we mean by *emergency services.*
- Your *primary care doctor* must authorize care you get once you are stabilized, unless Anthem Blue Cross Traditional HMO approves it.
- Once your *medical group* or Anthem Blue Cross Traditional HMO give an approval for *emergency services*, they cannot withdraw it.

You Need Urgent Care

If You Are In-Area. You are in-area if you are 15-miles or 30-minutes or less from your *medical group* (or 15-miles or 30-minutes or less from your *medical group's hospital*, if your *medical group* is an *independent practice association*).

If you are in-area, call your *primary care doctor* or *medical group.* Follow their instructions.

Your *primary care doctor* or *medical group* may:

- Ask you to come into their office;
- Give you the name of a *hospital* or emergency room and tell you to go there;
- Order an ambulance for you;
- Give you the name of another doctor or medical group and tell you to go there; or
- Tell you to call the 9-1-1 emergency response system.

If You Are Out of Area. You can get *urgent care* if you are more than 15-miles or 30-minutes away from your *primary care doctor* or *medical group.*

For *urgent care*, if care cannot wait until you get back to make an appointment with your *primary care doctor*, get the medical care you need right away. You must call us within 48 hours if you are admitted to a *hospital*.

If you need a *hospital stay* or long-term care, we will check on your progress. When you are able to be moved, we will help you return to your *primary care doctor's* or *medical group's* area.

Remember:

- We will not cover services that do not fit what we mean by *urgent care.*
- Your *primary care doctor* must authorize care you get once you are stabilized, unless Anthem Blue Cross Traditional HMO approves it.

Triage and 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, please contact your *primary care doctor*. In addition, triage or screening services are available to you from us by telephone. Triage or screening services are the evaluation of your health by a *doctor* or nurse who is trained to screen for the purpose of determining the urgency of your need for care. Please contact the 24/7 NurseLine at 1-800-700-9185, 24 hours a day, 7 days a week.

Telehealth

This *plan* provides benefits for covered services that are appropriately provided through telehealth, subject to the terms and conditions of the *plan* including the requirement that all care must be provided or authorized by your *medical group* or *primary care doctor*, except as specifically stated in this booklet. 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.

Getting Care When You Are Outside of California

If you or your family members will be away from home for more than 90 days, you may be able to get a *guest membership* in a *medical group* in the city you are visiting.

- Before you leave home, call the Anthem Blue Cross Traditional HMO *Customer service number* at 1-855-839-4524.
- Ask for the Guest Membership Coordinator.
- We will send you forms to fill out.
- If there is a *medical group* taking part in the national network in the city you will be visiting, you will be a guest member while you are away from home.
- The benefits you will get may not be the same as the benefits you would get at home.

Even without a *guest membership*, you can get *medically necessary* care (*urgent care*, *emergency services*, or follow-up care) when you are away from home.

- **If you are traveling outside California,** and need health care because of a non-emergency illness or injury, call the BlueCard Access 800 number, 1-800-810-BLUE (2583).

- **The BlueCard Access Call Center will tell you if there are *doctors* or *hospitals* in the area** that can give you care. They will give you the names and phone numbers of nearby *doctors* and *hospitals* that you go to or call for an appointment.
- **If it is an *emergency*, get medical care right away.** You or a member of your family must call us within 48 hours after first getting care.
- **The provider may bill you for these services**. Send these bills to us. We will make sure the services were *emergency services* or *urgent care*. You may need to pay a *copay*.

Note: Providers available to you through the BlueCard Program have not entered into contracts with Anthem Blue Cross. If you have any questions or complaints about the BlueCard Program, please call us at the *Customer Service number* at 1-855-839-4524.

Care Outside the United States-BlueCard Worldwide

Prior to travel outside the United States, call the *Customer Service number* at 1-855-839-4524 to find out if your plan has BlueCard Worldwide benefits. Your coverage outside the United States is limited and we recommend:

- Before you leave home, call the *Customer Service number* at 1-855-839-4524 for coverage details. **You have coverage for services and supplies furnished only in connection with *urgent care* or an *emergency* when travelling outside the United States.**
- Always carry your current Member ID card.
- In an *emergency* or if you need *urgent care*, 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 *doctor* appointment or hospitalization, if needed.
- If you are admitted to a *hospital*, you must call us within 48 hours at the *Customer Service number* at 1-855-839-4524. This number is different than the phone numbers listed above for BlueCard Worldwide.

Call the BlueCard Worldwide Service Center in these non-emergent situations:

- **You need to find a *doctor* or *hospital* or need medical assistance services.** An assistance coordinator, along with a medical professional, will arrange a *doctor* appointment or hospitalization, if needed.
- **You need to be hospitalized or need *inpatient* care.** After calling the Service Center, you must also call us at the *Customer Service number* at 1-855-839-4524 for pre-service review to determine whether the services are covered. Please note that this number is different than the phone numbers listed above for BlueCard Worldwide.

Payment Information.

- **Participating BlueCard Worldwide hospitals.** When you make arrangements for hospitalization through BlueCard Worldwide, you should not need to pay upfront for *inpatient* care at participating BlueCard Worldwide *hospitals* except for the out-of-pocket

costs (non-covered services, deductible, copays and coinsurance) you normally pay. The *hospital* will submit your claim on your behalf.

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

Claim Filing.

- **The hospital will file your claim** if the BlueCard Worldwide Service Center arranged your hospitalization. You will need to pay the hospital for the out-of-pocket costs you normally pay.
- **You must file the claim** for outpatient and *doctor* care, or *inpatient* care not arranged through the BlueCard Worldwide Service Center. You will need to pay the health care provider and subsequently send an international claim form with the original bills to Anthem.

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 us, from the BlueCard Worldwide Service Center, or online at:

  www.bcbs.com/bluecardworldwide.

  The address for submitting claims is on the form.

Revoking or Modifying a Referral or Authorization

A referral or authorization for services or care that was approved by your *medical group*, your *primary care doctor*, or by us may be revoked or modified prior to the services being rendered for reasons including but not limited to the following:

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

If You and Your Doctor Do Not Agree

If you think you need a certain kind of care, but your *doctor* or *medical group* is not recommending it, you have a right to the following:

- **Ask for a written notice** of being denied the care you felt you needed. You should get this notice within 48 hours.
- **Your *doctor* should give you a written reason** and another choice of care within 48 hours.
- **You can make a formal appeal** to the *medical group* and to Anthem. See "How to File a Complaint" starting on page 49.

We Want You to Have Good Health

Ask about our many programs to:

- Educate you about living a healthy life.
- Get a health screening.
- Learn about your health problem.

For more information, please call us at our *Customer service number* at 1-855-839-4524.

RelayHealth. We have made arrangements with RelayHealth to provide an online health care information and communication program. This program will allow you to contact your *doctor* on the internet if your *doctor* is a participant in RelayHealth. To see if your *doctor* is enrolled in the program, use the "Find Your Doctor" function on the website, www.relayhealth.com. Through this private, secure internet program, you can consult your *doctor*, request prescription refills, schedule appointments, and get lab results. You will only be required to pay a *copay* for consultations. This *copay* will be **$10** and must be paid by credit card. You will not be required to pay a *copay* when you request prescription refills, schedule appointments and get lab results.

Your Benefits at Anthem Blue Cross Traditional HMO

It is important to remember:

- The benefits of this *plan* are given only for those services that the *medical group* finds are *medically necessary*.
- Just because a *doctor* orders a service, it does not mean that:
  - The service is *medically necessary*; or
  - This *plan* covers it.
- If you have any questions about what services are covered, read this booklet, or give us a call at the *Customer Service number* at 1-855-839-4524.
- All benefits are subject to coordination with benefits available under certain other plans.
- We have the right to be repaid by a third party for medical care we cover if your injury, disease or other health problem is their fault or responsibility.
- Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. *Members* seeking *emergency services*, *urgent care* services or an *authorized referral* in accordance with this *plan* from non-*Anthem Blue Cross Traditional HMO provider* could be balance billed by the non-*Anthem Blue Cross Traditional HMO 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.

What are Copays?

A *copay* is a set amount you pay for each medical service. You need to pay a *copay* for some services given under this *plan*, but many other supplies and services do not need a *copay*. Usually, you must pay the *copay* at the time you get the services. The *copays* you need to pay for services are shown in the next section.

Here are the Copay Limits

If you pay more than the *Copay Limits* shown below in one *calendar year* (January through December), you will not need to pay any more *copays* for the rest of the *year*.

Per Number of Members	Copay Limits
One *Member*	**$1,500**
Family	**$3,000***

*But, not more than $1,500 for any one *Member* in a Family.

The following *copay* will not apply to the *Copay Limits*:

- For *infertility*, any *copay* for testing and diagnosis.

What We Cover

We list benefits for the services and supplies in this section. Any *copays* you must pay are shown next to the service or supply. We list things **we do NOT cover in the Exclusion section starting on page 44**.

Remember:

Your *primary care doctor* and your *medical group* must give or approve all your care.

Ambulance	**Copay**

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 us 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 us to one that does, or
  - Between a hospital and another approved facility.

Ambulance services are subject to medical necessity reviews by us or your *medical group*. When using an air ambulance in a non-emergency situation, we or your *medical group* reserve the right to select the air ambulance provider. If you do not use the air ambulance selected 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 *doctor* are not a covered service.

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

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

If provided through the 9-1-1 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*.

Your copays for covered ambulance services are:

- Base charge and mileage..... **No charge**
- Disposable supplies..... **No charge**
- Monitoring, EKG's or ECG's,
  cardiac defibrillation, CPR, oxygen,
  and IV solutions ..... **No charge**

IN SOME AREAS, THERE IS A 9-1-1 EMERGENCY RESPONSE SYSTEM. THIS SYSTEM IS TO BE USED ONLY WHEN THERE IS AN *EMERGENCY*.

IF YOU REASONABLY BELIEVE THAT YOU ARE EXPERIENCING AN EMERGENCY, YOU SHOULD CALL 9-1-1 OR GO DIRECTLY TO THE NEAREST HOSPITAL EMERGENCY ROOM. PLEASE USE THE 9-1-1 SYSTEM FOR MEDICAL EMERGENCIES ONLY.

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 *doctor'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 *doctor* prefers a specific *hospital* or *doctor*.

Clinical Trials	**Copay**

Routine patient costs, as described below, for an approved clinical trial.....**See *copays* that apply**

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

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

- Federally funded trials approved or funded by one or more of the following:
  - The National Institutes of Health,
  - The Centers for Disease Control and Prevention,
  - The Agency for Health Care Research and Quality,
  - The Centers for Medicare and Medicaid Services,
  - A cooperative group or center of any of the four entities listed above or the Department of Defense or the Department of Veterans Affairs,
  - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants, or
  - 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:
    - The Department of Veterans Affairs,
    - The Department of Defense, or
    - The Department of Energy.
- Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration.
- 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 section called "Important Words to Know" on page 82).

Participation in the clinical trial must be recommended by your *primary care doctor* after deciding it will help you. If the clinical trial is not provided by or through your *medical group*, your *primary care doctor* will refer you to the *doctor* or *health care provider* who provides the clinical trial. Please see "When You Need a Referral" on pages 10-11 in the section called "When You Need Care", starting on page 10, for information about referrals. You will only have to pay your normal copays for the services you get.

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

- The investigational item, device, or service itself.
- 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.
- Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Any item, device, or service that is paid for, or should have been paid for, by the sponsor of the trial.

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

If you do not agree with the coverage or medical necessity of possible clinical trial services, please read the "Independent Medical Review of Complaints Involving a Disputed Health Care Service" (see Table of Contents).

Dental Care	**Copay**

- *Inpatient hospital* services ..... **No charge**

  Inpatient hospital services are limited to 3 days when the *stay* is:

  - Needed for dental care because of other medical problems you may have.
  - Ordered by a *doctor* (M.D.) or a dentist (D.D.S. or D.M.D.)
  - Approved by the *medical group*.

- General anesthesia and facility services when dental care must be provided in an outpatient *hospital* or *surgery center* ..... **No charge**

These services are covered when:

- You are less than seven years old;
- You are developmentally disabled; or
- Your health is compromised and general anesthesia is *medically necessary*.

Note: No benefits are provided for the dental procedure itself or for the professional services of a dentist to do the dental procedure.

- Emergency care for accidental injury to natural teeth ..... **No charge**

- The care is not covered if you hurt your teeth while chewing or biting unless the chewing or biting results from a medical or mental condition.
- This *plan* does not cover any other kind of dental care.

♦ 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 ..... **No charge**

♦ *Medically necessary* dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. ..... **No charge**

"Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

Important: If you decide to receive dental services that are not covered under this *plan*, a dentist who participates in an Anthem Blue Cross network 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 us at the *Customer Service number* at 1-855-839-4524. To fully understand your coverage under this *plan*, please carefully review this Evidence of Coverage document.

Diabetes	**Copay**

♦ Equipment and supplies used for the treatment of diabetes (see below) ..... **See "Medical Equipment"**

- Blood glucose monitors, including monitors designed to help the visually impaired, and blood glucose testing strips.
- Insulin pumps
- Pen delivery systems for insulin administration (non-disposable).
- Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin.

♦ Podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes-related complications..... **See "Prosthetic Devices"**

♦ Diabetes education program services supervised by a *doctor* which include: **$15**

- Teaching you and your family members about the disease process and how to take care of it; and

- Training, education, and nutrition therapy to enable you to use the equipment, supplies, and medicines needed to manage the disease.

♦ Medical supplies ..... **No charge**

- Insulin syringes, disposable pen delivery systems for insulin administration. Charges for insulin and other prescriptive medications are not covered.
- Testing strips, lancets, and alcohol swabs.

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

Note: Certain supplies may be covered under your CVS Pharmacy benefit and you may be required to pay the applicable pharmacy copays. You may verify your pharmacy benefits by contacting CVS Caremark's Customer Care at 1-855-479-3660 or 1-866-236-1069 [TTY].

Doctor Care (or services of a Health Professional)	**Copay**

♦ Office visits for a covered illness, injury or health problem..... **$15**

♦ Home visits, when approved by your *medical group*, at the *doctor's* discretion **$15**

♦ Injectable or infused medications* given by the *doctor* in the office ..... **No charge**

*This does not include immunizations prescribed by your *primary care doctor*.

♦ Surgery in *hospital*, *surgery center* or *medical group* and surgical assistants..... **No charge**

♦ Anesthesia services ..... **No charge**

♦ *Doctor* visits during a *hospital stay* ..... **No charge**

♦ Visit to a *specialist*..... **$15**

Note: Benefit for Chiropractic and Acupuncture services are provided through Anthem and the American Specialty Health Plans of California (ASH). See the Chiropractic and Acupuncture Care Amendment at the end of the EOC, on pages 93-99, for more information.

General Medical Care (In a Non-Hospital-Based Facility)	**Copay**

♦ Hemodialysis treatment, including treatment at home if authorized by the *medical group* **$15**

♦ Medical social services ..... **No charge**

♦ Chemotherapy **$15**

♦ Radiation therapy..... **$15**

- Infusion therapy ..... **No charge**
- Allergy tests and care ..... **No charge**
- X-ray and laboratory tests ..... **No charge**
- Genetic testing (not including *medically necessary* genetic testing of the fetus or newborn) ..... **No charge**
- *Members* who participate in a smoking cessation class/program will be reimbursed up to $100 per class/program per *calendar year* for nicotine dependency. Smoking cessation drugs that may be purchased over-the-counter without a prescription are not covered. We cover *medically necessary* drugs for nicotine dependency that require a *prescription*. This does not include those services required under the "Preventive Care Services" benefit. ..... **No charge**

Prescription drugs to help you stop smoking or reduce your dependence on tobacco products, as well as over-the-counter nicotine replacement products (limited to nicotine patches and gum) are covered when obtained with a *doctor's* prescription. These drugs and products will be covered as *preventive care services*.

Hearing Aid Services	**Copay**

- Covered hearing aids (one per ear, every 3 *calendar years*) ..... **No charge**

The following hearing aid services are covered when ordered by or purchased as a result of a written recommendation from:

- an otolaryngologist; or
- a state-certified audiologist.

Services include:

- Audiological evaluations to:
  - measure the extent of hearing loss; and
  - determine the most appropriate make and model of hearing aid.

These evaluations will be covered under the *plan* benefits for office visits to *doctors*.

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

- Charges for a hearing aid which exceeds specifications prescribed for the correction of hearing loss;
- 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").
- Charges for a hearing aid which is not determined to be *medically necessary*.

Home Health Care	**Copay**

We will cover home health care furnished by a *home health agency* (HHA).

♦ Home health care services provided by a HHA ..... **No charge**

Home health care services include the following:

- Care from a registered nurse or licensed vocational nurse who works under a registered nurse or a *doctor*.
- Visits with a medical social service worker.
- Care from a health aide who works under a registered nurse with the HHA (one visit equals four hours or less)

♦ Physical therapy, occupational therapy, speech therapy, or respiratory therapy **$15**

♦ *Medically necessary* supplies from the HHA ..... **No charge**

Hospice Care	**Copay**

We will cover *hospice* care services shown below for the palliative care of pain and other symptoms if you have an illness that may lead to death. Palliative care is care that controls pain and relieves symptoms but is not intended to cure the illness. Your *primary care doctor* will work with the *hospice* and help develop your care plan. The *hospice* must send a written care plan to your *medical group* every 30 days.

♦ Interdisciplinary team care to develop and maintain a plan of care ..... **No charge**

♦ Short-term *inpatient hospital* care in periods of crisis or as respite care. Respite care is provided on an occasional basis for up to five consecutive days per admission ..... **No charge**

♦ Physical therapy, occupational therapy, speech therapy and respiratory therapy ..... **No charge**

♦ Social services and counseling services ..... **No charge**

♦ Skilled nursing services given by or under the supervision of a registered nurse. ..... **No charge**

- Certified home health aide services and homemaker services given under the supervision of a registered nurse. ..... **No charge**
- Diet and nutrition advice; nutrition help such as intravenous feeding or hyperalimentation ..... **No charge**
- Volunteer services given by trained *hospice* volunteers directed by a *hospice* staff member ..... **No charge**
- Drugs and medicines prescribed by a *doctor* ..... **No charge**
- Medical supplies, oxygen and respiratory therapy supplies ..... **No charge**
- Care which controls pain and relieves symptoms ..... **No charge**
- Bereavement services, including assessing the needs of the bereaved family and developing a care plan to meet those needs, both before and after death. Bereavement services are available to covered members of the immediate family (spouse, children, step-children, parents, brothers and sisters) for up to one year after the employee's or covered family member's death ..... **No charge**

Infertility and Birth Control	**Copay**

- Diagnosis and testing for *infertility* **50%***
- Sterilization for females ..... **No charge**

  Sterilizations for females will be covered under the "Preventive Care Services benefit. Please see that provision for further details.

- Sterilization for males ..... **See "Doctor Care" or "Inpatient Hospital Services"**
- Family planning services ..... **No charge**
- Shots and implants for birth control** ..... **No charge**
- Intrauterine contraceptive devices (IUDs) and diaphragms, dispensed by a *doctor*** ..... **No charge**
- *Doctor's* services to prescribe, fit and insert an IUD or diaphragm** ..... **No charge**

  ***Note:** The **50%** *copay* made for *infertility* services will not be applied to the "*Copay Limits*."

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

Inpatient Hospital Services	**Copay**

♦ A *hospital* room with two or more beds, or a private room only if *medically necessary*, ordered by your *primary care doctor* and authorized by your *medical group* ..... **No charge**

Inpatient hospital services and supplies include the following:

- Operating room and special treatment room;
- Special care units;
- Nursing care;
- Drugs and medicines, and supplies you get during your *stay*. This includes oxygen;
- Laboratory, cardiology, pathology and radiology services;
- Physical therapy, occupational therapy, speech therapy, radiation therapy, chemotherapy and hemodialysis; and
- Blood transfusions. This includes the cost of blood, blood products or blood processing.

Mastectomy	**Copay**

♦ Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema ..... **See *copays* that apply**

♦ Reconstructive surgery of both breasts performed to restore symmetry following a mastectomy ..... **See *copays* that apply**

Medical Equipment	**Copay**

♦ Medical equipment and supplies ..... **No charge**

You can get long-lasting medical equipment (called *durable medical equipment*) and supplies that are rented or bought for you if they are:

– Ordered by your *primary care doctor*.

– Used only for the health problem.

– Used only by the person who needs the equipment or supplies.

– Made only for medical use.

Equipment and supplies are **not** covered if they are:

– Only for your comfort or hygiene.

– For exercise.

– Only for making the room or home comfortable, such as air conditioning or air filters.

Mental or Nervous Disorders/Substance Abuse	**Copay**

You can get services for the *medically necessary* treatment of *mental or nervous disorders* or substance abuse or to prevent the deterioration of chronic conditions. These services do not include programs to stop smoking, or to help with nicotine or tobacco abuse.

- *Inpatient facility-based care* for the treatment of *mental or nervous disorders* or substance abuse..... **No charge**

- Outpatient *facility-based care*, including partial hospitalization and intensive outpatient programs for the treatment of *mental or nervous disorders* or substance abuse ..... **No charge**

Before you get services for *facility-based care* for the treatment of *mental or nervous disorders* or substance abuse, you must get our approval first. Read "Medical Management Programs" to find out how to get approvals.

- *Inpatient doctor* visits during a *stay* for the treatment of *mental or nervous disorders* or substance abuse..... **No charge**

- Office or home visits to a *doctor* for outpatient psychotherapy or psychological testing for the treatment of *mental or nervous disorders* or substance abuse **$15**

- Nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa **$15**

- Behavioral health treatment for pervasive developmental disorder or autism. **$15**

  You must get our approval first 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*. Read "Medical Management Programs" to find out how to get approvals. No benefits are payable for these services if our approval is not obtained.

  Behavioral health treatment services covered under this *plan* are subject to the same deductibles, coinsurance, and copayments, if any, that apply to services provided for other covered medical conditions.

Organ and Tissue Transplants	**Copay**

Services and supplies are given if:

– You are receiving the organ or tissue, or

– You are the organ or tissue donor, if the person who is receiving it is a *member* of Anthem Blue Cross Traditional HMO. If you are not a *member*, the benefits are lowered by any amounts paid by your own health plan.

♦ Services given with an organ or tissue transplant ..... **See *copays* that apply**

Outpatient (In a Hospital or Surgery Center)	**Copay**

♦ Emergency room use, supplies, other services drugs and medicines. This includes oxygen **$50***

*You do not have to pay the **$50** if you are admitted as an *inpatient*.

♦ Care given when surgery is done. This includes operating room use, supplies, drugs and medicines, oxygen, and other services. ..... **No charge**

♦ Upper and lower gastrointestinal (GI) endoscopy, cataract surgery, and spinal injection ..... **$250*** per procedure

*Only when an outpatient hospital is used instead of an *ambulatory surgery center*.

♦ X-ray and laboratory tests ..... **No charge**

♦ Other outpatient *hospital* services and supplies, including physical therapy, occupational therapy, or speech therapy **$15**

However, for the following outpatient services, your copay will be:

- ♦ Chemotherapy **$15**
- ♦ Radiation therapy **$15**
- ♦ Hemodialysis treatment **$15**
- ♦ Infusion therapy ..... **No charge**

Pediatric Asthma Equipment and Supplies	Copay

- Nebulizers, including face masks and tubing ..... **No charge**
- Inhaler spacers and peak flow meters ..... **No charge**

  These items are not subject to any limits or maximums that apply to coverage for Medical Equipment.

- Pediatric asthma education program services to help you use the items listed above **$15**

Pregnancy or Maternity Care	Copay

Medical services for an enrolled *member* are provided for pregnancy and maternity care, including the following services: Prenatal and postnatal care, ambulatory care services (including ultrasounds, fetal non-stress tests, *doctor* office visits, and other *medically necessary* maternity services performed outside of a *hospital*), involuntary complications of pregnancy, diagnosis of genetic disorders in cases of high-risk pregnancy, and *inpatient hospital* care including labor and delivery.

- Office visit ..... **No charge**
- *Doctor's* services for normal delivery or cesarean section ..... **No charge**
- *Hospital* services:
  - *Inpatient* services ..... **No charge**
  - Outpatient covered services ..... **No charge**
- Abortion services ..... **See "Doctor Care" or "Inpatient Hospital Services"**
- Genetic testing, when *medically necessary* ..... **No charge**
- *Hospital* services for routine nursery care of your newborn child if the newborn child's natural mother is an enrolled *member* ..... **No charge**

  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.

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

Note: For *inpatient hospital* services related to childbirth, we will provide at least 48 hours after a normal delivery or 96 hours after a cesarean section, unless the mother and her *doctor* decide on an earlier discharge. Please see the section called "For Your Information" on page 89 for a statement of your rights under federal law regarding these services.

Preventive Care Services	Copay

Covered *preventive care services* include screenings, services and supplies, when you have no current symptoms or prior history of a medical condition associated with that screening or service.

- Full physical exams and periodic check-ups ordered by your *primary care doctor* including well-woman visits ..... **No charge**
  - Vision or hearing screenings* ..... **No charge**
  - Immunizations prescribed by your *primary care doctor* ..... **No charge**
- Health education programs given by your *primary care doctor* or the *medical group* ..... **No charge**
- Health screenings as prescribed by your *doctor* or *health care provider* ..... **No charge**
  - Health screenings include: mammograms, Pap tests and any cervical cancer screening tests including human papillomavirus (HPV), prostate cancer screenings, and other medically accepted cancer screening tests, screenings for high blood pressure, type 2 diabetes mellitus, cholesterol, and obesity.**
- Preventive services for certain high-risk populations as determined by your *doctor*, based on clinical expertise. ..... **No charge**
- Counseling and intervention services as part of a full physical exam or periodic check-up for the purpose of education or counseling on potential health concerns, including sexually transmitted infections, human immunodeficiency virus (HIV), contraception, and smoking cessation counseling ..... **No charge**
- HIV testing, regardless of whether testing is related to a primary diagnosis ..... **No charge**
- Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following: ..... **No charge**
  - All FDA-approved contraceptive methods for women, including over-the-counter items, if prescribed by your *doctor*.
    In order to be covered as preventive care, contraceptive drugs must be either a generic or single source brand name drug. Also covered are sterilization procedures and counseling.
  - Breast feeding support, supplies, and counseling ordered by your *primary care doctor* or *medical group*. One breast pump will be covered per pregnancy under this benefit.

- Gestational diabetes screening.
- Screening for iron deficiency anemia in pregnant women.
- Breast cancer (BRCA) testing, if appropriate, in conjunction with genetic counseling and evaluation.

* Vision screening includes a vision check by your *primary care doctor* to see if it is *medically necessary* for you to have a complete vision exam by a vision *specialist*. If authorized by your *primary care doctor*, this may include an exam with diagnosis, a treatment program and refractions. Hearing screenings include tests to diagnose and correct hearing.

** This list is not exhaustive. Preventive tests and screenings with a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF), or those supported by the Health Resources and Services Administration (HRSA) will be covered at no charge.

See the definition of "Preventive Care Services" on page 86, in the "Important Words to Know" section for more information about services that are covered by this *plan* as *preventive care services*.

Prosthetic Devices	**Copay**

You can get devices to take the place of missing parts of your body.

- Surgical implants ..... **No charge**
- Artificial limbs or eyes ..... **No charge**
- The first pair of contact lenses or eye glasses when needed after a covered and *medically necessary* eye surgery ..... **No charge**
- Breast prostheses following a mastectomy ..... **No charge**
- *Prosthetic devices* to restore a method of speaking when required as a result of a laryngectomy ..... **No charge**
- Therapeutic shoes and inserts designed to treat foot complications due to diabetes ..... **No charge**
- Orthopedic footwear used as an integral part of a brace; shoe inserts that are custom molded to the patient ..... **No charge**
- Colostomy supplies ..... **No charge**
- Supplies needed to take care of these devices ..... **No charge**

Reconstructive Surgery	**Copay**

- Reconstructive surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function, reducing symptoms or creating a normal appearance, including *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 ..... **See *copays* that apply**

This does not apply to orthognathic surgery. Please see the "Dental Care" benefit on pages 25-26 for a description of this coverage.

Rehabilitative Care	**Copay**

Rehabilitative care is provided after an illness or injury. Rehabilitative care is also provided for a *member* who is being treated for a *severe mental disorder* or for pervasive developmental disorder or autism. This care is provided even though the *member* may not have suffered an illness or injury.

- Visits for rehabilitation, such as physical therapy, occupational therapy or speech therapy **$15**

Skilled Nursing Facility Services	**Copay**

You can get these kinds of care in a *skilled nursing facility* for **up to 100 days in a *calendar year***.

- Services and supplies provided by a *skilled nursing facility* ..... **No charge**
  - A room with two or more beds;
  - Special treatment rooms;
  - Regular nursing services;
  - Laboratory tests;
  - Physical therapy, occupational therapy, speech therapy, or respiratory therapy;
  - Drugs and medicines given during your *stay*. This includes oxygen;
  - Blood transfusions; and
  - Needed medical supplies and appliances.

Special Food Products	Copay

- Special food products and formulas that are part of a diet prescribed by a *doctor* for the treatment of phenylketonuria (PKU) ..... **No charge**

  These items are covered as medical supplies.

Transgender Services	Copay

Services and supplies provided in connection with gender transition when you have been diagnosed with gender identity disorder or gender dysphoria by a *doctor*. 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, medical management, and exclusions for cosmetic services, except as specifically stated in this provision. Coverage includes, but is not limited to, *medically necessary* services related to gender transition such as transgender surgery, hormone therapy, psychotherapy, and vocal training.

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

Services that are excluded on the basis that they are cosmetic include, but are not limited to, liposuction, facial bone reconstruction, voice modification surgery, breast implants, and hair removal.

You must obtain our approval in advance in order for transgender services to be covered. Please refer to "Medical Management Programs" beginning on page 40 for information on how to obtain the proper reviews.

We will also pay for 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. 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 **$10,000** per transgender surgery, or series of surgeries (if multiple surgical procedures are performed), for travel expenses listed below, incurred by you and one companion. This travel expense benefit is not available for non-surgical transgender services.

- 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.

Details regarding reimbursement can be obtained by calling the *Customer Service number* at 1-855-839-4524. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

You must obtain our approval in advance in order for travel expenses to be covered. Please refer to "Medical Management Programs" beginning on page 40 for information on how to obtain the proper reviews.

- Transgender services.....**See *copays* that apply**
- Transgender travel expense.....**No charge***

  *Our maximum payment will not exceed **$10,000** per transgender surgery, or series of surgeries (if multiple surgical procedures are performed).

Urgent Care	**Copay**

If you are more than 15-miles or 30-minutes away from your *primary care doctor* or *medical group* and require *urgent care*, get it right away. *Urgent care* is not an *emergency*. It is care that is needed right away to relieve pain, find out what is wrong, or treat the health problem. You must call us within 48 hours if you are admitted to a *hospital*.

- *Doctor's* office visit or urgent care facility use, supplies, other services, drugs and medicines. This includes oxygen.....**$15***

  *You do not have to pay the **$15** if you are admitted as an *inpatient* to a *hospital*.

- Care given when surgery is done. This includes operating room use, supplies, drugs and medicines, oxygen, and other services.....**No charge**

Vision Care	**Copay**

- Eye refraction to determine the need for corrective lenses.....**No charge**

This service is limited to one visit per *calendar year* for *members* age 18 and over. There is no limit on the number of visits for *members* under age 18. Eyeglasses are not covered, except when needed after a covered and *medically necessary* surgery.

Medical Management Programs

In order to be covered by this *plan*, most services must be provided or coordinated by your *primary care doctor* and approved by your *medical group*. Exceptions to this rule are explained in the section "When You Need Care" starting on page 10. You may get care for the treatment of certain conditions directly, without getting an approval from your *medical group*. Some of these services must however be reviewed and approved by us in advance, through our Medical Management Programs, which consist of the Utilization Review Program and the Authorization Program.

The services that need to be reviewed and approved by us are indicated as such in the "What We Cover" section. You're also welcome to call the *Customer Service number* at 1-855-839-4524 for a list of services that need to be reviewed.

We will provide benefits only if you are covered at the time you get services, and our payment will follow the terms and requirements of this *plan*.

Utilization Review Program

The utilization review program looks at whether care is *medically necessary* and appropriate, and the setting in which care is provided. We will let you and your *doctor* know if we have determined that services can be safely provided in an outpatient setting, or if we recommend an *inpatient stay*. We certify and monitor services so that you know when it is no longer *medically necessary* and appropriate to continue those services.

The purpose of utilization review is to promote the delivery of cost-effective medical care by reviewing the use of services and, where appropriate, the setting or place of service where care is provided. Covered services must be *medically necessary* in order for benefits to be provided.

- *Anthem Blue Cross Traditional HMO providers* will initiate the review on your behalf.
- You may ask a non-*Anthem Blue Cross Traditional HMO provider* to call the *Customer Service number* at 1-855-839-4524 to initiate the review for you. Remember that services provided by a non-*Anthem Blue Cross Traditional HMO provider* are covered only if they are emergency services, urgent care, or services for which you received an *authorized referral*.

In both cases, it is your responsibility to initiate the process and ask your *doctor* to request pre-service review. You may also call us directly. Pre-service review criteria are based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. We 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.

You need to make sure that your *doctor* contacts us before scheduling you for any service that requires utilization review. If you get any such service without following the directions under "How to Get Utilization Reviews", no benefits will be provided for that service.

Effect on Benefits

- When you do not get the required pre-service review before you get services that require it, we **will not provide benefits** for those services.
- We will approve services only when the type and level of care requested is *medically necessary* and appropriate for your condition. If you go ahead with any services that have been determined to be not *medically necessary* and appropriate at any stage of the utilization review process, we **will not provide benefits** for those services.
- When services are not reviewed before or during the time you receive the services, we will review those services when we receive the claim for benefit payment. If that review determines that part or all of the services were not *medically necessary* and appropriate, we **will not provide benefits** for those services.

How to Get Utilization Reviews

- You must tell your *doctor* that this *plan* requires pre-service review. *Doctors* who are *Anthem Blue Cross Traditional HMO providers* will ask for the review for you. The toll-free number for pre-service review is the *Customer Service number* at 1-855-839-4524. Remember, you must make sure the revise has been done.
- For all scheduled services that require utilization review, you or your *doctor* must ask for the pre-service review at least five working days before you are to get services.
- We will certify services that are *medically necessary* and appropriate. For *inpatient* care, we will, if appropriate, certify the type and level of services, as well as a specific length of *stay*. You, your *doctor* and the provider of the service will get a written notice showing this information.
- If you do not get the certified service within 60 days of the certification, or if the type of the service changes, you must get a new pre-service review.
- If pre-service review was not done, such as for an *emergency* admission or procedure, you need to let us know within 48 hours of the admission or procedure, unless your condition prevented you from telling us or a member of your family was not available to tell us for you within that time period. If we decide that the service is not *medically necessary* and appropriate, we will tell your *doctor* by telephone no later than 24 hours after the decision. We will send written notice to you and your *doctor* within two business days after our decision. But care will not be stopped until your *doctor* has been notified and a plan of care that meets your needs has been agreed upon.

Authorization Program

The authorization program provides prior approval for medical care or service by a non-*Anthem Blue Cross Traditional HMO provider*. The service you receive must be a covered benefit of this *plan*.

You must get approval before you get any non-emergency or non-urgent service from a non-*Anthem Blue Cross Traditional HMO provider*.

The toll-free number to call for prior approval is the *Customer Service number* at 1-855-839-4524.

If you do not follow the procedures set forth in this section, no benefits will be provided for that service.

Authorized Referrals. In order for the benefits of this *plan* to be provided, you must get approval **before** you get services from non-*Anthem Blue Cross Traditional HMO providers*. When you get proper approvals, these services are called *authorized referral* services.

Effect on Benefits. If you receive *authorized referral* services from a non-*Anthem Blue Cross Traditional HMO provider*, the applicable *Anthem Blue Cross Traditional HMO provider* copays will apply. When you do not get a referral, **no benefits are provided** for services received from a non-*Anthem Blue Cross Traditional HMO provider*.

How to Get an Authorized Referral. You or your *doctor* must call the *Customer Service number* at 1-855-839-4524 **before** scheduling an admission to, or before you get the services of, a non-*Anthem Blue Cross Traditional HMO provider*.

When an Authorized Referral Will be Provided. Referrals to non-*Anthem Blue Cross Traditional HMO providers* will be approved only when all of the following conditions are met:

- There is no *Anthem Blue Cross Traditional HMO provider* who practices the specialty you need, provides the required services or has the necessary facilities within 50-miles of your home; AND
- You are referred to the non-*Anthem Blue Cross Traditional HMO provider* by a *doctor* who is an *Anthem Blue Cross Traditional HMO provider;* AND
- We authorize the services as *medically necessary* before you get the services.

Disagreements with Medical Management Program Decisions

- If you or your *doctor* do not agree with a Medical Management Program decision, or question how it was reached, either of you may ask for a review of the decision. To request a review, call the number or write to the address included on your written notice of determination. If you send a written request it must include medical information to support that services are *medically necessary*.
- If you, your representative, or your *doctor* acting for you, are still not satisfied with the reviewed decision, a written appeal may be sent to us.
- If you are not satisfied with the appeal decision, you may use *binding arbitration*. Please read “How to File a Complaint” beginning on page 49 for more information.

Exceptions to the Medical Management Program

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

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

We may also 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 we may use one or more clinical utilization management guidelines in the review of claims submitted by this provider, even if those guidelines are not used for all providers delivering services to this *plan's members*.

You may determine whether a health care provider participates in certain programs by checking our online provider directory on our website at www.anthem.com/ca/calpers/hmo or by calling us at the *Customer Service number* at 1-855-839-4524.

Revoking or Modifying an Authorization

An authorization for services or care that was approved through either the Utilization Review Program or the Authorization Program may be revoked or modified prior to the services being rendered for reasons including but not limited to the following:

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

Exclusions

It is important for you to know that we are not able to cover all the care you may want. Some services and supplies are not covered and some have limited benefits.

Remember:

In most cases, you cannot get any care that has not been authorized by your *primary care doctor*, your *medical group*, or Anthem.

Kinds of Services You Cannot Get with this Plan

- **Air Conditioners.** Air purifiers, air conditioners, or humidifiers.
- **Birth Control Devices.** Any devices needed for birth control which can be obtained without a doctor's prescription, such as condoms. This does not apply to FDA-approved over the counter contraceptive methods for women, that are prescribed by a *doctor*, as specifically stated in "Preventive Care Services" under the section What We Cover, starting on page 22.
- **Blood.** Benefits are not provided for the collection, processing and storage of self-donated blood unless it is specifically collected for a planned and covered surgical procedure.
- **Braces or Other Appliances or Services** for straightening the teeth (orthodontic services) except as specifically stated in "Reconstructive Surgery" and "Dental Care" under the section What We Cover, starting on page 22.
- **Care Not Approved.** Care you got from a health care provider without the authorization of your *primary care doctor* or a *doctor* specializing in OB-GYN in your *medical group*, except for *emergency services* or *urgent care.*
- **Care Not Covered.** Services you got before you were on the *plan*, or after your coverage ended.
- **Care Not Listed.** Services not listed as being covered by this *plan*.
- **Care Not Needed.** Any services or supplies that are not *medically necessary*.
- **Commercial Weight Loss Programs.** Weight loss programs, whether or not they are pursued under medical or *doctor* 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 for treatment of anorexia nervosa or bulimia nervosa.
- **Consultations** given using telephones, facsimile machines, or electronic mail.
- **Cosmetic Surgery.** Surgery or other services done only:
  - To improve your appearance; or

- To change or reshape normal parts or tissues of the body.

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

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.

This does not apply to reconstructive surgery you might need to:

- Give you back the use of a body part.
- Have for breast reconstruction after a mastectomy.
- Correct or repair a deformity caused by birth defects, abnormal development, injury or illness in order to improve function, symptomatology or create a normal appearance.

Cosmetic surgery does not become reconstructive because of psychological or psychiatric reasons.

♦ **Custodial Care or Rest Cures.** Room and board charges for a *hospital stay* mostly for a change of scene or to make you feel good. Services given by a rest home, a home for the aged, or any place like that.

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

♦ **Educational or Academic Services.** This plan does not cover:

- Educational or academic counseling, remediation, or other services that are designed to increase academic knowledge or skills.
- Educational or academic counseling, remediation, or other services that are designed to increase socialization, adaptive, or communication skills.
- Academic or educational testing.
- Teaching skills for employment or vocational purposes.
- Teaching art, dance, horseback riding, music, play, swimming, or any similar activities.

- Teaching manners and etiquette or any other social skills.
- Teaching and support services to develop planning and organizational skills such as daily activity planning and project or task planning.

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

- **Eye Exercises or Services and Supplies for Correcting Vision.** Optometry services, eye exercises, and orthoptics, except for eye exams to find out if your vision needs to be corrected. Eyeglasses or contact lenses are not covered. Contact lens fitting is not covered.
- **Eye Surgery for Refractive Defects.** Any eye surgery just for correcting vision (like nearsightedness and/or astigmatism). Contact lenses and eyeglasses needed after this surgery.
- **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 ask that the denial be reviewed by an external independent medical review organization. (See the section "Independent Medical Review of Denials of Experimental or Investigative Treatment", starting on page 51, for how to ask for a review of your benefit denial.)
- **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.
- **Government Treatment.** Any services actually given to you by a local, state or federal government agency, or by a public school system or school district, except when this *plan's* benefits, must be provided by law. We 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*.
- **Health Club Membership.** 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 *doctor*. This exclusion also applies to health spas.
- **Infertility Treatment.** Any *infertility* treatment including artificial insemination or in vitro fertilization, and sperm banks.
- **Lifestyle Programs.** Programs to help you change how you live, like fitness clubs, or dieting programs. This does not apply to cardiac rehabilitation programs approved by your *medical group*.

- **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 *doctor*, except as specifically provided or arranged by us. This exclusion does not apply to the *medically necessary* treatment of pervasive developmental disorder or autism.

- **Non-Prescription Drugs.** Non-prescription, over-the-counter drugs or medicines.

- **Orthopedic Shoes.** 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 "Prosthetic Devices" under the section What We Cover, starting on page 22.

- **Outpatient Drugs.** Outpatient prescription drugs or medications including insulin except drugs for abortion or contraception when taken in the *doctor's* office. (Also see Preventive Care Services for what is covered).

- **Personal Care and Supplies.** Services for your personal care, such as: help in walking, bathing, dressing, feeding, or preparing food. Any supplies for comfort, hygiene or beauty purposes.

- **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.

- **Routine Exams.** Routine physical or psychological exams or tests asked for by a job or other group, such as a school, camp, or sports program.

- **Services Given by Providers Who Are Not With Anthem Blue Cross Traditional HMO.** We will not cover these services unless your *primary care doctor* refers you, except for *emergencies* or *urgent care*.

- **Services Not Needing Payment.** Services you are not required to pay for or are given to you at no charge, except services you got at a charitable research *hospital* (not with the government). This *hospital* must:

  - Be known throughout the world as devoted to medical research.
  - Have at least 10% of its yearly budget spent on research not directly related to patient care.
  - Have 1/3 of its income from donations or grants (not gifts or payments for patient care).
  - Accept patients who are not able to pay.
  - Serve patients with conditions directly related to the *hospital*'s research (at least 2/3 of their patients).

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

- **Sterilization Reversal.** Surgery done to reverse a sterilization.
- **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).
- **Transgender Services.** Services and supplies in connection with transgender services, except as specifically stated in "Transgender Services" under the section What We Cover, starting on page 22.
- **Work-Related.** Care for health problems that are work-related if such health problems are or can be covered by workers' compensation, an employer's liability law, or a similar law. We will provide care for a work-related health problem, but, we have the right to be paid back for that care. See "Other Things You Should Know: Getting Repaid by a Third Party" on pages 69-70.

How to File a Complaint

While Anthem Blue Cross Traditional HMO helps you get the care you need, we do not actually give the care.

We contract with *medical groups*, *doctors*, and other *health care providers*. They are not employees of Anthem. The *hospitals*, nursing facilities and other health agencies are independent contractors.

However, we want to help you get the care and service you need. Here is how:

- **Talk to your *Anthem Blue Cross Traditional HMO coordinator*.** If you have questions about your services, call your *Anthem Blue Cross Traditional HMO coordinator*. He or she may be able to help you right away. You may also call the *Customer Service number* at 1-855-839-4524.

- **If you believe your coverage has been cancelled unfairly.** If you believe your coverage has been or will be improperly cancelled, you may also file a complaint with us.

- **Medical Grievance Procedures.** You, an authorized representative (Member), or a provider on your behalf, may request a grievance within one hundred and eighty (180) days of the Adverse Benefit Determination (ABD), and must be submitted in one of the following ways:

  - Call *Customer Service number* at 1-855-839-4524 and ask one of our customer service representatives to fill out the Member Issue Form for you; or

  - Fill out the Member Issue Form through the Anthem Blue Cross website at www.anthem.com/ca/calpers/hmo; or

  - Or write to us at the following address:

Anthem Blue Cross

Grievance and Appeal Management

P.O. Box 60007

Los Angeles, CA 90060-0007

The Member may submit written comments, documents, records, scientific studies and other information related to the claim that resulted in the ABD in support of the grievance. All information provided will be taken into account without regard to whether such information was submitted or considered in the initial ABD.

Anthem Blue Cross will acknowledge receipt of your request within five (5) calendar days. Standard grievances are resolved within 30 calendar days. If your case is urgent and involves an imminent threat to your health, such as severe pain or the loss of life or limb or major bodily function, we will expedite the review and resolve your complaint within 72 hours. See the provision "Urgent Decision" described below.

You have the right to review the information that we have regarding your grievance. Upon request and free of charge, this information will be provided to you, including

copies of all relevant documents, records, and other information. To make a request call *Customer Service number* at 1-855-839-4524.

If we uphold the ABD, that decision becomes the Final Adverse Benefit Decision (FABD). When you receive the final FABD, the following options are available to you:

- For FABDs involving medical judgment, you may pursue the Independent External Review process described below;
- For FABDs involving benefit, you may pursue the CalPERS Administrative Review process as described in the CalPERS Administrative Review section.
- You may also, at any time, use *binding arbitration* to resolve your dispute. (See "Arbitration" on pages 55-56.)

♦ **Urgent Decision.** An urgent grievance is resolved within 72 hours upon receipt of the request, but only if we determine the grievance meets one of the following:

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

If we determine the grievance request does not meet one of the above requirements, the grievance will be processed as a standard request.

Note: If you believe your condition meets the criteria above, you have the right to contact the California Department of Managed Health Care (DMHC) at any time to request an Independent Medical Review (IMR), at 1-888-HMO-2219 (TDD 1-877-688-9891), without first filing an appeal with us.

♦ **If your complaint is about the cancellation of your coverage,** you may also complain to the DMHC right away if the DMHC agrees that your complaint requires immediate review. If your coverage is still in effect when you file your complaint, we will continue to provide coverage to you under the terms of the *plan* until a final determination of your request for review has been made, including any review by the Director of the Department of Managed Health Care (this does not apply if your coverage is cancelled because the subscription charges have not been paid). If your coverage is maintained in force pending the outcome of the review, subscription charges must still be paid to us on your behalf. If your coverage has already ended when you file the complaint, your coverage will not be maintained. If the Director of the Department of Managed Health Care determines that your coverage should not have been cancelled, we will reinstate your coverage back to the date it was cancelled. Subscription charges must be paid current to us on your behalf from the date coverage is reinstated.

Independent Medical Review of Denials of Experimental or Investigative Treatment

If coverage for a proposed treatment is denied because we or your *medical group* determine that the treatment is *experimental* or *investigative*, you may ask that the denial be reviewed by an external independent medical review organization which has a contract with the DMHC. Your request for this review may be sent to the DMHC. You pay no application or processing fees of any kind for this review. You have the right to provide information in support of your request for review. A decision not to participate in this review process may cause you to give up any statutory right to pursue legal action against us regarding the disputed health care service. We will send you an application form and an addressed envelope for you to use to ask for this review with any grievance disposition letter denying coverage for this reason. You may also request an application form by calling us at the *Customer Service number* at 1-855-839-4524 or write to us at Anthem Blue Cross Grievance and Appeals Management, P.O. Box 4310, Woodland Hills, CA 91367. To qualify for this review, all of the following conditions must be met:

- You have a life threatening or seriously debilitating condition. The condition meets either or both of the following descriptions:
  - A life threatening condition or a disease is one where the likelihood of death is high unless the course of the disease is interrupted. A life threatening condition or disease can also be one with a potentially fatal outcome where the end point of clinical intervention is the patient's survival.
  - A seriously debilitating condition or disease is one that causes major irreversible morbidity.
- Your *medical group* must certify that either (a) standard treatment has not been effective in improving your condition, (b) standard treatment is not medically appropriate, or (c) there is no more beneficial standard treatment covered by this *plan* than the proposed treatment.
- The proposed treatment must either be:
  - Recommended by an *Anthem Blue Cross Traditional HMO provider* who certifies in writing that the treatment is likely to be more beneficial than standard treatments, or
  - Requested by you or by a licensed board certified or board eligible *doctor* qualified to treat your condition. The treatment requested must be likely to be more beneficial for you than standard treatments based on two documents of scientific and medical evidence from the following sources:
    - Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized standards;
    - Medical literature meeting the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database of Health Services Technology Assessment Research (HSTAR);
    - Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;

- Either of the following: (i) The American Hospital Formulary Service's Drug Information, or (ii) the American Dental Association Accepted Dental Therapeutics;
- Any of the following references, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: (i) the Elsevier Gold Standard's Clinical Pharmacology, (ii) the National Comprehensive Cancer Network Drug and Biologics Compendium, or (iii) the Thomson Micromedex DrugDex;
- Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and
- Peer reviewed abstracts accepted for presentation at major medical association meetings.

In all cases, the certification must include a statement of the evidence relied upon.

You must ask for this review within six months of the date you receive a denial notice from us in response to your grievance, or from the end of the 30 day or three day grievance period, whichever applies. This application deadline may be extended by the DMHC for good cause.

Within three business days of receiving notice from the DMHC of your request for review we will send the reviewing panel all relevant medical records and documents in our possession, as well as any additional information submitted by you or your *doctor*. Any newly developed or discovered relevant medical records that we or an *Anthem Blue Cross Traditional HMO provider* identifies after the initial documents are sent will be immediately forwarded to the reviewing panel. The external independent review organization will complete its review and render its opinion within 30 days of its receipt of request for review (or within seven days if your *doctor* determines that the proposed treatment would be significantly less effective if not provided promptly). This timeframe may be extended by up to three days for any delay in receiving necessary records.

Please note: If you have a terminal illness (an incurable or irreversible condition that has a high probability of causing death within one year or less) and proposed treatment is denied because the treatment is determined to be *experimental*, you may also meet with our review committee to discuss your case as part of the complaint process. Call *Customer Service number* at 1-855-839-4524 for more information.

Independent Medical Review of Complaints Involving a Disputed Health Care Service

You may ask for an IMR of disputed health care services from the DMHC if you think that we or your *medical group* have wrongly denied, changed, or delayed health care services. A "disputed health care service" is any health care service eligible for coverage and payment under your *plan* that has been denied, changed, or delayed by us or your *medical group*, in whole or in part because the service is not *medically necessary*.

The IMR process is in addition to any other procedures or remedies that you may have. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. We must give you an IMR application form and an addressed envelope for you to use to ask for IMR with any complaint disposition letter that denies, changes, or delays health care services. A decision not to participate in the IMR process may cause you to lose any lawful right to pursue legal action against us about the disputed health care service.

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

1. One or more of the following conditions have been met:
   (a) Your provider has recommended a health care service as *medically necessary*, or
   (b) You have had *urgent care* or *emergency services* that a provider determined was *medically necessary*, or
   (c) You have been seen by an *Anthem Blue Cross Traditional HMO provider* for the diagnosis or treatment of the medical condition for which you want independent review;
2. The disputed health care service has been denied, changed, or delayed by us or your *medical group*, based in whole or in part on a decision that the health care service is not *medically necessary*; and
3. You have filed a complaint with us or your *medical group* and the disputed decision is upheld or the complaint is not resolved after 30 days. If your complaint requires expedited review you need not participate in our complaint process for more than three days. The DMHC may waive the requirement that you follow our complaint process in extraordinary and compelling cases.

You must apply for IMR within six months of the date you receive a denial notice from us in response to your complaint or from the end of the 30 day or three day complaint period, whichever applies. This application deadline may be extended by the DMHC for good cause.

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

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

For more information regarding the IMR process, or to ask for an application form, please call us at the *Customer Service number* 1-855-839-4524.

Department of Managed Health Care

The DMHC is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at the *Customer Service number* at **1-855-839-4524** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an IMR. If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's Internet Web site (**http://www.hmohelp.ca.gov**) has complaint forms, IMR applications forms and instructions online.

Appeal Procedure Following Grievance Procedure

If you do not achieve resolution of your complaint through the grievance process described under the sections Medical Grievance Procedures, Urgent Decision, Independent Medical Review of Denials of Experimental or Investigative Treatment, Independent Medical Review of Complaints Involving a Disputed Health Care Service, and DMHC, you have additional dispute resolution options, as follows:

1. **Eligibility Issues.** Issues of eligibility must be referred directly to CalPERS:

   CalPERS Member Account Management Division
   P.O. Box 942715
   Sacramento, CA 94229-2715

   or telephone CalPERS Customer Service at **1-888 CalPERS** (**1-888**-225-7377), 1-916-795-3245 (TDD) TTY 1-800-735-2929.

2. **Coverage Issues.** A coverage issue concerns the denial or approval of health care services substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under this Evidence of Coverage booklet. It does not include a plan or contracting provider decision regarding a disputed health care service.

If you are dissatisfied with the outcome of Anthem's internal complaint process or if you have been in the process for 30 days or more, you may request review by the DMHC, proceed to court or Binding Arbitration (as described in the previous section), if your coverage dispute is within the jurisdictional limits of Small Claims Court. Upon exhaustion of the DMHC review process, you may then request a CalPERS Administrative Review. You may not request a CalPERS Administrative Review if you decide to proceed to court or Binding Arbitration.

3. **Malpractice and Bad Faith.** You must proceed directly to court.

4. **Disputed Health Care Service Issue.** A decision regarding a disputed health care service relates to the practice of medicine and is not a coverage issue, and includes decisions as to whether a particular service is not *medically necessary*, or experimental or investigational.

   If you are dissatisfied with the outcome of Anthem's internal complaint process or if you have been in the process for 30 days or more, you may request an external IMR from the DMHC.

   If you are dissatisfied with the IMR determination, you may request a CalPERS Administrative Review within 30 days of the DMHC or IMR determination, or you may proceed to court. If you choose to proceed to court or Arbitration, you may **not** request a CalPERS Administrative Review.

Arbitration

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to:

- This *plan* or the *agreement*, 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 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 Anthem agree to be bound by these arbitration provisions and acknowledge that they are giving up their right to trial by jury for both medical malpractice claims and any other disputes.

California Health & Safety Code section 1363.1 requires that any arbitration agreement include the following notice based on California Code of Civil Procedure 1295(a): **It is understood that any dispute as to medical malpractice, that is, whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings and except for disputes regarding a claim for damages within the jurisdictional limits of the small claims court. Both parties to this contract, by entering into it, acknowledge that they are giving up their constitutional right to have any and all disputes, including medical malpractice claims, decided in a court of law before a jury, and instead are accepting the use of arbitration.**

The *member* and Anthem agree to give up the right to participate in class arbitrations against each other. Even if applicable law permits class actions or class arbitrations:

- The *member* waives any right to pursue, on a class basis, any such controversy or claim against Anthem; and
- Anthem waives any right to pursue on a class basis any such controversy or claim against the *member*.

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

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

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

Please send all *binding arbitration* demands in writing to Anthem Blue Cross, 21555 Oxnard Street, Woodland Hills, CA 91367 marked to the attention of the Customer Service Department listed on your identification card.

CalPERS Administrative Review and Hearing Process

If you remain dissatisfied with Anthem's internal complaint process, the DMHC determination or the IMR determination, you may request an Administrative Review. You must exhaust Anthem's internal complaint process, the DMHC's process and the IMR process, when applicable prior to submitting a request for CalPERS Administrative Review.

The request for an Administrative Review must be submitted in writing to CalPERS within thirty (30) days from the date of the DMHC FABD or, the IMR determination letter, in cases involving a disputed health care service, or experimental or investigational determination.

The request must be mailed to:

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

You are encouraged to include a signed Authorization to Release Health Information (ARHI) form in the request for an Administrative Review, which gives permission to Anthem Blue Cross to provide medical documentation to CalPERS. If you would like to designate an Authorized Representative to represent you in the Administrative Review process, complete Section IV. Election of Authorized Representative on the ARHI form. You must complete and sign the form. An ARHI assists CalPERS in getting health information needed to make a decision regarding your request for Administrative Review. The ARHI form will be provided to you with the FABD letter from Anthem Blue Cross. If you have additional medical records from *doctors* or scientific studies that you believe are relevant to CalPERS review, those records should be included with the written request. You should send **copies** of documents, not originals, as CalPERS will retain the documents for its files. You are responsible for the cost of copying and mailing medical records required for the Administrative Review. Providing supporting information to CalPERS is voluntary. However, failure to provide such information may delay or preclude CalPERS in providing a final Administrative Review determination.

CalPERS cannot review claims of medical malpractice, i.e. quality of care, or quality of service disputes.

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

Note: In urgent situations, if you request an IMR, at the same time you submit a request for a CalPERS Administrative Review, but before a determination has been made by the IMR, CalPERS will not begin its review or issue its determination until the IMR determination is issued.

Administrative Hearing

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

You must request an Administrative Hearing in writing within 30 days of the date of the Administrative Review determination. Upon satisfactorily showing of good cause, CalPERS may grant additional time to file a request for an Administrative Hearing, not to exceed 30 days.

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

If CalPERS accepts the request for an Administrative Hearing, it shall be conducted in accordance with the Administrative Procedure Act (Government Code section 11500 *et seq.*).

An Administrative Hearing is a formal legal proceeding held before an Administrative Law Judge (ALJ); you may, but are not required, to be represented by an attorney. After taking testimony and receiving evidence, the ALJ will issue a Proposed Decision. The CalPERS Board of Administration (Board) will vote regarding whether to adopt the Proposed Decision as its own decision at an open (public) meeting. The Board's final decision will be provided in writing to you within two weeks of the Board's open meeting.

Appeal Beyond Administrative Review and Administrative Hearing

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

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

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

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

Service of Legal Process

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

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

APPEAL CHART

Adverse Benefit Determination (ABD)

Appeals Process
Member Receives ABD

Standard Process
180 Days to File Appeal

Internal Review
Final Adverse Benefit Determination (FABD) issued within 30 days from receipt of request

Request for DMHC Review
Member must request DMHC review **within six (6) months** of FABD*

DMHC Review
FABD must be reviewed **within 30 days** from date DMHC Review requested

CalPERS Administrative Review (AR)
Member must file within 30 days of FABD for benefit decision, or Independent External Review decision for cases involving Medical Judgment. CalPERS will attempt to notify Member of determination within 60 days

Urgent Process
180 Days to File Appeal

Internal Review
Final Adverse Benefit Determination (FABD) issued within reasonable timeframes given medical condition but in no event longer than **72 hours**

Request for DMHC Review
Member should submit request for Urgent DMHC Review as soon as possible, but in no event longer than **six (6) months** of FABD*

DMHC Review
FABD must be reviewed within reasonable timeframes given medical condition but generally completed within **72 hours** from receipt of request

CalPERS Administrative Review (AR)
Member should file as soon as possible, but in no event longer than 30 days of Independent External Review decision. CalPERS will notify Member of AR determination within **three (3) days** of receipt of all pertinent information

*For FABDs that involve "Medical Judgment," you may request a DMHC Review prior to submitting a CalPERS Administrative Review

Process continued on following page

Administrative Hearing Process

Request for Administrative Hearing
Member may request Administrative Hearing within 30 days of CalPERS AR determination or independent External Review determination, whichever is later.

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Administrative Hearing
CalPERS submits a statement of issues to Administrative Law Judge. Member has right to attorney, to present witnesses and evidence.

↓

Proposed Decision
After hearing, ALJ issues a proposed decision pursuant to California Administrative Procedures Act.

↓

CalPERS Board of Administration
Adopts, rejects, or returns proposed decision for additional evidence. If adopts, decision becomes final decision.

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Member May Request
Reconsideration by Board or appeal final decision to Superior Court by Writ of Mandate

Definitions

When used in the How to File a Complaint section, the following words and phrases have the meanings explained here.

Adverse Benefit Determination (ABD) - a decision by us to deny, reduce, terminate or fail to pay for all or part of a benefit that is based on:

- determination of an individual's eligibility to participate in this Anthem Blue Cross Traditional HMO plan; or
- determination that a benefit is not covered; or
- determination that a benefit is experimental, investigational, or not *medically necessary* or appropriate.

Authorized Representative - means an individual designated by you to receive Protected Health Information about you for purposes of assisting with a claim, an appeal, a Grievance or other matter. The Authorized Representative must be designated by you in writing on a form approved by Anthem.

Disputed Health Care Service - any health care service eligible for coverage and payment under your Anthem Blue Cross Traditional HMO plan that has been denied, modified or delayed by us or your *medical group*, in whole or in part because the service is deemed not *medically necessary*.

Grievance - complaint regarding (1) payment that has been denied for services you already received, or (2) a medical provider, or (3) your coverage under this EOC, including an adverse benefit determination as set forth under the ACA, or (4) the denial of prior authorization to receive a service, or (5) the amount that you must pay, or (6) the care or services that you received from your plan, or some other aspect of the plan.

Life-Threatening Condition – having a disease or condition where the likelihood of death is high unless the course of the disease is interrupted, or diseases or conditions with potentially fatal outcomes where the end point of clinical intervention is survival.

Seriously Debilitating Condition – having a disease or condition that could cause major irreversible morbidity.

Keeping Anthem Blue Cross Traditional HMO After Your Coverage Status Changes

If your *employer* employs 20 or more people, you may be able to continue coverage even after you no longer work for that employer. This is called *COBRA*. Ask your *employer* for more information.

You or Your Family Members May Choose *COBRA*

You can continue coverage by Anthem:

- When your job ends, for any reason other than gross misconduct.
- When your work hours are reduced.
- When, as a retiree, your benefits are canceled or reduced because your former *employer* filed for Chapter 11 bankruptcy.

Your family members can go on being covered by Anthem even:

- If you were to die.
- If you are divorced or legally separated.
- If your domestic partnership ends.
- If your child is no longer qualifies as a dependent. For example, your child reaches the upper age limit of the *plan*.
- If you become entitled to Medicare.

Your *employer* will let you or your family members know that you have a right to keep your health plan under *COBRA*. If you marry, enter a domestic partnership, or have a new child during this time, your new spouse, domestic partner or child can be enrolled as a family member. But only a child born to or placed for adoption with you will have the same rights as someone who was covered under the *plan* just before *COBRA* was elected.

Your *employer* will notify you or your family members if you can continue your coverage under *COBRA* when:

- You lose your job or your work hours are reduced.
- Your benefits as a retiree are canceled or reduced because your former *employer* filed for Chapter 11 bankruptcy.
- You die or become entitled to Medicare. Your *employer* will notify your family members.

You must inform your *employer* if your family members want *COBRA* coverage within 60 days from the date:

- You get a divorce or legal separation.
- If your domestic partnership ends.

- Your child is no longer a dependent.

If You Want to Keep Your Health Plan

- Tell your *employer* within 60 days of the date you get your notice of your right to keep your health plan.
- You can have coverage for all the *members* of the family, or only some of them.
- If you do not choose *COBRA* during those 60 days, you cannot have it later.
- Your *employer* must send your payment and the *COBRA* forms to keep you covered within 45 days after you choose to keep it.

You may have to pay the whole cost. You should know that you may have to pay the whole cost of staying on the health plan.

- You must send your payment to the *employer* every month.
- Your *employer* must send it to Anthem. This will keep your coverage going.

The subscription charge that applies to the employee will also apply to:

- A spouse, because of divorce, separation or death.
- A domestic partner, because of the end of your domestic partnership or death.
- A child, even if you or your spouse do not choose *COBRA* (if more than one child enrolls, subscription charges for the number enrolling will apply).

How Long You Can Be Covered

You can go on being covered until the first of the following events takes place:

- The end of eighteen months (18) if you lost your job or your hours were lowered. (Note: If your *COBRA* began on or after January 1, 2003 and ends after 18 months, you can keep your medical coverage only under CalCOBRA for up to another 18 months, making a total of 36 months under *COBRA* and CalCOBRA combined. You must completely use up your eligibility under *COBRA* first. Your CalCOBRA rights are explained later in this section.)
- The date our *agreement* with CalPERS ends.
- The date you stop paying the monthly charges.
- The date you first become covered under another group health plan.
- The date you first become entitled to Medicare.

Your family members can go on being covered until the first of the following events takes place:

- Eighteen months (18) if you lost your job, or your hours were lowered. However, this does not apply if coverage did not end when you became entitled to Medicare before you lost your job or your work hours were lowered. *COBRA* coverage ends 36 months from the date you became entitled to Medicare if entitlement occurred within the 18 months before the date your job ended or your work hours were lowered. (Note: If your *COBRA* began on or after

January 1, 2003 and ends after 18 months, or some longer period if you became entitled to Medicare before you lost your job or your work hours were lowered but sooner than 36 months, you can keep your medical coverage only under CalCOBRA for the balance of 36 months under *COBRA* and CalCOBRA combined. You must completely use up your eligibility under *COBRA* first. Your CalCOBRA rights are explained later in this section.)

- Thirty-six months (36) if there was a death, divorce, legal separation, or end of a domestic partnership.
- Thirty-six months (36) if the child is no longer dependent.
- Thirty-six months (36) from your entitlement to Medicare.
- The date our *agreement* with CalPERS ends.
- The date they first become eligible under another group health plan.
- They stop paying monthly charges.
- They first become entitled to Medicare.

Your family members may be able to get extended *COBRA* coverage if they experience another event described above. If a second event occurs, your family members may extend *COBRA* up to 36 months from the date of the first event if:

- Your family members were originally covered under the first event; and
- Your family members were covered under the *plan* when the second event occurred.

This period may not go beyond 36 months from the date of the first event.

Other Coverage Options Besides COBRA Continuation Coverage

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

Retirement and COBRA

If you are a retiree and your benefits are canceled or reduced because your former *employer* filed for Chapter 11 bankruptcy, you may be covered for the remainder of your life. Your covered family members may continue coverage for 36 months after your death. Coverage ends when:

- Our *agreement* with CalPERS ends.
- You or your family member stops paying the monthly charges.
- You or your family member first becomes covered under another group health plan.

If You or a Family Member is Disabled

If you or a family member is determined by Social Security to be disabled, your whole family may be able to be covered for up to 29 months. This is an additional 11 months following the 18 months of *COBRA* coverage due to your job loss or reduction of work hours. You may be covered for the additional 11 months if you or a family member is determined to be disabled by Social Security before the job loss or reduction of work hours or during the first 60 days of *COBRA* continuation.

You must show your *employer* proof that the Social Security Administration (SSA) found that you or your family member was disabled. You must show your *employer* this proof during the first 18 months of your *COBRA* continuation and no later than 60 days after the later of the following:

- The date of the Social Security Administration's finding of the disability.
- The date the original qualifying event happened.
- The date you lost coverage.
- The date you are told you must show your *employer* the disability notice.

For the 19th through 29th months that the disability goes on, the *employer* must send the monthly charges.

- This will be **150%** of the applicable rate for the length of time the disabled person is covered, depending on how many family members are being covered.
- If the disabled person is not covered during this additional 11 months, the charge will stay at **102%** of the applicable rate.
- The *employer* must send the charges to us every month.
- You may have to pay the whole cost.

This coverage will last until the first of the following events takes place:

- The end of the month following a period of 30 days after the SSA finds that the family member is no longer disabled.
- The end of 29 months. (Note: If your *COBRA* began on or after January 1, 2003 and ends after 29 months, you can keep your medical coverage only under CalCOBRA for up to another seven (7) months, making a total of 36 months under *COBRA* and CalCOBRA combined. You must completely use up your eligibility under *COBRA* first. Your CalCOBRA rights are explained later in this section.)
- You stop paying the monthly charges.
- The *agreement* with CalPERS ends.
- You get another health plan that will cover the disability.
- The disabled person becomes entitled to Medicare.

You must let your *employer* know within 30 days that the SSA found that you or your family member is no longer disabled.

If a second event occurs during this additional 11 months, *COBRA* may extend for up to 36 months from the date of the first event. The charge will be **150%** of the applicable rate for the 19th through 36th months if the disabled person is covered. This charge will be **102%** of the applicable rate for any periods of time the disabled person is not covered after the 18th month.

What About After COBRA?

After *COBRA* ends, you may be able to keep your coverage through another program called "CalCOBRA", which is explained in the next section.

CalCOBRA

If your coverage under federal *COBRA* started on or after January 1, 2003, you can keep on being covered under CalCOBRA if your federal *COBRA* ended:

- 18 months after your qualifying event, if your job ended or your work hours were reduced; or
- 29 months after your qualifying event if you qualified for the additional 11 months of federal *COBRA* because of a disability.

You must completely use up your eligibility under federal *COBRA* before you can get coverage under CalCOBRA. You are not eligible for CalCOBRA if:

- You have Medicare;
- You have or get coverage under another group plan; or
- You are eligible for or covered under federal *COBRA*.

Coverage under CalCOBRA is for medical benefits only.

You will be told about your rights. Within 180 days before your federal *COBRA* ends, we will tell you that you have a right to keep your coverage under CalCOBRA. If you want to keep your coverage, you must tell us in writing within 60 days before the date your federal *COBRA* ends or when you are told of your right to keep your coverage under CalCOBRA, whichever is later. If you do not tell us in writing during this time period you will not be able to keep your coverage.

You can add family members to your CalCOBRA coverage. For dependents acquired while you are covered under CalCOBRA, coverage begins according to the enrollment provisions of this *plan*.

You may have to pay the whole cost of your CalCOBRA coverage. This cost will be:

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

We must receive your payment every month to keep your coverage going. You must send your payment to us, along with your enrollment form, within 45 days after you tell us you want to

keep your coverage. You must send us the payment by first class mail or some other reliable means. Your payment must be enough to pay the amount required and the entire amount due. If we do not get the correct payment within this 45 day period, you will not be able to get coverage under CalCOBRA. After you make the first payment, all other payments are due on the first day of each following month.

If your payment of the subscription charge is not received when due, your coverage will be cancelled. We will cancel your coverage only after sending you written notice of cancellation at least 30 days before 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 this payment in full within this time period, your coverage will be cancelled as of 12:00 midnight on the thirtieth day after the date the cancellation notice is sent (or any longer period of time required by applicable federal law, rule, or regulation) and will not be reinstated. Any payment we get after this time period runs out will be refunded to you within 20 business days. You are still responsible for any unpaid subscription charges that you owe to us, including subscription charges that apply during any grace period.

We may change the amount of your payment as of any payment due date. If we do, we will tell you in writing at least 60 days before the increase takes effect.

You must give us current information. We will rely on the eligibility information you give us as correct without checking on it, but we maintain the right to check any information you give us.

Coverage through a *prior plan*. If you were covered through CalCOBRA under the *prior plan*, you can keep your coverage under this plan for the rest of the continuation period. But your coverage will end if you do not follow the enrollment rules and make the payments within 30 days of being told your CalCOBRA coverage under the *prior plan* will end.

When CalCOBRA starts. When you tell us in writing that you want to keep your coverage through CalCOBRA and pay the first payment, we will reinstate your coverage back to the date federal *COBRA* ended. If you enroll a family member while you are covered through CalCOBRA, the family member's coverage begins according to the enrollment provisions of this *plan*.

When CalCOBRA ends. Your coverage under CalCOBRA will end when the first of the following events takes place:

- The end of 36 months after the date of your qualifying event under federal *COBRA**.
- The date our *agreement* with CalPERS ends.
- The date your *employer* stops providing coverage to the class of *members* you belong to.
- The date you stop paying the monthly charges. Your coverage will be cancelled after written notification, as explained above.
- The date you become covered under another group health plan.
- The date you become entitled to Medicare.

- The date you become covered under federal *COBRA*.

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

* If your coverage under CalCOBRA started under a *prior plan*, the 36 month period will be dated from the time of your qualifying event under that *prior plan*.

Note. 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.

Extension

If our *agreement* with CalPERS ends. Your coverage can be canceled or changed without us telling you.

But, if you or a family member is *totally disabled* and getting the care of a *doctor*, your benefits for treating the totally disabling condition will go on, if:

- The disabled person is staying in a *hospital* or *skilled nursing facility* as long as the *stay* is *medically necessary*. You will get your benefits until you are no longer staying in the *hospital*.
- If you are not now in a *hospital* or nursing facility, you may still be able to get total disability benefits. Your *doctor* must send us a written statement of your disability. It must be sent within 90 days and every 90 days after that.

If you get coverage under another health *plan* that provides benefits, without limitation, for your disability, this extension of benefits is not available.

Your benefits will end when:

- You are no longer disabled.
- Your *plan* has paid the most it can.
- You get another health plan which will cover your disability.
- Twelve (12) months have passed.

Continuation of Group Coverage for Members on Military Leave

Continuation of group coverage is available for *members* on military leave if the *member's employer* is subject to the Uniformed Services Employment and Re-employment Rights Act (USERRA).

If you are planning to enter the Armed Forces, you should contact your *employer* for information about your rights under the USERRA. *Employers* are responsible for compliance with this act and other state and federal laws regarding leaves of absence including the California Family Rights Act, the Family and Medical Leave Act, and Labor Code requirements for medical disability.

Other Things You Should Know

Using a Claim Form to Get Benefits

Here is what you or your health care provider must do:

- Fill out the claim form.
- List and describe clearly the services you got and how much they cost.
- Send the form to Anthem within 90 days of the date you got the service.

If you are not able to send the claim in within 90 days, you may have up to 12 more months. We will not pay for your benefits if you or the health care provider do not send the claims within that time. You must use claim forms; we will not accept canceled checks or receipts.

Getting Repaid by a Third Party

Sometimes someone else may have to pay for your medical care if an injury, disease, or other health problem is their fault or their responsibility. Whatever we cover will depend on the following:

- Your *medical group* and Anthem will automatically have a legal claim (lien) to get back the costs we covered, if you get a settlement or judgment from the other person or their insurer or guarantor. We should get back what we spent on your medical care.
  - If we paid the provider other than on a capitated basis, our lien will not be more than amount we paid for those services.
  - If we paid the provider on a capitated basis, our lien will not be more than 80% of the usual and customary charges for those services in the geographic area in which they were given.
  - If you hired an attorney to gain your recovery from the third party, our lien will not be for more than one-third of the money due you under any final judgment, compromise, or settlement agreement.
  - If you did not hire an attorney, our lien will not be for more than one-half of the money due you under any final judgment, compromise or settlement agreement.
  - If a final judgment includes a special finding by a judge, jury, or arbitrator that you were partially at fault, our lien will be reduced by the same comparative fault percentage by which your recovery was reduced.
  - Our lien is subject to a pro rata reduction equal to your reasonable attorney's fees and costs in line with the common fund doctrine.
- You must write to your *medical group* and Anthem about your claim within 60 days of filing a claim against the third party.
  - You will need to sign papers and give us the help we need to get back our costs.
  - If you do not do this, you will have to pay us back out of your own money.

- We will have the right to get our money back, even if what you, or someone acting for you, got back is less than the actual loss you suffered.

Coordination of Benefits

If you are covered by this group health plan, and one or more other medical or dental plans, total benefits may be limited as shown below. These provisions apply separately each *calendar year* to each person and are based mainly on California law.

Definitions

When used in this section, the following words and phrases have the meanings explained here.

Allowed Expense is any needed, reasonable and customary item of expense which is at least partially covered by at least one Other 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.

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, except when by law Medicare's benefits are secondary to those of any private insurance program or another non-governmental program.

Each contract or arrangement for coverage listed above will be considered a separate plan. The rules of these provisions will apply only when the other plan has coordination of benefits provisions.

Primary Plan is the plan which will have its benefits figured first.

This Plan is the part of this *plan* that provides benefits subject to this provision.

Effect on Benefits

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

1. If This Plan is the primary plan, then we will figure out its benefits first without taking into account any other plan.
2. If This Plan is not the primary plan, then we may reduce its benefits so that the benefits of all the plans are not more than the allowed expense.

3. The benefits of This Plan will never be more than the benefits we would have paid if you were covered only under this *plan*.

If This Plan is not the primary plan, you may be billed by a health care provider. If you receive a bill, you should submit it to your *medical group*.

Order of Benefits Determination

The following rules determine the order in which benefits will be paid:

1. A plan with no coordination provision will pay its benefits first. This always includes Medicare except when by law This Plan must pay before Medicare.

2. A plan which covers you through your *employer* pays before a plan which covers you as a family member. But if you have Medicare and are also a dependent of an active employee under another employer plan, this rule might change. If Medicare's rules say that Medicare pays after the plan that covers you as a dependent but before your *employer's* plan, then the plan that covers you as a dependent pays before a plan which covers you through your *employer*. This might happen if you are covered under This Plan as a retiree.

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 year. But if one plan does not have a birthday rule provision, that plan's provisions will determine the order of benefits.

   Exception to rule 3: If a dependent child's parents are divorced or separated, the following rules will be used instead of rule 3:

   a. The plan of the parent who has custody, will pay first, unless he or she has remarried.

   b. If the parent with custody has remarried, then the order is 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. However, if there is a court decree which holds one parent responsible for that child's health care coverage, the plan which covers that child as a dependent of the responsible parent pays first.

4. The plan covering you as a laid-off or retired employee or as such employee's dependent pays after another plan covering you. But if either plan does not have a rule about laid-off or retired employees, rule 6 applies.

5. A plan covering you under a state or federal continuation of coverage pays after another plan. However, if the other plan does not have this rule, this rule will not apply.

6. When the rules above do not apply, the plan that has covered you longer pays first unless two of the plans have the same effective date. In this case, allowed expense is split evenly between the two plans.

Our Rights Under This Provision

Responsibility For Timely Notice. We are not responsible for coordination of benefits unless we get information from the asking party.

Reasonable Cash Value. If you get benefits from another plan in the form of services, the value of services in cash will be considered allowed expense and a benefit paid.

Facility of Payment. If another plan pays benefits that this plan should have paid, we will pay the other plan an amount determined by us. This will be considered a benefit paid under this *plan*, and will fully satisfy what we are responsible for.

Right of Recovery. If we pay benefits that are more than we should have paid under this provision, the *medical group* and we may recover the extra amounts from one or more of the following:

- The persons to or for whom payments were made;
- Insurance companies or service plans; or
- Other organizations.

If You Qualify for Medicare

Members Age 65 or Over Who Are Eligible for Medicare

If you are:

- Age 65 or over; AND
- An Employee who is not retired; OR
- A Dependent of the Employee above who is not retired; AND
- Eligible for Part A of Medicare; AND
- Eligible and enrolled under this *plan*;

you will get the benefits of this *plan* without taking into account Medicare unless you have chosen Medicare as your primary plan. If you have chosen Medicare as your primary health plan, you will not be able to get any benefits under this *plan*.

Other Members Who are Eligible for Medicare

If you are:

- Getting treatment for end-stage renal disease after the first 30 months you are entitled to end-stage renal disease benefits under Medicare; OR

- Entitled to Medicare benefits as a disabled person, unless you have a current employment status (as determined by Medicare's rules) and are enrolled in this *plan* through a group of 100 or more employees;

Medicare is your primary health plan. You will get the benefits of this *plan* if and only if you have actually enrolled in Medicare and completed any consents, assignments, releases, and other documents needed to get Medicare repayments for this *plan* or its *medical groups*. This applies to services covered by those parts of Medicare that you can enroll in without paying any premium. If you must pay any premium for any part of Medicare, this applies to that part of Medicare only if you are enrolled in that part.

If you are enrolled in Medicare, your Medicare coverage will not affect the services provided or covered under this *plan* except as follows:

- Medicare must provide benefits first for any services covered both by Medicare and under this *plan*.
- For services you receive that are covered both by Medicare and under this *plan*, that are not prepaid by us, coverage under this *plan* will apply only to Medicare deductibles, coinsurance, and other charges for covered services over and above what Medicare pays.
- For services you received that are covered both by Medicare and under this *plan*, that are prepaid by us, we make no additional payment.
- For any given claim, the combination of benefits provided by Medicare and the benefits provided under this *plan* will not be more than what is considered allowed expense for the covered services.

If you have questions about how your benefits will be coordinated with Medicare, please call our *Customer Service number* at 1-855-839-4524.

Other Things You Should Know

Transition Assistance for New *Members*: Transition Assistance is a process that allows for completion of covered services for new *members* receiving services from a *doctor* who is not an *Anthem Blue Cross Traditional HMO provider*. If you are a new *member*, you may request Transition Assistance if any one of the following conditions applies:

- An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
- A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Anthem in consultation with you and the *doctor* who is not an *Anthem Blue Cross Traditional HMO provider* and

consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time you enroll with Anthem.

- A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.
- A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.
- The care of a newborn child between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the time the child enrolls with Anthem.
- Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the time you enroll with Anthem.

Call us at the *Customer Service number* at 1-855-839-4524 to ask for transition assistance or to get 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*.

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

Continuity of Care after Termination of *Medical Group*: Subject to the terms and conditions set forth below, Anthem will provide benefits at the *Anthem Blue Cross Traditional HMO provider* level for covered services (subject to applicable copayments, coinsurance, deductibles and other terms) received from a *medical group* at the time the *medical group's* contract with us terminates (unless the *medical group's* contract terminates for reasons of medical disciplinary cause or reason, fraud, or other criminal activity).

You must be under the care of the *medical group* at the time the *medical group's* contract terminates. The terminated *medical group* must agree in writing to provide services to you in accordance with the terms and conditions of the agreement with Anthem prior to termination. The terminated *medical group* must also agree in writing to accept the terms and reimbursement rates that apply to *Anthem Blue Cross Traditional HMO providers* who are not capitated. If the terminated *medical group* does not agree with these contractual terms and conditions, we are not required to continue the terminated *medical group's* services beyond the contract termination date.

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

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

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

Please call us at the *Customer Service number* at 1-855-839-4524 to ask for continuity of care or to get a copy of the written policy. Eligibility is based on the *member's* clinical condition and is not determined by diagnostic classifications. Continuity of care does not provide coverage for services not otherwise covered under the *plan*.

We will notify you by telephone, and the *medical group* 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 *medical groups* are negotiated on a case-by-case basis. We will ask that the terminated *medical group* agree to accept reimbursement and contractual requirements that apply to *Anthem Blue Cross Traditional HMO providers*, including payment terms, who are not capitated. If the terminated *medical group* does not agree to accept the same reimbursement and contractual requirements, we are not required to continue that *medical group's* services. If you disagree with our determination regarding continuity of care, you may

file a complaint with us by following the procedures described in the section called "How to File a Complaint" starting on page 49.

This provision also applies if the contractual or employment relationship between your *medical group* or us and the *primary care doctor* or *specialist* from whom you are receiving care terminates. In this situation, please request continuity of care through your *Anthem Blue Cross Traditional HMO coordinator*.

Transition Assistance and Continuity of Care may be revoked or modified prior to the services being rendered for reasons including but not limited to the following:

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

How we pay your providers. Your *medical group* is paid a set amount for each *member* per month. Your *medical group* may also get added money for some kinds of special care or for overall efficiency, and for managing services and referrals. *Hospitals* and other health care facilities are paid a set amount for the kind of service they give you or an amount based on a negotiated discount from their standard rates. If you want more information, please call us at the *Customer Service number* at 1-855-839-4524, or you may call your *medical group*.

You do not have to pay any *Anthem Blue Cross Traditional HMO provider* for what we owe them, even if we do not pay them. But you may have to pay a non-*Anthem Blue Cross Traditional HMO provider* any amounts not paid to them by us.

Inter-Plan Programs. Inter-Plan programs are as follows:

- **Out of Area Services.** We have a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates (“Licensees”) referred to generally as “Inter-Plan Programs”. Whenever you obtain healthcare services outside of our service area, the claims for these services may be processed through one of these Inter-Plan Programs.

  Typically, when accessing care outside of our service area and the service area of our corporate parent, you will obtain care from healthcare providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, you may obtain care from non-participating healthcare providers.

  Our payment practices in both instances are described below.

  We cover only limited healthcare services received outside of our corporate parent’s service area. As used in this provision, “Out-of-Area Covered Healthcare Services” consist of *urgent care, emergency services*, or follow-up care obtained outside the geographic area our corporate parent serves (see “Getting Care When You Are Outside of California” on pages 17-18 in the section “When You Need Care” starting on page 10). Any other services will

not be covered when processed through any Inter-Plan Programs arrangements. These "other services" must be provided or authorized by your *primary care doctor*.

- **BlueCard® Program.** Under the BlueCard® Program, when you obtain Out-of-Area Covered Healthcare Services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations. However the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

  The BlueCard® Program enables you to obtain Out-of-Area Covered Healthcare Services, as defined above, from a healthcare provider participating with a Host Blue, where available. The participating healthcare provider will automatically file a claim for the Out-of-Area Covered Healthcare Services provided to you, so there are no claim forms for you to fill out. You will be responsible for any *copay* amount, as stated in this *plan*.

  If you need *emergency services*, get the medical care you need right away (see "When There is an Emergency" on pages 15-16 in the section "When You Need Care" starting on page 10). In some areas, there is a 9-1-1 emergency response system that you may call for *emergency services* (this system is to be used only when there is an *emergency* that requires an emergency response).

  Whenever you access covered healthcare services outside our and, if applicable, our corporate parent's service area and the claim is processed through the BlueCard® Program, the amount you pay for covered healthcare services, if not a flat dollar copayment, 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 us.

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

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

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

- **Non-participating healthcare providers outside of our service area:**

  Member liability calculation. When out-of-area covered healthcare services are received from non-participating healthcare providers, the amount you pay for such services will

generally be based on either the Host Blue's non-participating healthcare 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 healthcare provider bills and the payment we will make for the covered services as set forth in this paragraph.

Exceptions. In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount we will pay for services rendered by non-participating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we 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* at 1-855-839-4524 or go to www.anthem.com/ca/calpers/hmo for more information about such arrangements.

Financial Arrangements with Providers. Anthem (or an affiliate) contracts with certain health care providers and suppliers ("Providers"). They do this to provide and pay for health care services for you and others covered under individual certificates, evidence of coverages, and group policies, contracts, or agreements to which Anthem is a party. This applies to you and all persons covered under the *agreement*.

Anthem offers several products and programs. Under the above contracts between Providers and Anthem, the negotiated rates used for certain medical services provided may not be the same for all products and programs. In negotiating the terms of the *agreement*, your *employer* was aware that Anthem offered different types of products and programs and chose this *plan*. You and the employer are entitled to receive only the benefits of those discounts, payments, settlements, incentives, adjustments and/or allowances specifically set forth in the *agreement* for this *plan*.

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

Right of Recovery. Whenever payment has been made in error, or the reasonable cash value of benefits provided under this *plan* exceeds the maximum amount for which we are liable, we and your *medical group* will have the right to recover such payment or excess amount from you or, if applicable, the provider, in accordance with applicable laws and regulations. In the event we recover a payment made in error from the provider, except in cases of fraud or misrepresentation on the part of the provider, we will only recover such payment from the provider within 365 days of the date we made the payment on a claim submitted by the provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

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

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

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

Who takes care of your COBRA coverage. Anthem is not the *plan* administrator of your *COBRA* coverage. Your *employer*, or someone your *employer* hires, most often takes care of administrating your *employer's* health plan. The *employer* must let you know about any changes, give you notices, or let you know about the details of the health plan.

Workers' Compensation. Our health plan *agreement* with your *employer* does not change your coverage by the Workers' Compensation program. It does not take the place of Workers' Compensation.

Renewing our *agreement* with CalPERS. We can renew our *agreement* at certain times. We may change the subscription charges, or other terms of the *plan* from time to time without your consent.

Terms of Coverage

- In order for you to be entitled to benefits, both the *agreement* and your coverage under it must be in effect on the date the expense giving rise to a claim for benefits is incurred.
- Your benefits will depend on what is covered on the date you get the service or supply for which the charge is made.
- The *agreement* can be amended, modified or terminated without your consent.

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.

Consumer Relations Committee. We have a special committee made up of people who are covered by our plan, health care providers taking part in Anthem Blue Cross Traditional HMO, and a member of our Board of Directors. This committee reviews information about finances and any complaints of *members* among other things. It advises the Board of Directors about how to make sure *members* are served well and with respect.

Confidential Information. We will make every effort and take care to keep your medical data secret. We may use data about services provided to you and others for statistical study and research. If the data is released to a third party, it will not identify you. Medical data about you can only be given to others if you agree to it in writing or if required by law. A consent to

release medical data must be signed, dated and describe the kind of data and to who it may be disclosed. You may access your own medical records.

We may release your medical data to:

- professional peer review organizations; and
- CalPERS.

This will only be done to report claims experience to them or for them to audit our operation. We will only give them data that is needed to do the review or audit.

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

Medical Policy and New Technology. Anthem reviews and evaluates new technology. It does this using criteria set by its medical directors. The criteria it uses helps it decide if:

- the new technology is still investigational; or
- has medical necessity.

A committee called Medical Policy and Technology Assessment Committee (MPTAC) gives Anthem guidance. They also validate Anthem's medical policy. MPTAC is made up of about 20 doctors. They come from various medical specialties and geographic areas. They include Anthem's medical directors, doctors in academic medicine and doctors who practice managed care medicine. Anthem's conclusions, based on MPTAC guidance, are incorporated into Anthem's medical policy used to:

- form decision protocols for particular diseases and injuries; or
- treatments for particular disease or injuries; and
- determine what is *medically necessary*.

Conformity with Laws. Any provision of the *agreement* which, on its effective date, is in conflict with the laws of the governing jurisdiction, is hereby amended to conform to the minimum requirements of such laws.

Voluntary Clinical Quality Programs. Anthem 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. Anthem 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. Anthem may offer health or fitness related program options for purchase by CalPERS 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 CalPERS 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. Under other options CalPERS may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact the *Customer Service number* at 1-855-839-4524 and we will work with you (and, if you wish, your *doctor*) to find a wellness program with the same reward that is right for you in light of your health status. 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.

Important Words to Know

The meanings of key terms used in this booklet are shown below.

Agreement is the Group Benefit Agreement between Anthem and CalPERS. In it, we agree to what benefits will be given to you.

Ambulatory Surgical Center is a freestanding outpatient surgical facility, with a staff of *doctors*, that:

1. is licensed as required;
2. has permanent facilities and equipment to perform surgical procedures on an outpatient basis;
3. gives treatment by or under the supervisions of *doctors* and nursing services when the patient is in the facility;
4. does not have *inpatient* accommodations; and
5. is not, other than incidentally, used as an office or clinic for the private practice of a *doctor* or other professional provider.

Anthem Blue Cross (Anthem) is a health care service plan, regulated by the California Department of Managed Health Care.

Anthem Blue Cross Traditional HMO coordinator is the person at your *medical group* who can help you with understanding your benefits and getting the care you need.

Anthem Blue Cross Traditional HMO providers are licensed health care providers who have an agreement with Anthem to provide services to you.

Authorized referral occurs when you, because of your medical needs, are referred to a non-*Anthem Blue Cross Traditional HMO provider* for the treatment of *mental or nervous disorders* or substance abuse, behavioral health treatment for pervasive developmental disorder or autism, or transgender services, but only when:

1. There is no *Anthem Blue Cross Traditional HMO provider* who practices in the appropriate specialty, provides the required services, or has the necessary facilities within a 50-mile radius of your home or within the county in which your home is located, whichever is less;
2. You are referred in writing to the non-*Anthem Blue Cross Traditional HMO provider* by a *doctor* who is an *Anthem Blue Cross Traditional HMO provider*, and
3. We have authorized the referral before you receive services.

Binding Arbitration is a process used to resolve complaints. It is used instead of going to a court of law. In binding arbitration, you and Anthem agree to meet with an arbitrator and go by the decision of the arbitrator.

COBRA is a special law that gives you a chance to keep your health plan even if you lose your job, have a reduction in hours or a change in dependents status. You will usually have to pay the monthly charges to keep the *plan* under COBRA.

Copay is the amount you pay to get a *medically necessary* service with an *Anthem Blue Cross Traditional HMO provider*. Anthem pays the provider the rest.

Copay Limit is the most you will have to pay in one *calendar year* in *copays*.

Custodial care is care for 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 giving medicine which you usually do yourself, or any other care for which the services of a health care provider are not needed.

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

Customer Service number is 1-855-839-4524. You can call Anthem to answer your questions about Anthem Blue Cross Traditional HMO. The number is also on your Member ID card.

Dependent is a family member which includes spouse, domestic partner or child.

Doctor means a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is given.

Durable Medical Equipment and medical devices when the equipment meets the following criteria:

- is meant for repeated use and is not disposable.
- is used for a medical purpose and is of no further use when medical needs ends.
- is meant for use outside a medical facility.
- is only for the use of the patient.
- is made to serve a medical use.
- is ordered by a provider.

Emergency is a sudden, serious, and unexpected illness, injury, or health problem (including sudden and unexpected severe pain), or a *psychiatric emergency medical condition*. This includes any illness, injury or health problem you reasonably believe could endanger your health if you do not get medical care right away. We or your *medical group* will make the final decision about whether services were given for an emergency.

Emergency services are services given because of a medical or psychiatric *emergency*.

Employer means any person, firm, proprietary or non-profit corporation, partnership, public agency or association that has at least two employees and that is actively engaged in business or service, in which a bona fide employer-employee relationship exists, in which the majority of employees were employed within this state, and which was not formed primarily for purposes of buying health care coverage or insurance.

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

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

Guest membership is a special way you can get care when you go out of town for more than 90 days. If you know ahead of time, you can apply for a guest membership in a *medical group* in the city you are going to visit. Call the Anthem Blue Cross Traditional HMO *Customer service number* at 1-855-839-4524 and ask for the Guest Membership Coordinator.

Health care provider means the kinds of providers, other than M.D.s or D.O.s, that take care of your health and are covered under this *plan*. The provider must:

- Have a license to practice where the care is given.
- Provide a service covered by that license.
- Give you a service that is paid for under this *plan*.

A "health care provider" also includes any agency licensed by the state to provide services for the treatment of mental or nervous disorders or substance abuse, when we are required by law to cover those services.

For nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa, "health care provider" includes registered dietitians 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.

Home health agencies are licensed providers who give you skilled nursing and other services in your home. Medicare must approve them as home health providers and/or be recognized by the Joint Commission on the Accreditation of Healthcare Organizations.

Hospice is an agency or organization that gives a specialized form of interdisciplinary care that controls pain and relieves symptoms and helps with the physical, emotional, social, and spiritual discomforts of a terminally ill person, as well as giving support to the primary caregiver and the patient's family. A hospice must be currently licensed as a hospice according to Health and Safety Code section 1747 or a licensed *home health agency* with federal Medicare certification according to Health and Safety Code sections 1726 and 1747.1. You may ask for a list of *hospices*.

Hospital is a place which provides diagnosis, treatment and care supervised by *doctors*. It must be licensed as a general acute care hospital.

The term hospital will also include *psychiatric health facilities* (only for acute care of a *mental or nervous disorder* or substance abuse) and *residential treatment centers*.

Independent practice association (IPA) is a *medical group* made up of a group of *doctors* who practice in private offices. The IPA has an agreement with Anthem to provide health care.

Infertility means: (1) you have a health problem your *doctor* sees as the reason you are unable to have a baby; or (2) you are unable to get pregnant or to carry a pregnancy to a live birth after a year or more of having sex without birth control or after 3 cycles of artificial insemination.

Inpatient is a *member* who is treated as a registered bed patient in a *hospital* and for whom a room and board charge is made.

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

Medical group is a group of *doctors* with an agreement with Anthem to provide health care.

Medically necessary procedures, services, supplies or equipment are those that your *medical group* or Anthem decides are:

- Appropriate and necessary for the diagnosis or treatment of the medical condition.
- Provided for the diagnosis or direct care and treatment of the medical condition.
- Within standards of good medical practice within the organized medical community.
- Not primarily for your convenience, or for the convenience of your *doctor* or another provider.
- Not more costly than an alternative 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.
- 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:
    - There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, equipment, service or supply 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
    - Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
    - 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 an employee, annuitant, or family member as those terms are defined in Sections 22760, 22772 and 22775 and domestic partner as defined in Sections 22770 and 22771 of the Government code.

Membership Change Form is a form you need to make changes in your health plan. You may need a new *medical group*, or to add a new family member. Ask your *employer* for the form if you need it.

Mental or nervous disorders, including substance abuse, 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").

Plan is the set of benefits talked about in this booklet. From time to time, there may be some changes in what is covered depending on the *agreement* we have with CalPERS. If changes are made to the plan, you will get a new booklet or a copy of an amendment showing the changes that were made.

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, and are to become effective in accordance with those laws, including but not limited to, the Patient Protection and Affordable Care Act (PPACA). Sources for determining which services are recommended include the following:

- Services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF);
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- 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
- 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* at 1-855-839-4524 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

Primary care doctor is a *doctor* who is a member of the *medical group* you have chosen to give you health care. *Primary care doctor*s include general and family practitioners, internists and pediatricians. Certain *specialists* as we may approve may also be designated *primary care doctor*s.

Prior plan is a plan sponsored by CalPERS which was replaced by this *plan* within 60 days of when it ended. You are considered covered under the prior plan if you:

- Were covered under the prior plan on the date that plan ended;
- Properly enrolled for coverage within 31 days of this *plan's* effective date; and
- Had coverage terminate solely due to the prior plan's ending.

Prosthetic devices take the place of a body part that does not work or is missing. These include orthotic devices, rigid or semi-supportive devices which may support the 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:

- An immediate danger to himself or herself or to others, or
- Immediately unable to provide for or utilize food, shelter, or clothing due to the *mental or nervous disorder*.

Psychiatric health facility is a 24-hour facility, that is:

- Licensed by the California Department of Health Services.
- Qualified to provide short-term *inpatient* treatment.
- Accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHCO).
- Staffed by a professional staff which includes a *doctor* as medical director.

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

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

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

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

Skilled nursing facility is a place that gives 24-hour skilled nursing services. It must be licensed and be seen as a skilled nursing facility under Medicare.

Stay is when you are admitted as an *inpatient* to a *hospital* or nursing facility. It starts when you are admitted to a facility and ends when you are discharged from that facility.

Specialist is a *doctor* who is not a general practitioner, internist, family practitioner, pediatrician, gynecologist, or obstetrician.

Specialty care center means a center that is accredited or designated by an agency of the State of California or the federal government or by a voluntary national health organization having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

Standing referral means a referral by a *primary care doctor* to a *specialist* for more than one visit to the *specialist*, as indicated in the treatment plan, if any, without the *primary care doctor* having to provide a specific referral for each visit.

Surgery center is a facility (not a *hospital* or *doctor's* office) that does surgery when you do not have to stay overnight. The center must be licensed and meet the standards of JCAHCO.

Totally disabled means because of illness or injury, you cannot work for income at any job that you are trained for and you are unemployed. For your family members, it means they cannot do all the activities usual for persons of their age.

Urgent care means the services you get for a sudden, serious, or unexpected illness, injury or condition to keep your health from getting worse. It is not an *emergency*. Care is needed right away to relieve pain, find out what is wrong, or treat the health problem.

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

For Your Information

Your Rights and Responsibilities as an Anthem Blue Cross Member

As an Anthem Blue Cross *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 is 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 do not 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.
- Notify CalPERS if you have any changes to your name, address or family members covered under your plan.
- 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.

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

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 Evidence of Coverage 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 "Helpful Links>Contact Us", or you may call the *Customer service number* at 1-855-839-4524.

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 *Customer Service number* at 1-855-839-4524 or on the Anthem Blue Cross web site at www.anthem.com/ca/calpers/hmo. To access benefit information, claims payment status, benefit maximum status, participating providers or to order an ID card, simply log on to the web site, select "Member", and click the "Register" button on your first visit to establish a User ID and Password to access the personalized and secure MemberAccess Web site. Once registered, simply click the "Login" button and enter your User ID and Password to access the MemberAccess Web site. Our privacy statement can also be viewed on our website. You may also submit a grievance online or print the Plan Grievance form through the website.

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 *Customer Service number* at 1-855-839-4524 to update your language preference to receive future translated documents or to request interpretation assistance. Anthem Blue Cross also sends/receives TDD/TTY messages at **866-333-4823** or by using the National Relay Service through **711.**

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

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 *doctor* (e.g., your *doctor*, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

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

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

This *plan*, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). If you have any questions about this coverage, please contact your *medical group* or call us at the *Customer Service number* at 1-855-839-4524.

Chiropractic and Acupuncture Care Amendment

Your Anthem Blue Cross Traditional HMO Combined Evidence of Coverage and Disclosure (Evidence of Coverage) Form is changed by this amendment. All other provisions of the Evidence of Coverage which don't conflict with this amendment remain in effect.

The benefits described in this amendment are provided through a Health Care Services Agreement between Anthem and American Specialty Health Plans of California, Inc. (ASH Plans). **The services described in this amendment are covered only if provided by an *ASH Plans Chiropractor* or *ASH Plans Acupuncturist.***

When you are treated by an *ASH Plans Chiropractor* or *ASH Plans Acupuncturist*, services will not be covered other than those benefits specifically described in this amendment.

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

Words and phrases in italics are described in the "Important Words to Know" sections of your Evidence of Coverage and this amendment.

When You Need Chiropractic or Acupuncture Care

Choosing an *ASH Plans Chiropractor* or *ASH Plans Acupuncturist.* Your employer will give you a directory listing of *ASH Plans chiropractors* or *ASH Plans acupuncturists* in your area. You may also call **1-800-678-9133** to get help in finding an *ASH Plans chiropractor* or *ASH Plans acupuncturist* or to make sure that a *chiropractor* is an *ASH Plans chiropractor* or *an acupuncturist* is an *ASH Plans acupuncturist*.

Your First Visit. You must make an appointment with an *ASH Plans chiropractor* or *ASH Plans acupuncturist* for an examination of your condition. You do not need a referral from your *primary care doctor* to see an *ASH Plans chiropractor* or *ASH Plans acupuncturist*.

Bring your Member ID card. You will be asked to fill out an ASH Plans Eligibility Guarantee and Assignment of Benefits form.

Services Must be Approved. All services must be approved by ASH Plans as *medically/clinically necessary*, except for:

- An initial new patient exam by an *ASH Plans chiropractor* or *ASH Plans acupuncturist* and the provision or commencement, during the initial new patient exam, of *medically/clinically necessary* services that are chiropractic or acupuncture services, to the extent services are consistent with professionally recognized, valid, evidence-based standards of practice; and
- Emergency services.

If additional services are required after the initial new patient exam and ASH Plans approves them as *medically/clinically necessary*, you are covered up to the maximum number of visits shown under "What We Cover."

All visits to an *ASH Plans chiropractor* or *ASH Plans acupuncturist* will be applied towards the maximum number of visits in a *calendar year*.

Services Not Approved. An *ASH Plans chiropractor* or *ASH Plans acupuncturist* may provide non-covered services. However, you must agree in writing, before receiving non-covered services, to pay for them yourself. If an *ASH Plans chiropractor* or *ASH Plans acupuncturist* provides non-covered services without obtaining your written acknowledgment prior to providing the non-covered services, you will not be financially responsible to pay the provider for such non-covered services.

What We Cover

Chiropractic Care	Copay

♦ Office visit..... **$15***

***** Only one Copay will be required per visit regardless of the number of covered services furnished during the visit.

You may have up to **20** visits, combined with visits for acupuncture services, in a *calendar year* for covered services that are determined by ASH Plans to be *medically/clinically necessary*. Covered services include:

- An initial new patient exam provided by an *ASH Plans chiropractor* to determine the appropriateness of chiropractic services. An initial new patient exam is only covered if the *member* seeks services from an *ASH Plans chiropractor* for any injury, illness, disease, functional disorder or condition with regard to which the *member* is not, at that time, receiving services from an *ASH Plans chiropractor*. You are required to pay a Copay.
- Follow-up office visits, as set forth in a treatment plan approved by ASH Plans, including manipulation of the spine, joints and/or musculoskeletal soft tissue, re-evaluation, and/or other services, in various combinations, provided by an *ASH Plans chiropractor*. All follow-up office visits must be *medically/clinically necessary*. You are required to pay a Copay.
- An established patient exam performed by an *ASH Plans chiropractor* when determined by ASH Plans to be *medically/clinically necessary* to assess the need to continue, extend or change a treatment plan approved by ASH Plans. An established patient exam is only covered when used to determine the appropriateness of chiropractic services. You are required to pay a Copay.
- Adjunctive physiotherapy modalities and procedures, as set forth in a treatment plan approved by ASH Plans, including therapies such as ultrasound, hot packs, cold packs, electrical muscle stimulation, and other therapies provided by an *ASH Plans chiropractor*. Adjunctive physiotherapy modalities and procedures are covered only when provided during the same course of treatment, and in conjunction with, chiropractic manipulation of the spine, joints and/or musculoskeletal soft tissue. All adjunctive physiotherapy modalities and procedures must be *medically/clinically necessary* for the treatment of neuromusculoskeletal disorders and provided in conjunction with chiropractic services. If adjunctive therapy is provided separately from an office visit, you are required to pay a Copay.

Your *ASH Plans chiropractor* is responsible for submitting a treatment plan to ASH Plans for prior approval.

- X-rays and laboratory tests when prescribed by an *ASH Plans chiropractor* and approved by ASH Plans..... **No Copay**

  Covered services include radiological consultations when determined by ASH Plans to be *medically/clinically necessary* and provided by a licensed chiropractic radiologist, medical radiologist, radiology group or hospital which has contracted with ASH Plans to provide those services.

- Chiropractic appliances, up to **$50** in a *calendar year*, when prescribed by an *ASH Plans chiropractor* and approved by ASH Plans as *medically/clinically necessary* by ASH Plans ..... **No Copay**

  Covered chiropractic appliances are limited to:

  - Elbow supports, back supports (thoracic), lumbar braces and supports, rib supports, or wrist supports;
  - cervical collars or cervical pillows;
  - ankle braces, knee braces, or wrist braces;
  - heel lifts;
  - hot or cold packs;
  - lumbar cushions;
  - rib belts or orthotics; and
  - home traction units for treatment of the cervical or lumbar regions.

Acupuncture Services	**Copay**

- Office visit..... **$15***

  ***** Only one Copay will be required per visit regardless of the number of covered services furnished during the visit.

  You may have up to **20** visits, combined with visits for chiropractic care, in a *calendar year* for covered services that are determined by ASH Plans to be *medically/clinically necessary*. Covered services include:

  - An initial new patient exam provided by an *ASH Plans acupuncturist* to determine the appropriateness of acupuncture services. An initial new patient exam is only covered if the *member* seeks services from an *ASH Plans acupuncturist* for any injury, illness, disease, functional disorder or condition with regard to which the *member* is not, at that time, receiving services from an *ASH Plans acupuncturist*. You are required to pay a Copay.

- Follow-up office visits, as set forth in a treatment plan approved by ASH Plans, including acupuncture services and/or re-evaluation provided by an *ASH Plans acupuncturist*. All follow-up visits must be *medically/clinically necessary*. You are required to pay a Copay.
- An established patient exam performed by an *ASH Plans acupuncturist* when determined by ASH Plans to be *medically*/*clinically necessary* to assess the need to continue, extend or change a treatment plan approved by ASH Plans. An established patient exam is only covered when used to determine the appropriateness of acupuncture services. You are required to pay a Copay.
- Adjunctive therapy, as set forth in a treatment plan approved by ASH Plans, including therapies such as acupressure, cupping, moxibustion, or breathing techniques provided by an *ASH Plans acupuncturist*. Adjunctive therapy is covered only when provided during the same course of treatment, and in conjunction with, acupuncture. All adjunctive therapy must be *medically*/*clinically necessary* for the treatment of neuromusculoskeletal disorders, nausea or pain and provided in conjunction with acupuncture services. If adjunctive therapy is provided separately from an office visit, you are required to pay a Copay.

When You Want a Second Opinion. If you would like a second opinion with regard to covered services provided by an *ASH Plans chiropractor* or *ASH Plans acupuncturist*, you will have direct access to another *ASH Plans chiropractor* or *ASH Plans acupuncturist*. If an *ASH Plans chiropractor* or *ASH Plans acupuncturist* refers you to another *ASH Plans chiropractor* or *ASH Plans acupuncturist,* your visit for the second opinion will not be applied towards the maximum visits in a *calendar year*. If you self-refer to another *ASH Plans chiropractor* or *ASH Plans acupuncturist,* your visit for the second opinion will count towards the *calendar year* visit maximum, and you must pay any office visit Copay that applies.

What We Do Not Cover

- **Care Not Approved.** Any services provided by an *ASH Plans chiropractor* or *ASH Plans acupuncturist* that are not approved by ASH Plans, except as specified under "When You Need Chiropractic or Acupuncture Care." An *ASH Plans chiropractor* or *ASH Plans acupuncturist* is responsible for submitting a treatment plan to ASH Plans for prior approval.
- **Care Not Covered.** In addition to any service or supply specifically excluded in the "What We Do Not Cover" section of your Evidence of Coverage, no benefits will be provided for chiropractic or acupuncture services or supplies in connection with:
  - Diagnostic scanning, such as magnetic resonance imaging (MRI) or computerized axial tomography (CAT) scans. Diagnostic services for acupuncture.
  - Thermography.
  - Hypnotherapy.
  - Behavior training.
  - Sleep therapy.
  - Weight programs.
  - Any non-medical program or service.

- Pre-employment exams, any chiropractic or acupuncture services required by an employer that are not *medically/clinically necessary*, or vocational rehabilitation.
- Services and/or treatments which are not documented as *medically/clinically necessary*.
- Massage therapy.
- Acupuncture performed with reusable needles.
- Acupuncture services benefits are not provided for magnets used for diagnostic or therapeutic use, ion cord devices, manipulation or adjustments of the joints, physical therapy services, iridology, hormone replacement products, acupuncture point or trigger-point injections (including injectable substances), laser/laser biostim, colorpuncture, NAET diagnosis and/or treatment, and direct moxibustion.
- Any service or supply for the exam and/or treatment by an *ASH Plans chiropractor* for conditions other than those related to neuromusculoskeletal disorders.
- Services from an *ASH Plans acupuncturist* for examination and/or treatment for conditions not related to neuromusculoskeletal disorders, nausea or pain, including, without limitation, asthma or addictions such as nicotine addiction.
- Transportation costs including local ambulance charges.
- Education programs, non-medical self-care or self-help, or any self-help physical exercise training or any related diagnostic testing.
- Hospitalization, surgical procedures, anesthesia, manipulation under anesthesia, proctology, colonic irrigation, injections and injection services, or other related services.
- All auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.
- Adjunctive therapy not associated with spinal, muscle or joint manipulation.
- Laboratory and diagnostic x-ray studies, unless specifically stated in the section "What We Cover."

♦ ***Non-ASH Plans chiropractors* or *non-ASH Plans acupuncturists*.** Services and supplies provided by a *chiropractor* or an *acupuncturist* who does not have an agreement with ASH Plans to provide covered services under this *plan*.

♦ **Work-Related.** Care for health problems that are work-related if such health problems are covered by workers' compensation, an employer's liability law, or a similar law. We will provide care for a work-related health problem, but, we have the right to be paid back for that care. See "Getting Repaid by a Third Party" below.

♦ **Government Treatment.** Any services actually given to you by a local, state or federal government agency, except when this *plan's* benefits, must be provided by law. We will not cover payment for these services if you are not required to pay for them or they are given to you for free.

♦ **Drugs**. Prescription drugs or medicines, including a non-legend or proprietary medicine or medication not requiring a prescription.

- **Supplements**. Vitamins, minerals, dietary and nutritional supplements or other similar products, and any herbal supplements.
- **Air Conditioners.** Air purifiers, air conditioners, humidifiers, supplies or any other similar devices or appliances. All appliances or *durable medical equipment*, except as specifically stated in the section "What We Cover."
- **Personal Items.** Any supplies for comfort, hygiene or beauty purposes, including therapeutic mattresses.
- **Out-of-Area and Emergency Care.** Out-of-area care is not covered under this Chiropractic and Acupuncture Care benefit, except for emergency services. Please follow the procedures outlined in the "When There is an Emergency" section of your Evidence of Coverage to obtain *emergency* care or out-of-area care.

Getting Repaid by a Third Party

Sometimes someone else may have to pay for your medical care if an injury, disease, or other health problem is their fault or their responsibility. Whatever we cover will depend on the following:

- Your *medical group* and Anthem will automatically have a legal claim (lien) to get back the costs we covered, if you get a settlement or judgment from the other person or their insurer or guarantor. We should get back what we spent on your medical care.
  - If we paid the provider other than on a capitated basis, our lien will not be more than amount we paid for those services.
  - If we paid the provider on a capitated basis, our lien will not be more than 80% of the usual and customary charges for those services in the geographic area in which they were given.
  - If you hired an attorney to gain your recovery from the third party, our lien will not be for more than one-third of the money due you under any final judgment, compromise, or settlement agreement.
  - If you did not hire an attorney, our lien will not be for more than one-half of the money due you under any final judgment, compromise or settlement agreement.
  - If a final judgment includes a special finding by a judge, jury, or arbitrator that you were partially at fault, our lien will be reduced by the same comparative fault percentage by which your recovery was reduced.
  - Our lien is subject to a pro rata reduction equal to your reasonable attorney's fees and costs in line with the common fund doctrine.
- You must write to your *medical group* and Anthem about your claim within 60 days of filing a claim against the third party.
  - You will need to sign papers and give us the help we need to get back our costs.
  - If you don't do this, you will have to pay us back out of your own money.

- We will have the right to get our money back, even if what you, or someone acting for you, got back is less than the actual loss you suffered.

Important Words to Know

Acupuncturist means a doctor of acupuncture (L.A.C.), qualified and licensed by state law.

ASH Plans acupuncturist means an *acupuncturist* who has entered into an agreement with American Specialty Health Plans of California, Inc. (ASH Plans) to provide acupuncture services under this *plan*.

ASH Plans chiropractor means a *chiropractor* who has entered into an agreement with the American Specialty Health Plans of California, Inc. (ASH Plans) to provide covered services under this *plan*.

Chiropractor means a doctor of chiropractic (D.C.), qualified and licensed by state law.

Medically/clinically necessary services or supplies, for the purposes of this amendment only, are those chiropractic services and/or acupuncture services which are necessary, appropriate, safe, effective, and rendered in accordance with professionally recognized, valid, evidenced-based standards of practice.

Non-ASH Plans acupuncturist means an *acupuncturist* who does not have an agreement with ASH Plans to provide covered services under this *plan*.

Non-ASH Plans chiropractor means a *chiropractor* who does not have an agreement with the ASH Plans to provide covered services under this *plan*.

Your Prescription Drug Plan

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

Dispute Resolution

Pharmacy Grievance Procedures

Please refer to your CVS Pharmacy Evidence of Coverage booklet for Pharmacy grievance procedures or you may contact CVS Caremark's Customer Care at 1-855-479-3660 or 1-866-236-1069 [TTY].

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