

***LOS ANGELES COUNTY EMPLOYEES
RETIREMENT ASSOCIATION (LACERA)***

July 1, 2020

Plan III (In State)

**COMBINED EVIDENCE OF COVERAGE
AND DISCLOSURE FORM**

**Anthem Blue Cross
21215 Burbank Blvd.
Woodland Hills, California 91367**

This Combined Evidence of Coverage and Disclosure (Evidence of Coverage) Form is a summary of the important terms of your health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage. LACERA will provide you with a copy of the health plan contract upon request.

TABLE OF CONTENTS

YOUR ANTHEM BLUE CROSS BENEFITS	1
BENEFITS TO SUPPLEMENT MEDICARE	2
HOSPITAL INPATIENT BENEFITS (PART A)	2
HOSPITAL INPATIENT BENEFITS FOR CONDITIONS OTHER THAN MENTAL OR NERVOUS DISORDERS	3
HOSPITAL INPATIENT BENEFITS FOR MENTAL OR NERVOUS DISORDERS	4
SKILLED NURSING FACILITY BENEFITS.....	5
HOME HEALTH CARE BENEFITS.....	5
HOSPICE CARE BENEFITS.....	5
MEDICAL BENEFITS (PART B)	6
HOSPITAL OUTPATIENT BENEFITS	6
PROFESSIONAL SERVICES AND SUPPLIES	7
BENEFITS OUTSIDE THE UNITED STATES	9
EXCLUSIONS AND LIMITATIONS	11
REIMBURSEMENT FOR ACTS OF THIRD PARTIES	17
YOUR PRESCRIPTION DRUG BENEFITS	18
PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED.....	22
HOW COVERAGE BEGINS AND ENDS	27
HOW COVERAGE BEGINS.....	27
HOW COVERAGE ENDS	30

CONTINUATION OF COVERAGE32

EXTENSION OF BENEFITS.....37

GENERAL PROVISIONS38

BINDING ARBITRATION43

DEFINITIONS.....46

GRIEVANCE PROCEDURES54

 Independent Medical Review of Denials of Experimental or Investigative
 Treatment56

 Independent Medical Review of Grievances Involving a Disputed Health
 Care Service58

FOR YOUR INFORMATION.....60

YOUR ANTHEM BLUE CROSS BENEFITS

This plan is intended only for *members* who have *Medicare* Part A and Part B coverage. The benefits described in this booklet are payable only for covered services to supplement *Medicare* benefits, except as specifically stated in BENEFITS OUTSIDE THE UNITED STATES, and YOUR PRESCRIPTION DRUG BENEFITS.

The benefits of this *plan* are provided only for services that *Medicare* determines to be allowable and *medically necessary*, except as specifically stated in this booklet. For covered services for which *Medicare* does not provide coverage (as described in BENEFITS OUTSIDE THE UNITED STATES, and YOUR PRESCRIPTION DRUG BENEFITS), the benefits of this *plan* are provided only for services that we determine to be *medically necessary*. The fact that a *physician* prescribes or orders a service does not, in itself, mean that the service is *medically necessary* or that the service is a covered expense. Consult this booklet or telephone us at the number shown on your identification card if you have any questions regarding whether services are covered.

This *plan* contains many important terms (such as “medically necessary”) that are defined in the DEFINITIONS section. When reading through this booklet, consult the DEFINITIONS section to be sure that you understand the meanings of these italicized words.

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

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

Care After Hours. If you need care after your *physician's* normal office hours and you do not have an *emergency* medical condition or need *urgent care*, please call your *physician's* office for instructions.

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

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

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

BENEFITS TO SUPPLEMENT MEDICARE

In the following benefit sections, we provide a summary of what you pay, what *Medicare* pays, and what we pay. However, for complete information about *Medicare*, you should contact your local Social Security office or the Health Care Finance Administration, or refer to its publications.

HOSPITAL INPATIENT BENEFITS (PART A)

Part A refers to the portion of the *Medicare* program which provides benefits for inpatient *hospital* services and *skilled nursing facility* care.

We will provide payment for our portion of the Part A benefits whether or not a *hospital stay* has been approved by *Medicare* or services were received in a *hospital* participating in the *Medicare* program. However, SERVICES MUST BE *MEDICALLY NECESSARY AS DETERMINED BY US, AND ARE SUBJECT TO THE EXCLUSIONS AND LIMITATIONS OF THIS BOOKLET.*

The following paragraphs describe what you pay, what *Medicare* pays and what we pay:

HOSPITAL INPATIENT BENEFITS FOR CONDITIONS OTHER THAN MENTAL OR NERVOUS DISORDERS

You Pay:

- Any amounts in excess of *Medicare's* Allowable Charge amount for the first three pints of unreplaced whole blood.

Medicare Pays:

- Covered inpatient *hospital* services received for the first 60 days of each *benefit period* during an approved *stay*, EXCEPT FOR THE *MEDICARE* PART A DEDUCTIBLE and the first three pints of unreplaced blood.
- Covered inpatient *hospital* services received for the 61st through 90th day of each *benefit period*, EXCEPT FOR THE *MEDICARE CO-PAYMENT*.
- If you exercise your option to use the 60 day lifetime reserve, covered inpatient *hospital* services received for the 91st through 150th day, EXCEPT FOR THE *MEDICARE CO-PAYMENT*. *MEDICARE DOES NOT PAY ANY BENEFITS AFTER THE 150TH DAY*.

We Pay:

- The *Medicare* Part A deductible.
- Benefits (UP TO *MEDICARE'S* ALLOWABLE CHARGE AMOUNT) for the first three pints of **unreplaced** whole blood, packaged red blood cells or any other blood derivative received during each *year* unless already paid for under Part B.
- The *Medicare co-payment* for *hospital stays* from the 61st through 90th day.

If you choose to use the 60-day lifetime reserve, the *Medicare co-payment* for *hospital stays* from the 91st through 150th day.

HOSPITAL INPATIENT BENEFITS FOR MENTAL OR NERVOUS DISORDERS

You Pay:

- Any additional inpatient *mental or nervous disorder* services you receive after *Medicare* has paid either (a) the first 90 days of coverage during any one *benefit period*, provided you have no additional lifetime reserve days remaining; or (b) the first 150 days of coverage during any one *benefit period*, provided you have all of your lifetime reserve days remaining and choose to use them. If you have fewer than 60 lifetime reserve days available, or choose to use fewer than the number you have available, your payment responsibility increases accordingly.
- Any additional inpatient *mental or nervous disorder* services you receive after *Medicare* has paid the 190 day lifetime maximum for these services.

Medicare Pays:

- Covered inpatient *hospital* services received for the first 60 days of each *benefit period* during an approved *stay*, EXCEPT FOR THE *MEDICARE PART A DEDUCTIBLE*.
- Covered inpatient *hospital* services received for the 61st through 90th day of each *benefit period*, EXCEPT FOR THE *MEDICARE CO-PAYMENT*.
- If you exercise your option to use the 60 day lifetime reserve, covered inpatient *hospital* services received for the 91st through 150th day, EXCEPT FOR THE *MEDICARE CO-PAYMENT*.

MEDICARE DOES NOT PAY ANY BENEFITS AFTER THE 150TH DAY OF EACH *BENEFIT PERIOD* OR BEYOND THE LIFETIME MAXIMUM OF 190 DAYS.

We Pay:

- The *Medicare Part A deductible*.
- The *Medicare co-payment* for *hospital stays* from the 61st day through 90th day.
- If you choose to use the 60-day lifetime reserve, the *Medicare co-payment* for *hospital stays* from the 91st through 150th day.

SKILLED NURSING FACILITY BENEFITS

You Pay:

- Any additional *skilled nursing facility* services you receive after *Medicare* has paid the 100 day maximum allowance during a *benefit period* for these services.

Medicare Pays:

- When you are admitted within 30 days of a covered inpatient *hospital stay* of three or more consecutive days, covered Part A services for up to 100 days for each *benefit period*, EXCEPT FOR THE *MEDICARE CO-PAYMENT* FROM THE 21ST TO THE 100TH DAY. *MEDICARE DOES NOT PAY FOR SERVICES BEYOND THE 100TH DAY DURING A BENEFIT PERIOD.*

We Pay:

- The *Medicare Part A co-payment* for *skilled nursing facility* services received from the 21st to the 100th day per *benefit period*.

HOME HEALTH CARE BENEFITS

Medicare Pays:

- **100%** of *Medicare's Allowable Charge* amount for covered *home health care* and **80%** of *Medicare's Allowable Charge* for durable medical equipment.

We Pay:

- **20%** of *Medicare's Allowable Charge* amount for durable medical equipment, plus charges in excess of the approved amount on unassigned claims.

HOSPICE CARE BENEFITS

Medicare Pays:

- **100%** of *Medicare's Allowable Charge* amount for covered *hospice care*.

We Pay:

- **100%** of reasonable charges for the remaining costs not covered by *Medicare* for covered *hospice care*.

MEDICAL BENEFITS (PART B)

Part B refers to the portion of the *Medicare* Program which provides benefits for *physician* services, outpatient *hospital* care, outpatient X-rays and laboratory procedures, local ground ambulance and other specified health services and supplies.

We will pay **100%** of the difference between *Medicare's* Allowable Charge(s) and the amount *Medicare* pays for *medically necessary* Part B services and supplies, SUBJECT TO ANY MAXIMUMS STATED BELOW. We will also pay benefits (up to *Medicare's* Allowable Charge amount) for the first three pints of unreplaced blood, packaged red blood cells or any other blood derivative received during each *year* unless already paid for under Part A.

We will provide payment for our portion of the Part B benefits only when services are allowed by *Medicare* and *Medicare* has provided benefits for the same services, except when required by State or Federal law.

The following paragraphs describe what you pay, what *Medicare* pays and what we pay:

HOSPITAL OUTPATIENT BENEFITS

Medicare Pays:

- **80%** of *Medicare's* Allowable Charge amount for covered *hospital* outpatient services listed below.

We Pay:

- The *Medicare* Part B deductible.
- **20%** of *Medicare's* Allowable Charge amount for the covered *hospital* outpatient services listed below, after you have met the *Medicare* Part B deductible.

Covered Services:

- Outpatient medical care.
- Outpatient surgical treatment.
- Radiation therapy, chemotherapy and hemodialysis treatment.

PROFESSIONAL SERVICES AND SUPPLIES

You Pay:

- Any amounts in excess of *Medicare's* Allowable Charge amount.
- Any amounts in excess of our yearly maximum benefits for certain services, as stated in the section entitled COVERED SERVICES.

Medicare Pays:

- **80%** of *Medicare's* Allowable Charge amount for covered professional services and supplies.

We Pay:

- The *Medicare* Part B deductible.
- **20%** of *Medicare's* Allowable Charge amount for covered professional services and supplies listed below, subject to any stated maximums, after you have met the *Medicare* Part B deductible.

Exceptions. For hearing aids, we will pay **50%** of the amount for professional services and supplies. For hearing examinations, we will pay **80%** of the reasonable charges. For outpatient mental or nervous disorders, we will pay **30%** of Medicare's allowable charge.

Covered Services:

- *Physicians'* services for surgery and surgical assistance.
- Anesthesia during surgery.
- Consultations requested by the attending *physician*.
- Visits of a *physician* during a covered *hospital stay*, including a *hospital stay* for *mental or nervous disorders*.
- Radiation therapy and chemotherapy.
- A *physician's* services for outpatient *emergency* care.
- A *physician's* services for home or office visits.
- Diagnostic radiology and laboratory services.
- Routine and diagnostic mammograms, mastectomy, complications from a mastectomy, reconstructive surgery of both breasts following mastectomy, and breast prostheses following mastectomy.

- Medical supplies, rental or purchase of durable medical equipment, including therapeutic shoes and inserts for the prevention and treatment of diabetes related foot complications.
- Contraceptive services and supplies, limited to injectable drugs and implants for birth control, IUDs and diaphragms dispensed by a *physician*, and the services of a *physician* in connection with the prescribing, fitting and insertion of intrauterine contraceptive devices or diaphragms.

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

- Diabetes instruction program which: (1) is designed to teach a member who is a patient and covered members of the patient's family about the disease process and the daily management of diabetic therapy; (2) includes self management training, education, and medical nutrition therapy to enable the member to properly use the equipment, supplies and medications necessary to manage the disease; and (3) is supervised by a *physician*.
- Air and Ground ambulance services of a licensed ambulance company to or from the nearest *hospital* or *skilled nursing facility*. Emergency services or transportation services that are provided to you by a licensed ambulance company as a result of a "911" emergency response system request for assistance if you believe you have an emergency medical condition requiring such assistance.

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

- Blood and blood plasma beginning with the fourth pint during any *year*.
- The first pair of contact lenses or the first pair of eyeglasses following eye surgery.
- Hearing examination, limited to one examination during any *year*.
- Hearing aids, limited to a \$300.00 lifetime maximum.
- Physical therapy and occupational therapy.
- Speech therapy.

- Outpatient care for *mental or nervous disorders*, limited to 50 visits per *calendar year*.

BENEFITS OUTSIDE THE UNITED STATES

After you pay a **\$50** calendar year deductible, we will provide the benefits listed below when you require emergency medical care outside the *United States* during a temporary absence. We will pay up to **\$25,000** per trip. These benefits are subject to all provisions of the *agreement*, which may limit benefits or result in benefits not being payable.

Special Instructions for Foreign Claims Submission

When you submit a claim to us for medical care services rendered outside the *United States*, you must include any canceled checks, receipts or other documents you receive in connection with those services along with your properly completed claim form.

If you receive drugs or medicines during an inpatient or outpatient hospital admission outside the *United States*, you should ask the provider of service to include the chemical or generic name of the drug on your bill.

INPATIENT HOSPITAL SERVICES

Your *hospital* care must be rendered in a facility which is properly licensed and accredited as a *hospital* in the country where services are rendered. We provide benefits for services of a *hospital* as follows:

1. Payment

We provide payment for **80%** of billed *reasonable charges* for *medically necessary* inpatient services listed below when provided by a *hospital*. You pay any amounts in excess of *reasonable charges*.

2. Covered Services

The following services of a *hospital* are covered:

- Accommodations in a room of two or more beds, or the prevailing charge for two-bed room accommodations in that *hospital* if a private room is used.
- Services in *special care units*.
- Operating and special treatment rooms.
- Supplies and ancillary services including laboratory, cardiology, pathology, radiology and any professional component of these services.

- Physical therapy, radiation therapy, chemotherapy and hemodialysis treatment.
- Drugs and medicines (equivalent to those approved for general use by the Food and Drug Administration in the *United States*) which are supplied by the *hospital* for use during your *stay*.
- Blood transfusions, but not the cost of blood, blood products or blood processing.

4. **Conditions of Service**

- Services must be those which are regularly provided and billed by a *hospital*.
- Services are provided only for the number of days required to treat your illness, injury or condition.

OUTPATIENT HOSPITAL SERVICES

1. **Payment**

We provide payment for **80%** of billed *reasonable charges* for *medically necessary* outpatient services listed below when provided by a *hospital*. You pay any amounts in excess of *reasonable charges*.

2. **Covered Services**

- *Emergency* room use, supplies, ancillary services, drugs and medicines as listed under Inpatient Hospital Covered Services.
- Care received when outpatient surgery is performed. Covered services are operating room use, supplies, ancillary services, drugs and medicines as listed under Inpatient Hospital Covered Services.

3. **Conditions of Service**

- Services must be those which are regularly provided and billed by a *hospital*.
- *Emergency* room care must be for the first treatment of an *emergency*.

PROFESSIONAL MEDICAL BENEFITS

Your professional medical care must be rendered by a provider who is properly licensed and accredited as a *physician* in the country where services are provided. We provide benefits for professional medical services as follows:

1. Payment

We provide payment for **80%** of covered expense incurred for *medically necessary* services listed below. Covered expense is expense incurred for a covered service, but not more than a *reasonable charge*.

2. Covered Services

- Surgery and surgical assistance.
- Anesthesia during surgery.
- Visits during a covered *hospital stay* (except those relating to surgery), limited to one per day unless additional visits are needed due to your medical condition.

EXCLUSIONS AND LIMITATIONS

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

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

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

Services outside the United States. Services and supplies provided outside the *United States*, except as specifically stated in the section entitled BENEFITS OUTSIDE THE UNITED STATES.

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

Not Covered. Services received before your *effective date* or after your coverage ends, except as specifically stated under EXTENSION OF BENEFITS.

Non-Licensed Providers. Treatment or services rendered by non-licensed health care providers and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed provider under the supervision of a licensed *physician*, except as specifically provided or arranged by us.

Excess Amounts. Any amounts in excess of:

1. Allowable Charges as determined by *Medicare*, for benefits provided under the sections entitled HOSPITAL INPATIENT BENEFITS (PART A) and MEDICAL BENEFITS (PART B); and
2. *Reasonable charges*, as we determine, for benefits provided under the sections entitled BENEFITS OUTSIDE THE UNITED STATES; and
3. Prescription drug covered expense, as we determine, for benefits provided under the section entitled YOUR PRESCRIPTION DRUG BENEFITS; and
4. The Lifetime maximum payments and benefits stated in this booklet.

Work Related. Work related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if you do not claim those benefits. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, benefits will be provided subject to our right of recovery and reimbursement under California Labor Code Section 4903, and as described in REIMBURSEMENT FOR ACTS OF THIRD PARTIES.

Government Treatment. Any services you actually received that were provided by a local, state, or federal government agency, or by a public school system or school district, except when payment under this *plan* is expressly required by federal or state law. 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*.

Services of Relatives. Professional services received from a person who lives in your home or who is related to you by blood or marriage.

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

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

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

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

Mental or Nervous Disorders or Substance Abuse. Academic or educational testing, counseling, and remediation. Any treatment of *mental or nervous disorders* or substance abuse, including rehabilitative care in relation to these conditions, except as specifically stated in the "Hospital Inpatient Benefits for Mental or Nervous Disorders" provision of HOSPITAL INPATIENT BENEFITS (PART A) and in the "Professional Services and Supplies" provision of MEDICAL BENEFITS (PART B). Any educational treatment or any services that are educational, vocational, or training in nature except as specifically provided or arranged by us.

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use.

Orthodontia. Braces and other orthodontic appliances or services.

Dental Services or Supplies. Cosmetic dental surgery or other dental services for beautification. Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth or treatment to the teeth or gums, except for surgery of the jaw or related

structures, setting fractures of the jaw or facial bones, or services that would be covered when provided by a *physician*.

This exclusion also does not apply to the following services:

- General anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a *hospital* or ambulatory surgical center. This applies only if you are developmentally disabled or your health is compromised and general anesthesia is *medically necessary*. Charges for the dental procedure itself, including professional fees of a dentist, are not covered.
- *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.
- Orthognathic surgery for a physical abnormality that prevents normal function of the upper or lower jaw and is *medically necessary* to attain functional capacity of the affected part.

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

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics, routine eye exams and routine eye refractions. Eyeglasses or contact lenses, except as specifically stated in the “Professional Services and Supplies” provision of MEDICAL BENEFITS (PART B).

Outpatient Physical and Occupational Therapy. Outpatient physical and occupational therapy, except as specifically stated in the “Professional Services and Supplies” provision of MEDICAL BENEFITS (PART B).

Outpatient Speech Therapy. Outpatient speech therapy, except as specifically stated in the “Professional Services and Supplies” provision of MEDICAL BENEFITS (PART B).

Cosmetic Surgery. Cosmetic surgery or other services performed to alter or reshape normal (including aged) structures or tissues of the body to improve appearance.

Obesity. Services primarily for weight reduction or treatment of obesity. This exclusion will not apply to treatment of morbid obesity as determined by us if we authorize the treatment in advance as *medically necessary* and appropriate.

Sterilization Reversal. Reversal of an elective sterilization.

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

Orthopedic Supplies. Orthopedic shoes (other than shoes joined to braces) or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications as specifically stated under “Covered Services” in the “Professional Services and Supplies” provision of MEDICAL BENEFITS (PART B).

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

Custodial Care and Rest Cures. Inpatient room and board charges in connection with a *hospital stay* primarily for environmental change or physical therapy. *Custodial care* or rest cures. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a *skilled nursing facility*, except as specifically stated under in the “Skilled Nursing Facility” provision of HOSPITAL INPATIENT BENEFITS (PART A).

Chronic Pain. Inpatient room and board charges in connection with a *hospital stay* primarily for treatment of chronic pain.

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

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

Education or Counseling. Any educational treatment, nutritional counseling or food supplements. Any services that are educational, vocational, or training in nature except as specifically provided or arranged by us.

Telephone, Facsimile Machine, and Electronic Mail Consultations.

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

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority.

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

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

Outpatient Prescription Drugs and Medications. Outpatient *prescription drugs* or medications and insulin, except as specifically stated in the section entitled YOUR PRESCRIPTION DRUG BENEFITS. Any non-*prescription*, over-the-counter patent or proprietary *drug* or medicine. Cosmetics, dietary supplements, health or beauty aids.

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specifically stated under "Covered Services" in the "Professional Services and Supplies" provision of MEDICAL BENEFITS (PART B).

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

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

Clinical Trials. Services and supplies provided in connection with a clinical trial except for routine costs associated with a clinical trial for which *Medicare* provides benefits.

REIMBURSEMENT FOR ACTS OF THIRD PARTIES

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

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

YOUR PRESCRIPTION DRUG BENEFITS

Prescription Drug Benefits are administered through CVS Caremark; please review the following information for details on Retail, Mail Order and Specialty drug coverage.

Contact Information:

For General Inquiries such as: Finding a Network Pharmacy, Obtaining Retail or Mail Order Claim Forms and Drug Coverage Questions	CVS Caremark P.O. Box 65929 San Antonio, TX 78265-9529 www.caremark.com	(800) 450-3755 FastStart Mail Order: (800) 875-0867
Specialty Pharmacy General Inquiries, Claim Forms and Drug Coverage Questions	CVS Caremark Specialty Pharmacy	(800) 237-2767
Status of Retail Claim, Obtain New ID Card	Anthem Blue Cross www.anthem.com/ca	(800) 284-1110
Appeals	CVS Caremark Appeals Dept MC 109 P.O. Box 52084 Phoenix, AZ 85072-2084	Fax: (866) 689-3092 Physician Only Phone: (866) 443-1183

When You Obtain Your Prescription at a Retail Pharmacy expense is incurred on the date you receive the *drug* for which the charge is made. Prescription drug covered expense is the maximum charge for each covered service or supply that will be accepted by CVS Caremark for each different type of *pharmacy*. It is not necessarily the amount a *pharmacy* bills for the service.

Prescription Drug Covered Expense will always be the lesser of the billed charge or the amount shown below.

Type of Provider	Maximum Prescription Drug Covered Expense is...
Network Pharmacies and Mail Service Program	Prescription Drug Specified Rate
Non-Network Pharmacies.....	Customary and Reasonable

When you go to a network pharmacy. Provided you have properly identified yourself as a member, a *network pharmacy* will only charge the negotiated rate. CVS Caremark will then transmit the claim to Anthem Blue Cross for processing. You will pay 100% of the cost of the drug at a retail pharmacy and will be reimbursed later at the participating or non-participating provider rate by Anthem Blue Cross.

When you go to a non-network pharmacy. If you purchase a *prescription drug* from a *non-network pharmacy*, you will have to pay the full cost of the *drug* and submit a claim directly to CVS Caremark.

Type of Prescription	Your Share of the Cost
Network Retail Pharmacy	20%
Non-Network Retail Pharmacy*	40%

* If you do not live within a CVS Caremark service area you will be reimbursed 80% of Customary and Reasonable charges.

Prescription drugs dispensed at a retail pharmacy are limited to a thirty-four (34) day supply per prescription or refill and are subject to the retail prescription benefit as described above. Maintenance drugs, as classified by the Plan, can be filled for a ninety (90) day supply at mail order or a CVS/pharmacy and are subject to the mail order co-pay.

When You Order Your Prescription Through the Mail. If you take prescription medication on an ongoing basis, you may order up to a 90 day supply by mail through CVS Caremark Prescription Service.

CVS Caremark Prescription Service guarantees that every prescription will be screened and filled by a registered pharmacist and be accurate in quantity and potency. Your prescription will be sent to you in a sealed container for your protection.

When you order by mail, your prescription is reviewed by a pharmacist, checked against your Patient Profile, dispensed and verified by CVS Caremark's Quality Control Department before it is mailed to you.

To use this service, ask your physician to prescribe needed medication for up to a 90 day supply, plus refills. If you are presently taking medication, ask your doctor for a new prescription. Send a completed Patient Questionnaire, your original prescriptions and the appropriate co-payment for each prescription to CVS Caremark Prescription Service. Make your check or money order payable to CVS Caremark Prescription Service.

CVS Caremark makes it easier for you to get started with mail service and stay on track with your therapies. You can fill out and print the form online at www.caremark.com by clicking on New Prescriptions. You can then mail in your form along with prescription and payment. You can also contact FastStart from 7am to 7pm CT Monday – Friday to get started on your mail order. Your medications will be delivered within 10 days from the time your order is placed.

Type of Prescription	Your Share of the Cost
Mail Order Generic	\$10 copay
Mail Order Brand Name	\$30 copay
Mail Order Non-Formulary	\$50 copay

Ordering Refills

With your original prescription medication, you will receive a notice showing the number of times it may be refilled. Simply enclose this refill notice along with your co-payment and mail to CVS Caremark Prescription Service in the pre-addressed envelope. (Specialty drugs that are not administered at a provider's office must be filled through the mail order program with CVS Caremark.) To avoid the risk of running out, order your refills two weeks before you need them.

Emergency Situations

If you need medication immediately but will be taking it on an ongoing basis, ask your physician for two prescriptions: the first should be for a 14 day supply that you can have filled at a local pharmacy; the second prescription should be for the balance, up to a 90 day supply. Send the larger prescription with the appropriate co-payment to CVS Caremark Prescription Service. (Specialty drugs that are not administered at a provider's office must be filled through the mail order program with CVS Caremark.)

When You Order Your Prescription Through Specialty Drug Program.

You can only order your *prescription* for a *specialty drug* through the specialty drug program unless you are given an exception from the specialty drug program. Specialty Drug Program only fills *specialty drug prescriptions*. Specialty Drug Program will deliver your medication to you by mail or common carrier.

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

You or your *physician* may obtain a list of *specialty drugs* available through Specialty Drug Program or order forms by contacting CVS Caremark Specialty Pharmacy.

Type of Prescription	Your Share of the Cost
Specialty Pharmacy	\$50 copay for a 1-30 day supply
	\$100 copay for a 31-60 day supply
	\$150 copay for a 61-90 day supply

If you don't get your *specialty drug* through the specialty drug program or in a physician's office, you will not receive any benefits under this *plan*.

Special Programs

From time to time, we may initiate various programs to encourage you to utilize more cost-effective or clinically-effective *drugs* including, but, not limited to, *generic drugs*, mail service *drugs*, over-the-counter *drugs* or preferred drug products. If we initiate such a program, and we determine that you are taking a *drug* for a medical condition affected by the program, you will be notified in writing of the program and how to participate in it and how it may affect your benefits.

The CVS Caremark Claims and Appeals Process Pre-authorization Review:

CVS Caremark will implement the prescription drug cost containment programs requested by the *group* by comparing your requests for certain medicines and/or other prescription benefits against pre-defined preferred drug lists or formularies before those prescriptions are filled. If CVS Caremark determines that your request for pre-authorization cannot be

approved, that determination will constitute an Adverse Benefit Determination.

Appeals of Adverse Benefit Determinations:

If an Adverse Benefit Determination is rendered on your Claim, you may file an appeal of that determination. Your appeal of the Adverse Benefit Determination must be made in writing and submitted to CVS Caremark within 180 days after you receive notice of the Adverse Benefit Determination. If the Adverse Benefit Determination is rendered with respect to an Urgent Care Claim, you and/or your attending physician may submit an appeal by calling CVS Caremark.

Your appeal should include the following information:

- Name of the person the appeal is being filed for;
- CVS Caremark Identification Number;
- Date of birth;
- Written statement of the issue(s) being appealed;
- Drug name(s) being requested; and
- Written comments, documents, records or other information relating to the Claim.

Your appeal and supporting documentation may be mailed or faxed to CVS Caremark.

CVS Caremark will provide the first-level review of appeals of Pre-Service Claims. If you appeal CVS Caremark's decision, you can request an additional second-level Medical Necessity review. That review will be conducted by an Independent Review Organization ("IRO").

PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED

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

1. Minoxidil (Rogaine) in compounded lotion form when prescribed for cosmetic purposes.
2. Anorectics (any drug or medicine for the purpose of weight loss).
3. Nicorette (or any other drug or medicine containing nicotine or other smoking deterrent, including but not limited to patches).

4. Non-legend drugs or medicines.
5. Therapeutic devices or appliances and support garments and other non-medical substances, regardless of their intended use.
6. Drugs or medicines delivered or administered by the prescriber.
7. Obsolete drugs or medicines (obsolete drugs or medicines are those drugs or medicines which are no longer being produced or have been taken off the market by the manufacturer).
8. Unit dose drugs or medicines (unit dose drugs or medicines are those drugs or medicines which are individually packaged when the same drug or medicine is available in a multi-dose container).
9. More than a 90 day supply or a 270 unit dose of any one prescription or refill when purchased under the Mail Order Drug Plan.
10. Any charge for the giving of insulin.
11. With respect to drugs and medicines, any refill over the number the physician lists.
12. With respect to drugs and medicines, any refill made more than one year after the date of the original prescription order.
13. Drugs or medicines for which benefits are provided under any other provisions of the Plan.
14. Growth hormones, including the drug Protropin (Somatrem).
15. Retin-A.
16. Any drug not listed on the CVS Caremark Preferred Drug List.

COORDINATION OF BENEFITS

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

DEFINITIONS

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

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

The following are not Allowable Expense:

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

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage;

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

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

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

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

EFFECT ON BENEFITS

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

ORDER OF BENEFITS DETERMINATION

The first of the following rules which applies will determine the order in which benefits are payable:

1. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision.
2. A plan which covers you as a *subscriber* pays before a plan which covers you as a dependent. But, if you are a Medicare beneficiary and also a dependent of an employee with current employment status under another plan, this rule might change. If, according to Medicare's rules, Medicare pays after that plan which covers you as a dependent then, the plan which covers you as a dependent pays before a plan which covers you as a *subscriber*.

For example: You are covered as a retired *subscriber* under this plan and a Medicare beneficiary (Medicare would pay first, this plan would

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

3. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But, if either plan does not have a provision regarding laid-off or retired employees, provision 5 applies.
4. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan do not agree under these circumstances with the order of benefit determination provisions of This Plan, this rule will not apply.
5. When the above rules do not establish the order of payment, the plan on which you have been enrolled the longest pays first unless two of the plans have the same effective date. In this case, Allowable Expense is split equally between the two plans.

OUR RIGHTS UNDER THIS PROVISION

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

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

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

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

HOW COVERAGE BEGINS AND ENDS

HOW COVERAGE BEGINS

ELIGIBLE STATUS

1. **Subscriber.** You are eligible to enroll as a *subscriber* if you are a *retiree* who is actively enrolled under both Part A and Part B of *Medicare*. A *retiree* is retired from active full-time employment from Los Angeles County and eligible to participate in the health plan benefit program administered by the Los Angeles County Employees Retirement Association (LACERA).
2. **Family Member.** The *subscriber's spouse* or *domestic partner* is eligible to be enrolled as a *family member*, provided that the *spouse* or *domestic partner* is actively enrolled under both Part A and Part B of *Medicare*. *Spouse* is the *employee's* spouse as recognized under state or federal law. This includes same sex spouses when legally married in a state that recognizes same-sex marriages. *Domestic partner* is the *subscriber's domestic partner* under a legally registered and valid domestic partnership. *Spouse* or *domestic partner* does not include any person who is covered as a *subscriber*.

ELIGIBILITY DATE

For *subscribers*, you become eligible for coverage on the first day of the month coinciding with or following the date you retire. For the *subscriber's spouse* or *domestic partner*, you become eligible on the later of (a) the date the *subscriber* becomes eligible for coverage or (b) the date the *spouse* or *domestic partner* meets the definition of a *spouse* or *domestic partner*, respectively.

ENROLLMENT

To enroll as a *subscriber*, or to enroll *family members*, the *subscriber* must properly file an application. An application is considered properly filed, only if it is personally signed, dated, and given to the *group* within 60 days from your date of retirement. To enroll a family member after the subscriber has been covered, the family member must be enrolled within 30 days from his or her eligibility date. We must receive this application

from the *group* within 90 days. If any of these steps are not followed, your coverage may be denied.

EFFECTIVE DATE

Subject to the timely payment of subscription charges on your behalf, your coverage will begin as follows:

1. **Timely Enrollment.** If you enroll for coverage before, on, or within the required number of days after your eligibility date, then your coverage will begin as follows: (a) for *subscribers*, on your eligibility date; and (b) for *family members*, on the later of (i) the date the *subscriber's* coverage begins, or (ii) the first day of the month after the *family member* becomes eligible. If you become eligible before the *agreement* takes effect, coverage begins on the effective date of the *agreement*.
2. **Late Enrollment.** If you enroll more than the required number of days after your eligibility date, your coverage will begin six months following the date you filed the enrollment application.
3. **Disenrollment:** If you voluntarily choose to disenroll from coverage under this *plan*, you must complete a six month waiting period from the date you submit an application to the group. You may enroll earlier than the six months if you meet any of the conditions listed under SPECIAL ENROLLMENT PERIODS.

Special Enrollment Periods

You may enroll without having to satisfy the six month waiting period specified in the Late Enrollment and Disenrollment provisions if you are otherwise eligible under any one of the circumstances set forth below:

1. You have met all of the following requirements:
 - a. You were covered as an individual or dependent under either:
 - i. Another employer group health plan or health insurance coverage, including coverage under a COBRA continuation; or
 - ii. A state Medicaid plan or under a state child health insurance program (SCHIP), including the Healthy Families Program or the Access for Infants and Mothers (AIM) Program.
 - b. You certified in writing at the time you became eligible for coverage under this *plan* that you were declining coverage under this *plan* or disenrolling because you were covered under another health plan as stated above and you were given written notice that

if you choose to enroll later, you may be required to complete a six-month waiting period to do so.

- c. Your coverage under the other health plan wherein you were covered as an individual or dependent ended as follows:
 - i. If the other health plan was another employer group health plan or health insurance coverage, including coverage under a COBRA continuation, coverage ended because you lost eligibility under the other plan, your coverage under a COBRA continuation was exhausted, or employer contributions toward coverage under the other plan terminated. You must properly file an application with the *group* within 31 days after the date your coverage ends or the date employer contributions toward coverage under the other plan terminate.

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

- ii. If the other health plan was a state Medicaid plan or a state child health insurance program (SCHIP), including the Healthy Families Program or the Access for Infants and Mothers (AIM) Program, coverage ended because you lost eligibility under the program. You must properly file an application with the *group* within 60 days after the date your coverage ended.
- 2. You were covered under another *group* sponsored health plan, administered by Anthem Blue Cross or Anthem Blue Cross Life and Health, as an individual or dependent immediately prior to enrolling under this *plan*.
- 3. A court has ordered coverage be provided for a *spouse* or *domestic partner* under your group health plan and application is filed within the required number of days from the date the court order is issued.
- 4. We do not have a written statement from the *group* stating that prior to declining coverage or disenrolling, you received and signed acknowledgment of a written notice specifying that if you do not enroll for coverage within the required number of days after your eligibility date, or if you disenroll, and later file an enrollment application, your

coverage may not begin until six months following the date you filed the enrollment application.

5. You have a change in family status through marriage or establishment of a domestic partnership. You may also enroll a new *spouse* or *domestic partner* at that time. You must enroll within the required number of days of the marriage or establishment of the domestic partnership.
6. You meet or exceed a lifetime limit on all benefits under another health plan. Application must be made within 31 days of the date a claim or a portion of a claim is denied due to your meeting or exceeding the lifetime limit on all benefits under the other plan.
7. You become eligible for assistance, with respect to the cost of coverage under the employer's group *plan*, under a state Medicaid or SCHIP health plan, including any waiver or demonstration project conducted under or in relation to these plans. You must properly file an application with the *group* within 60 days after the date you are determined to be eligible for this assistance.

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

HOW COVERAGE ENDS

Your coverage under the agreement can be cancelled immediately upon written notice by us if we learn that you do not have coverage under both Part A and Part B of *Medicare*. You are responsible for notifying us if you do not have, or lose, coverage under either Part A or Part B of *Medicare*.

Additionally, your coverage ends without notice from us as provided below:

1. If the *agreement* terminates, your coverage ends at the same time. This *agreement* may be canceled or changed without notice to you.
2. If the *group* no longer provides coverage for the class of *members* to which you belong, your coverage ends on the effective date of that change. If the *agreement* is amended to delete coverage for the *spouse* or *domestic partner*, the *spouse's* or *domestic partner's* coverage ends on the effective date of that change.
3. Coverage for the *spouse* or *domestic partner* ends when the *subscriber's* coverage ends.

4. Coverage ends at the end of the period for which subscription charges have been paid to us on your behalf when the required subscription charges for the next period are not paid.
5. If you voluntarily cancel coverage at any time, coverage ends on the subscription charge due date coinciding with or following the date of voluntary cancellation, as provided by written notice to us.
6. If you no longer meet the requirements set forth in the "Eligible Status" provision of HOW COVERAGE BEGINS, your coverage ends as of the subscription charge due date coinciding with or following the date you cease to meet such requirements.

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

You may be entitled to continued benefits under terms which are specified elsewhere under CONTINUATION OF COVERAGE and EXTENSION OF BENEFITS.

Unfair Termination of Coverage. If you believe that your coverage has been or will be improperly terminated, you may file a grievance with us in accordance with the procedures described in the section entitled GRIEVANCE PROCEDURES. You should file your grievance as soon as possible after you receive notice that your coverage will end. You may also request a review of the matter by the Director of the Department of Managed Health Care. If your coverage is still in effect when you submit a grievance, we will continue to provide coverage to you under the terms of this *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 for non-payment of subscription charges). If your coverage is maintained in force pending outcome of the review, subscription charges must still be paid to us on your behalf.

CONTINUATION OF COVERAGE

LACERA is subject to the federal law which governs this provision (Title X of P. L. 99-272), you may be entitled to a continuation of coverage. Check with your employer for details.

DEFINITIONS

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

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

Qualified Beneficiary means a person enrolled for this COBRA continuation coverage who, on the day before the Qualifying Event, was covered under this *agreement* as either a *subscriber* or enrolled *spouse*. Qualified Beneficiary does not include any person who was not enrolled during the Initial Enrollment Period, including a *spouse* acquired during the COBRA continuation period. It does not include domestic partners if they are eligible under HOW COVERAGE BEGINS AND ENDS.

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

1. **For Retired Employees and the Spouse.** Cancellation or a substantial reduction of retiree benefits under the *plan* due to the *group's* filing for Chapter 11 bankruptcy, provided that:
 - a. The *agreement* expressly includes coverage for retirees; and
 - b. Such cancellation or reduction of benefits occurs within one year before or after the *group's* filing for bankruptcy.
2. **For the Spouse:**
 - a. The death of the *subscriber*; or
 - b. The *spouse's* divorce or legal separation from the *subscriber*.

ELIGIBILITY FOR COBRA CONTINUATION

A *subscriber* or enrolled *spouse* may choose to continue coverage under the *agreement* if coverage would otherwise end due to a Qualifying Event.

TERMS OF COBRA CONTINUATION

Notice. The *group* or its administrator (we are not the administrator) will notify either the *subscriber* or *spouse* of the right to continue coverage under COBRA, as provided below:

1. For Qualifying Events 1 or 2, the *group* or its administrator will notify the *subscriber* of the right to continue coverage.
2. For Qualifying Event 3(a), the *spouse* will be notified of the COBRA continuation right.
3. You must inform the *group* within 60 days of Qualifying Event 3(b) if you wish to continue coverage. The *group* in turn will promptly give you official notice of the COBRA continuation right.

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

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

Notice of continued coverage, along with the initial subscription charge, must be delivered to us by the *group* within 45 days after you elect COBRA continuation coverage.

Additional Family Members. A *spouse* acquired during the COBRA continuation period is eligible to be enrolled, provided that the *spouse* meets the eligibility requirements specified in HOW COVERAGE BEGINS. The standard enrollment provisions of the *agreement* apply to enrollees during the COBRA continuation period.

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

Besides applying to the *subscriber*, the *subscriber's* rate also applies to a *spouse* whose COBRA continuation began due to divorce, separation or death of the *subscriber*.

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

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

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

For a *spouse* properly enrolled during the COBRA continuation, coverage begins according to the enrollment provisions of the *agreement*.

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

1. The end of 18 months from the Qualifying Event, if the Qualifying Event was termination of employment or reduction in work hours;*
2. The end of 36 months from the Qualifying Event, if the Qualifying Event was the death of the *subscriber*, divorce or legal separation;*
3. The date the *agreement* terminates;
4. The end of the period for which subscription charges are last paid;
5. The date, following the election of COBRA, the *member* first becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a *pre-existing condition* of the *member*, in which case this COBRA continuation will end at the end of the period for which the *pre-existing condition* exclusion or limitation applied.

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

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

EXTENSION OF CONTINUATION DURING TOTAL DISABILITY

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

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

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

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

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

Cost of Coverage. For the 19th through 29th months that the total disability continues, the *group* must remit the cost for the extended

continuation coverage to us. This cost (called the "subscription charge") shall be subject to the following conditions:

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

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

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

1. The end of the month following a period of 30 days after the Social Security Administration's final determination that you are no longer totally disabled;
2. The end of 29 months from the Qualifying Event;
3. The date the *agreement* terminates;
4. The end of the period for which subscription charges are last paid;
5. The date, following the election of COBRA, the *member* first becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the *member*, in which case this COBRA extension will end at the end of the period for which the pre-existing condition exclusion or limitation applied.

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

EXTENSION OF BENEFITS

If you are a *totally disabled retiree* or a *totally disabled family member* and under the treatment of a *physician* on the date of discontinuance of the *agreement*, your benefits will be continued for treatment of the totally disabling condition. This extension of benefits is subject to the following conditions:

1. If you are confined as an inpatient in a *hospital* or *skilled nursing facility*, you are considered totally disabled as long as the inpatient *stay* is *medically necessary*, and no written certification of the total disability is required. If you are discharged from the *hospital* or *skilled nursing facility*, you may continue your total disability benefits by submitting written certification by your *physician* of the total disability within 90 days of the date of your discharge. Thereafter, we must receive proof of your continuing total disability at least once every 90 days while benefits are extended.
2. If you are not confined as an inpatient but wish to apply for total disability benefits, you must do so by submitting written certification by your *physician* of the total disability. We must receive this certification within 90 days of the date coverage ends under this *plan*. At least once every 90 days while benefits are extended, we must receive proof that your total disability is continuing.
3. Your extension of benefits will end when any one of the following circumstances occurs:
 - a. You are no longer totally disabled.
 - b. The maximum benefits available to you under this *plan* are paid.
 - c. You become covered under another group health plan that provides benefits without limitation for your disabling condition.
 - d. A period of up to 12 months has passed since your extension began.

GENERAL PROVISIONS

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

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

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

Terms of Coverage

1. In order for you to be entitled to benefits under the *agreement*, both the *agreement* and your coverage under the *agreement* must be in effect on the date the expense giving rise to a claim for benefits is incurred.
2. The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date you receive the service or supply for which the charge is made.
3. The *agreement* is subject to amendment, modification or termination according to the provisions of the *agreement* without your consent or concurrence.

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

Protection of Coverage. We do not have the right to cancel your coverage under this *plan* while: (1) this *plan* is still in effect; and (2) you are eligible; and (3) your subscription charges are paid according to the terms of the *agreement*.

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

state and local laws. However, your choice may affect the benefits payable according to this *plan*.

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

Availability of Care. If there is an epidemic or public disaster and you cannot obtain care for covered services, we refund the unearned part of the subscription charge paid for you. A written request for that refund and satisfactory proof of the need for care must be sent to us within 31 days. This payment fulfills our obligation under this *plan*.

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

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

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

Notice of Claim. You or the provider of service must send properly and fully completed claim forms to us within 90 days of the date you receive the service or supply for which a claim is made. Services received and charges for the services must be itemized, and clearly and accurately described. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 24 months will be allowed. We are not liable for the benefits of the *agreement* if you do not file claims within the required time period. Claim forms must be used; canceled checks or receipts are not acceptable.

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

Payment to Providers. We will pay the benefits of this *plan* directly to *contracting hospitals*, *participating providers* and medical transportation providers. Also, we will pay *non-contracting hospitals* and other providers of service directly when you assign benefits in writing. If you are a MediCal

beneficiary and you assign benefits in writing to the State Department of Health Services, we will pay the benefits of this *plan* to the State Department of Health Services. These payments will fulfill our obligation to you for those covered services.

Care Coordination. We pay *participating providers* in various ways to provide covered services to you. For example, sometimes we may pay *participating providers* a separate amount for each covered service they provide. We may also pay them one amount for all covered services related to treatment of a medical condition. Other times, we may pay a periodic, fixed pre-determined amount to cover the costs of covered services. In addition, we may pay *participating providers* financial incentives or other amounts to help improve quality of care and/or promote the delivery of health care services in a cost-efficient manner, or compensate *participating providers* for coordination of your care. In some instances, *participating providers* may be required to make payment to us because they did not meet certain standards. You do not share in any payments made by *participating providers* to us under these programs.

Right of Recovery. Whenever payment has been made in error, we will have the right to make appropriate adjustment to claims, recover such payment 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.

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

Worker's Compensation Insurance. The *agreement* does not affect any requirement for coverage by worker's compensation insurance. It also does not replace that insurance.

Prepayment Fees. LACERA is responsible for paying subscription charges to us for all coverage provided to you and your eligible *spouse* or *domestic partner*. LACERA may require that you contribute all or part of the costs of these subscription charges. You should consult LACERA for details.

Liability of Subscriber to Pay Providers. In accordance with California law, you will not be required to pay any *participating provider* any amounts we owe to that provider (not including co-payments or deductibles), even in the unlikely event that we fail to pay that provider. You may be liable, however, to pay *non-participating providers* or *other health care providers* any amounts not paid to them by us.

Renewal Provisions. LACERA's health plan *agreement* with us is subject to renewal at certain intervals. We may change the subscription charges or other terms of the *plan* from time to time.

Entitlement to Medicare Benefits. We have the right to require that you furnish information concerning your entitlement to *Medicare* benefits. We may need this information to determine your eligibility under the *agreement* and to process your claims.

Public Policy Participation. We have established a Public Policy Committee (that we call our Consumer Relations Committee) to advise our Board of Directors. This Committee advises the Board about how to assure the comfort, dignity, and convenience of the people we cover. The Committee consists of members covered by our health plan, participating providers and a member of our Board of Directors. The Committee may review our financial information and information about the nature, volume,

and resolution of the complaints we receive. The Consumer Relations Committee reports directly to our Board.

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.

Financial Arrangements with Providers. Anthem or an affiliate has contracts with certain health care providers and suppliers (hereafter referred to together as “Providers”) for the provision of and payment for health care services rendered to its *subscribers* and *members/insured* persons entitled to health care benefits under individual certificates and group policies or contracts to which Anthem or an affiliate is a party, including all persons covered under the *agreement*.

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

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

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

We may release your medical information to professional peer review organizations and to the *group* for purposes of reporting claims experience or conducting an audit of our operations, provided the information disclosed is reasonably necessary for the *group* to conduct 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 Technology Assessment. Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria is used to determine the investigational status or medical necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 physicians from various medical specialties including Anthem's medical directors, physicians in academic medicine and physicians in private practice. Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to *medical necessity* criteria used to determine whether a procedure, service, supply or equipment is covered.

BINDING 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 BINDING ARBITRATION provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, state law governing agreements to arbitrate shall apply.

The *member* and 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, P.O. Box 4310, Woodland Hills, CA 91365-4310 marked to the attention of the Member Services Department listed on your identification card.

NOTE: If you wish to appeal a decision made by *Medicare* and not by us, you must initiate the appeal process by contacting your local Social Security Administration office.

DEFINITIONS

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

Agreement is the Group Benefit Agreement issued by us to the *group*.

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

Benefit period, as defined by *Medicare* for inpatient *hospital* and *skilled nursing facility* services (Part A), begins when you first enter a *hospital* after your *Medicare* insurance begins. In no event will a new benefit period start until you have been discharged and have remained out of the *hospital* or other facility as an inpatient for at least 60 consecutive days. For medical services (Part B), Benefit period is defined as a calendar year.

Contracting hospital is a hospital which has a Standard Hospital Contract with us to provide care to you.

Cosmetic services are services or surgery performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance.

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

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

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

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

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

Emergency or Emergency Medical Condition means a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity including severe pain such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient's health or the health of another person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency includes being in active labor when there is inadequate time for a safe transfer to another *hospital* prior to delivery, or when such a transfer would pose a threat to the health and safety of the *member* or unborn child.

An *emergency medical condition* includes a *psychiatric emergency medical condition*, which is a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following: a) an immediate danger to himself or herself or to others, or b) immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

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

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

Family member means the *subscriber's* enrolled *spouse* or *domestic partner*.

Group refers to the business entity to which we have issued this *agreement*. The name of the group is LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION (LACERA).

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

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

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

Medically necessary services, procedures, equipment or supplies are those which are:

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease;
3. Provided for the diagnosis or direct care and treatment of the medical condition;
4. Within standards of good medical practice within the organized medical community;
5. Not primarily for your convenience, or the convenience of your *physician* or another provider;
6. Not more costly than an equivalent service or sequence of services that is medically appropriate and is likely to produce equivalent therapeutic or diagnostic results in regard to the diagnosis or treatment of the patient's illness, injury, or condition; and
7. The most appropriate procedure, supply, equipment or service which can safely be provided.

NOTE: We will accept *Medicare's* determination of medical necessity.

Medicare is the name commonly used to describe "Health Insurance Benefits for the Aged and Disabled" provided under Public Law 89-97 and its amendments.

Medicare co-payment is that portion of the Medicare approved amount not paid by Medicare for covered inpatient *hospital* days, lifetime reserve days, *skilled nursing facility* days and Professional (Part B) services, not including amounts applied to the Part A or Part B deductibles. Medicare may increase the co-payment amounts for certain services.

Member is the *subscriber* or covered *spouse* or *domestic partner* of the *subscriber*.

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

Network pharmacy is a *pharmacy* or drug store which has entered into a service agreement with CVS Caremark to provide benefits under the plan at specified rates for members covered under the plan.

Note. You are outside of the network pharmacy area if there is no network pharmacy within 10 miles of your address of record with LACERA.

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

Non-network pharmacy is a *pharmacy* or drug store which has NOT entered into a service agreement with CVS Caremark to provide benefits under the plan at specified rates for members covered under the plan.

Pharmacy means a licensed retail *pharmacy*.

Physician means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or
2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license and such license is required to render that service, and is providing a service for which benefits are specified in this booklet:
 - A dentist (D.D.S. or D.M.D.)
 - An optometrist (O.D.)
 - A dispensing optician
 - A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
 - A licensed clinical psychologist
 - A chiropractor (D.C.)
 - A licensed clinical social worker (L.C.S.W.)
 - A marriage and family therapist (M.F.T.)
 - A licensed professional clinical counselor (L.P.C.C.)*
 - A physical therapist (P.T. or R.P.T.)*
 - A speech pathologist*

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

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

Plan is the set of benefits described in this booklet and in the amendments to this booklet, if any. This plan is subject to the terms and conditions of the *agreement* we have issued to the *group*. If changes are made to the plan, an amendment or revised booklet will be issued to the *group* for distribution to each *subscriber* affected by the change. (The word "plan" here does not mean the same as plan as used in ERISA).

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

Prescription drug specified rate is the rate that CVS Caremark has negotiated with *network pharmacies* under a network pharmacy Agreement for *prescription drug covered expense*. *Network pharmacies* have agreed to charge *members* no more than the prescription drug specified rate. It is also the rate which CVS Caremark Prescription Mail Service has agreed to accept as payment in full for mail service *prescription drugs*.

Prior plan is a plan sponsored by the *group* which was replaced by this *plan* within 60 days. You are considered covered under the prior plan if you: (1) were covered under the prior plan on the date that plan terminated; (2) properly enrolled for coverage within 31 days of this *plan's*

effective date; and (3) had coverage terminate solely due to the prior plan's termination.

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

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

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

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

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

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

Retiree is a former *full-time employee* who meets the eligibility requirements described in the "Eligible Status" provision in HOW COVERAGE BEGINS AND ENDS.

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

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

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

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

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

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

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

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

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

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

United States means all the States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, the Northern Mariana Islands, Guam and American Samoa.

We (us, our) refers to Anthem Blue Cross.

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

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

GRIEVANCE PROCEDURES

We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your *plan* or a service you have received. If you have a question or complaint about your eligibility, (including if you believe your coverage under this *plan* has been or will be improperly terminated), your benefits under this *plan*, a *participating provider*, concerning a claim, or about us, please call the telephone number listed on your identification card, or you may write to us (please address your correspondence to Anthem Blue Cross, P.O. Box 4310, Woodland Hills, CA 91365-4310 marked to the attention of the Member Services Department listed on your identification card). Our Member Services staff will answer your questions or assist you in resolving your issue.

If you are not satisfied with the resolution based on your initial inquiry, you may request a copy of the Plan Grievance Form from the Member Services representative. You may complete and return the form to us, or ask the Member Services representative to complete the form for you over the telephone. You may also submit a grievance to us online or print the Plan Grievance Form through the Anthem Blue Cross website at www.anthem.com/ca. You must submit your grievance to us no later than 180 days following the date you receive a denial notice from us or any other incident or action with which you are dissatisfied. Your issue will then become part of our formal grievance process and will be resolved accordingly.

All grievances received by us will be acknowledged in writing, together with a description of how we propose to resolve the grievance. After we have reviewed your grievance, we will send you a written statement on its resolution within 30 days. If your case is urgent and involves an imminent threat to your health, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, review of your grievance will be expedited and resolved within three days. You have the right to review all documents that are part of your grievance file and to present evidence and testimony as part of the grievance process.

If, after our denial, we consider, rely on or generate any new or additional evidence in connection with your claim, we will provide you with that new or additional evidence, free of charge. We will not base our appeal decision on a new or additional rationale without first providing you (free of charge) with, and a reasonable opportunity to respond to, any such new or additional rationale. If we fail to follow the appeal procedures outlined under this section the appeals process may be deemed exhausted. However, the appeals process will not be deemed exhausted due to minor violations that do not cause, and are not likely to cause, prejudice or harm

so long as the error was for good cause or due to matters beyond our control.

If you are dissatisfied with the resolution of your grievance, or if your grievance has not been resolved after at least 30 days (or within three days for urgent cases), you may submit your grievance to the California Department of Managed Health Care for review prior to binding arbitration (see DEPARTMENT OF MANAGED HEALTH CARE). If your case is urgent and involves an imminent threat to your health, as described above, you are not required to complete our grievance process or to wait at least 30 days, but may immediately submit your grievance to the Department of Managed Health Care (DMHC) for review. If your grievance concerns the termination of your coverage, you may also immediately submit your grievance to the DMHC if the DMHC determines your grievance requires immediate review.

If your grievance concerns the termination of your coverage and your coverage is still in effect when you submit a grievance, we will continue to provide coverage to you under the terms of this *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. (Note: This does not apply if your coverage is cancelled due to non-payment of subscription charges.) If your coverage is maintained in force pending outcome of the review, subscription charges must still be paid to us on your behalf. If your coverage has already ended when you submit the grievance, your coverage will not be maintained. If the Director of the Department of Managed Health Care determines that your coverage should not have been terminated, we will reinstate your coverage back to the date it was terminated. Subscription charges must be paid current to us on your behalf from the date coverage is reinstated.

If at the conclusion of review of your grievance by the Department of Managed Health Care you continue to be dissatisfied with its resolution, or prior to and instead of review of your case by the Department of Managed Health Care, your remedy may be binding arbitration (see BINDING ARBITRATION).

Questions about your prescription drug coverage. If you have outpatient *prescription drug* coverage and you have questions or concerns, you may call the Pharmacy Member Services number listed on your ID card. If you are dissatisfied with the resolution of your inquiry and want to file a grievance, you may write to us at the address listed above and follow the formal grievance process.

Independent Medical Review of Denials of Experimental or Investigative Treatment

If coverage for a proposed treatment is denied because we determine that the treatment is *experimental* or *investigative*, you may ask that the denial be reviewed by an external independent medical review organization contracting with the Department of Managed Health Care ("DMHC"). Your request for this review may be submitted 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 forfeit 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 request this review with any grievance disposition letter denying coverage for this reason. You may also request an application form, by calling us at the telephone number listed on your identification card or write to us at Anthem Blue Cross, 21215 Burbank Blvd., 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, described as follows:
 - ◆ A life-threatening condition is a condition or disease where the likelihood of death is high unless the course of the disease is interrupted or a condition or disease with a potentially fatal outcome where the end point of clinical intervention is the patient's survival.
 - ◆ A seriously debilitating condition is a disease or condition that causes major, irreversible morbidity.
- Your *physician* 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 a *participating 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 *physician* 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:

- a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized standards;
- b) Medical literature meeting the criteria of the National Institutes 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);
- c) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;
- d) Either of the following: (i) The American Hospital Formulary Service's Drug Information, or (ii) the American Dental Association Accepted Dental Therapeutics;
- e) 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;
- f) 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
- g) 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 request 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 *physician*. Any newly developed or discovered relevant medical records identified by us or by a *participating provider* 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 *physician* 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 grievance process (see GRIEVANCE PROCEDURES).

Independent Medical Review of Grievances Involving a Disputed Health Care Service

You may request an independent medical review (“IMR”) of disputed health care services from the Department of Managed Health Care (“DMHC”) if you believe that we have improperly denied, modified, or delayed health care services. A “disputed health care service” is any health care service eligible for coverage and payment under your *plan* that has been denied, modified, or delayed by us, in whole or in part because the service is not *medically necessary*.

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

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

1. One or more of the following conditions has been met:
 - (a) Your provider has recommended a health care service as *medically necessary*,

- (b) You have received *urgent care* or *emergency services* that a provider determined was *medically necessary*, or
 - (c) You have been seen by a *participating provider* for the diagnosis or treatment of the medical condition for which you seek independent review;
2. The disputed health care service has been denied, modified, or delayed by us, based in whole or in part on a decision that the health care service is not *medically necessary*; and
 3. You have filed a grievance with us and the disputed decision is upheld or the grievance remains unresolved after 30 days. If your grievance requires expedited review you need not participate in our grievance process for more than three days. The DMHC may waive the requirement that you follow our grievance 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 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.

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 receive a copy of the assessment made in your case. If the IMR determines the service is *medically necessary*, we will provide benefits for the health care service.

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

For more information regarding the IMR process, or to request an application form, please call us at the Member Services telephone number listed on your ID card.

Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at the **telephone number listed on your identification card** and use your health plan's grievance process before contacting the department. Utilizing this

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

FOR YOUR INFORMATION

ORGAN DONATION

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

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

Organ and tissue donations may be used for transplants and medical research. Today it is possible to transplant more than 25 different organs and tissues. 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. Obtain a donor card from the Department of Motor Vehicles. Be sure to sign the donor card and keep it with your driver's license or identification card.

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

LANGUAGE ASSISTANCE PROGRAM

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

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

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

- Spanish
- Chinese
- Vietnamese
- Korean
- Tagalog

Oral interpretation services are available in additional languages.

Requesting a written or oral translation is easy. Just contact Member Services by calling the phone number on your ID card to update your language preference to receive future translated documents or to request interpretation assistance. Anthem Blue Cross 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.

IDENTITY PROTECTION SERVICES

Identity protection services are available with our Anthem health plans. To learn more about these services, please visit www.anthem.com/resources.



Get help in your language

Language Assistance Services

Curious to know what all this says? We would be too. Here's the English version:

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish

IMPORTANTE: ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

Arabic

مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم 1-888-254-2721 (TTY/TDD: 711).

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Armenian

ՈՒՇԱԴԴՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

Chinese

重要事項：您能看懂這封信函嗎？如果您看不懂，我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助，請立即撥打1-888-254-2721。(TTY/TDD: 711)

Farsi

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید. (TTY/TDD: 711)

Hindi

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

Hmong

TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Japanese

重要: この書簡を読めますか? もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。1-888-254-2721 (TTY/TDD: 711)

Khmer

សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចឱ្យនរណាម្នាក់អានវាជូនអ្នក។ អ្នកក៏អាចទទួលលិខិតនេះដោយសរសេរជាភាសារបស់អ្នកផងដែរ។ ដើម្បីទទួលបានជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅលេខ 1-888-254-2721។ (TTY/TDD: 711)

Korean

중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오. (TTY/TDD: 711)

Punjabi

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵਧੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਫੋਰਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian

ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Tagalog

MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai

หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้ เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้ ท่านยังอาจให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่หมายเลข 1-888-254-2721 (TTY/TDD: 711)

Vietnamese

QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (TTY/TDD: 711)

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279 or by email to compliance.coordinator@anthem.com. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.