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SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF LOS ANGELES

JANE BLUMENFELD, an individual,

Plaintiff,

vs.

BLUE CROSS OF CALIFORNIA, dba ANTHEM BLUE CROSS, a California corporation; ANTHEM HOLDING CORP., formerly known as WELLPOINT HEALTH NETWORKS, INC., a Delaware corporation; ANTHEM UM SERVICES, INC., an Indiana corporation; ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY formerly known as BC LIFE & HEALTH INSURANCE COMPANY, a California corporation; and DOES 1 through 100, inclusive,

Defendants.

Case No.: BC 582101

COMPLAINT AND DEMAND FOR JURY TRIAL

1. BREACH OF THE IMPLIED COVENANT OF GOOD FAITH AND FAIR DEALING
2. BREACH OF CONTRACT
3. NEGLIGENT INFLICTION OF EMOTIONAL DISTRESS
4. INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS
5. VIOLATIONS OF BUSINESS & PROFESSIONS CODE §17200, *ET SEQ.* FOR UNLAWFUL, UNFAIR, AND FRAUDULENT CONDUCT

I.

INTRODUCTION

1. Blue Cross of California, dba Anthem Blue Cross (Blue Cross) sells and markets its insurance products to millions of vulnerable consumers in California, and across the nation, who have the right to rely on Blue Cross to handle their health insurance claims with the utmost good faith.

2. The privilege of selling insurance in California imposes solemn, obligatory responsibilities on insurers such as Blue Cross to promptly, thoroughly, and fairly conduct balanced investigations of claims for benefits made by their insureds.

3. In discharging this responsibility, Blue Cross is required to:

- Give as much consideration to the interests of its insureds as it does to its own; and
- Search diligently for any and all facts that support the payment of the claim for benefits.

4. Despite these solemn obligations, Blue Cross is engaged in an unremediated pattern and practice of unreasonable and egregious claims investigation procedures, particularly regarding Hepatitis C patients in stages F0, F1, or F2 such as Plaintiff Jane Blumenfeld ("Jane" or "plaintiff"). Blue Cross's systematic violations of California law include repeatedly ignoring treating physicians' recommendations and using undisclosed criteria at variance with the Evidence of Coverage ("EOC"), which violates well-established standards in California. This conduct has not only caused harm to Jane in this action, but to millions of other Californians similarly situated.

5. In December 2000, Jane tried to donate blood at Cedars-Sinai and was then notified that she had chronic Hepatitis C. Hepatitis C is a contagious liver disease that is transmitted through contact with an infected person's blood. Hepatitis C leads to serious health complications including severe liver damage, infections, liver cancer, and death. In fact, Hepatitis C is the leading cause of cirrhosis—a disease in which healthy liver tissue is replaced with scar tissue, which prevents the liver from functioning

properly and can lead to liver failure—and liver cancer in the United States. Even before liver deterioration, those with Hepatitis C can suffer other health issues including a higher risk of heart attack, fatigue, depression, joint pain, itchy skin, fever, sore muscles, arthritis, and jaundice.

6. Following her diagnosis, Jane began extensive research to locate the best hepatologist in California. Jane finally found Steven-Huy Han, M.D. of UCLA's Pfleger Liver Institute. On February 1, 2001, Jane began treating with Dr. Han and at his instruction received quarterly blood work for one year, then semi-annual blood work for another year, and thereafter annual blood work to track the progress of the disease. Jane quickly learned that there were no available Hepatitis C treatment options.

7. In or about 2010, Jane began experiencing chronic fatigue and joint pain.

8. In 2012, the U.S. Food and Drug Administration approved a three-drug treatment containing boceprevir, interferon, and ribavirin. This was the first available Hepatitis C treatment. At that time, the standard of care in the medical community for treating Hepatitis C patients was this three-drug treatment, at a cost of $170,000. The treatment provided a cure rate of approximately 70-75% but came with tremendous adverse side effects including, anemia, insomnia, anxiety, depression, and memory loss.

9. Dr. Han immediately prescribed the three-drug treatment for Jane. Desperate for a cure, Jane began, and continued the treatment despite the unbearable side effects. After 8 weeks of treatment, Jane's viral load—the amount of the Hepatitis C virus present in her blood—was reduced from 12.8 million to 1,590. Unfortunately, because the virus was still detectable, she was forced to terminate the medication under the governing medical standards.

10. The eight weeks of this treatment were the most excruciating days of Jane's life. For fifty-six days she experienced devastating side effects including anemia, depression, headaches, and insomnia.

11. Following the three-drug therapy, Jane's viral load increased drastically from 1,590 to 38.5 million. Dr. Han and Jane remained hopeful that more treatment options with fewer side effects would become available in the future.

12. Just two years later, in October 2014, the U.S. Food and Drug Administration approved Harvoni, a prescription drug that dramatically changes the lives of those infected with Hepatitis C. Harvoni is a once daily tablet that can cure Hepatitis C in as little as eight weeks with few side effects. In clinical studies, 95-99% of Hepatitis C patients were cured with just eight to twelve weeks of Harvoni treatments. Since 2014, the standard of care in the medical community for treating Hepatitis C patients is Harvoni at a cost of $99,000 for a 12-week treatment with little to no harmful side effects.

13. On October 13, 2014, Dr. Han prescribed Harvoni for Jane and promptly requested authorization from Blue Cross for the medication.

14. Within one week, on October 20, 2014, Blue Cross denied coverage for Harvoni claiming the medication was "not medically necessary" for Jane. Blue Cross stated that it needed additional information in order to approve her request for Harvoni, including, if she currently has scarring in her liver. (Exhibit 3.)

15. Jane was shocked by the denial, and could not comprehend why Blue Cross would deny her access to a proven cure, particularly since she had previously approved and paid for the three-drug treatment that costs $170,000. Jane and Dr. Han appealed Blue Cross' October 20, 2014 denial.

16. Jane would later learn that Blue Cross only approves Harvoni for those insureds with severe liver deterioration. One of the manifestations of Hepatitis C is fibrosis, which is the first stage of liver scarring. The degree of fibrosis varies and is described in several stages from F0 to F4. A normal liver is designated as stages F0 or F1. Stage F3 is reserved for individuals suffering from severe fibrosis and those with cirrhosis are designated as stage F4. Although Harvoni is a proven cure for those in all stages of fibrosis, Blue Cross, without explanation or medical support, has restricted

access to the cure to only those insureds in stages 3 and 4. But cirrhosis—fibrosis stage 4—is largely irreversible and has debilitating symptoms, including dementia. Thus, even if Harvoni cures a patient's Hepatitis C, that patient can remain very sick if they wait to cure their Hepatitis C until they have cirrhosis.

17. On November 19, 2014, Blue Cross wrote a letter to Jane, with a copy to Dr. Han, asking for her provider to send additional extensive documentation. (Exhibit 4.) Two weeks later, on December 3, 2014, Blue Cross issued a second denial letter again on the basis that Harvoni was not medically necessary for Jane because her liver did not yet have enough scarring to be considered Stage 3 or higher. (Exhibit 5.)

18. On January 8, 2015, Blue Cross upheld its denial on appeal stating again that it could not approve Harvoni for Jane because the medical records did not show that she had advanced scarring on her liver. (Exhibit 8.)

19. On March 3, 2015, Dr. Han wrote to Blue Cross requesting that it reconsider its denial of coverage. Dr. Han explained why the treatment was medically necessary for Jane as that term is defined in Blue Cross's own Evidence of Coverage (EOC). Dr. Han also explained that Jane's maternal grandmother died of liver cancer, and Jane thus carries an increased risk of developing liver cancer. (Exhibit 9.) Dr. Han detailed Jane's medical status and risks of further progression of the disease. (*Id.*)

20. Less than two weeks later, on March 12, 2015, Jane wrote to Blue Cross, also requesting that it reconsider its position. Jane explained that living with chronic Hepatitis C "means living with the daily fear and anxiety that results from never knowing if today will be the day that asymptomatic Hepatitis C turns into a catastrophic illness that might be too late to treat." (Exhibit 10.)

21. In a letter dated April 15, 2015, Blue Cross refused to reconsider its decision, claiming that there was no new pertinent medical information provided despite Dr. Han's two-page letter. (Exhibit 12.)

22. As a result of Blue Cross's unreasonable denials, Jane has been unable to begin the Harvoni treatment which would cure her deadly, contagious disease. Jane

lives each day with the anxiety of not knowing when she will develop cirrhosis or liver cancer as a result of her Hepatitis C. Thus, Jane has sustained damages including personal physical injuries, physical sickness, physical disability, economic damages, severe emotional distress, and attorney's fees.

II.

THE PARTIES

23. Plaintiff Jane, an individual, is and at all relevant times was, a resident of the State of California, County of Los Angeles, City of Los Angeles.

24. Defendant Blue Cross of California, dba Anthem Blue Cross ("Blue Cross") is, and at all relevant times was, a corporation duly organized and existing under the laws of the State of California and is authorized to transact, and is transacting, the business of insurance in the State of California, with its principle place of business in the County of Los Angeles. Plaintiff further alleges that Blue Cross is a wholly-owned subsidiary of Anthem Holding Corp., formerly known as Wellpoint Health Networks, Inc.

25. Plaintiff is informed and believes and thereon alleges that Anthem Holding Corp., formerly known as Wellpoint Health Network, Inc. ("Anthem") is, and at all relevant times was, a corporation duly organized and existing under the laws of the State of Delaware, and is authorized to transact and is transacting the business of insurance in the State of California, with its headquarters in Indianapolis, Indiana.

26. Plaintiff is informed and believes and thereon alleges that Anthem UM Service, Inc. ("Anthem UM") is, and at all relevant times was, a corporation duly organized and existing under the laws of the State of Indiana, and is authorized to transact and transacting the business of insurance in the State of California, with its headquarters in Indianapolis, Indiana.

27. Plaintiff is informed and believes and thereon alleges that Anthem Blue Cross Life and Health Insurance Company, formerly known as BC Life & Health

Insurance Company ("Anthem Blue Cross") is, and at all relevant times was, a corporation duly organized and existing under the laws of the State of California, and is authorized to transact and transacting the business of insurance in the State of California, with its headquarters in Indianapolis, Indiana.

28. Plaintiff alleges on information and belief that profits made on policies issued by Blue Cross and Anthem Blue Cross are shared with Anthem and Anthem UM. Blue Cross and Anthem Blue Cross are backed by the financial strength of Anthem and Anthem UM. Anthem and Anthem UM provide a host of services to Blue Cross and Anthem Blue Cross, including regulatory compliance, accounting, marketing, and personnel. Anthem and Anthem UM operate through various subsidiaries in various states; and these subsidiaries, including Blue Cross and Anthem Blue Cross, are mere conduits that allow Anthem and Anthem UM to conduct business in those states.

29. Plaintiff alleges on information and belief that Anthem and Anthem UM owned, operated, managed, maintained, and controlled the activities of Blue Cross and Anthem Blue Cross. Therefore, in reality, the activities, acts, and omissions of Blue Cross and Anthem Blue Cross are and were the activities, acts, and omissions of Anthem and Anthem UM. Blue Cross, Anthem UM, Anthem Blue Cross, and Anthem will be collectively referred to herein in the singular as Blue Cross.

30. The true names or capacities, whether individual, corporate, associate, or otherwise, of defendants DOES 1 through 100, inclusive, are unknown to plaintiff, who therefore sues said defendants by such fictitious names. Plaintiff is informed and believes and on such information and belief alleges that each of the defendants sued herein as a DOE is legally responsible in some manner for the events and happenings referred to herein, and will ask leave of this court to amend this complaint to insert their true names and capacities in place and instead of the fictitious names when the same become known to plaintiff.

31. Plaintiff is informed and believes and based thereon alleges that at all times mentioned herein, each of the defendants was the agent, partner, joint venturer,

associate and/or employee of one or more of the other defendants and was acting in the course and scope of such agency, partnership, joint venture, association and/or employment when the acts giving rise to the cause of action occurred.

III.

FACTUAL BACKGROUND

A. Jane's Blue Cross Plan

32. After a thirty-two year career, in 2010 Jane retired from her position with the City of Los Angeles. During the course of her career Jane worked for the Mayor, City Council, and Department of City Planning. Through her work with the City of Los Angeles, Jane acquired a Blue Cross PPO plan (the "Plan"). The Plan promises to provide coverage for medically necessary treatment in exchange for payment of premiums. A true and correct copy of the EOC is attached as Exhibit 1.

33. The Plan defines Medically necessary as follows:

> **Medically necessary** procedures, supplies, equipment, or services are those we determine to be:
>
> 1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
> 2. Provided for the diagnosis or direct care and treatment of the medical condition;
> 3. Within standards of good medical practice within the organized medical community;
> 4. Not primarily for your convenience, or for the convenience of your *physician* or another provider; and
> 5. The most appropriate procedure, supply, equipment, or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:
>   a. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or

complications, for you with the particular medical condition being treated than other possible alternatives; and

b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and

c. For *hospital stays*, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received by you as an outpatient or in a less intensified medical setting.

(Exhibit 1, pg. 119-120.)

B. Jane is diagnosed with Hepatitis C

34. In December 2000, Jane tried to donate blood to her mother-in-law, who was scheduled for surgery at Cedars-Sinai hospital. Shortly thereafter, Jane received a call from the Cedars-Sinai lab advising her that she had Hepatitis C. Jane was shocked and devastated by the diagnosis.

35. Hepatitis C was first discovered in 1990 and is a contagious virus that attacks the liver. It spreads primarily through contact with the blood of an infected person. In 1992, the United States began screening blood utilized in transplants and transfusions for the presence of contagious diseases including Hepatitis C. Before 1992, Hepatitis C was commonly spread through blood transfusions or transplant surgeries. Hepatitis C can also be transmitted from mothers to infants at birth.

36. Hepatitis C has six different genotypes, or virus classifications, based on the virus's genetic material in the RNA strands. Genotype 1 is the most common in the United States. It accounts for approximately 75% of Americans with the disease and is considered the most difficult genotype to treat. Jane has genotype 1 Hepatitis C. Genotypes 2 and 3 are less common, affecting approximately 20% of those with Hepatitis C, and are much easier to treat.

37. Due to its contagious nature, Hepatitis C has severe public health ramifications. It is estimated that more than three million individuals in the United

States are living with chronic Hepatitis C and it is estimated that 3% of the world's 7.2 billion population is infected with the disease. Approximately 15,000 people in the United States die each year due to liver disease caused by Hepatitis C. By 2000, Hepatitis C had infected almost 600,000 people in California alone, and another 5,000 Californians become infected with the virus each year.

38. Hepatitis C can lead to severe liver damage, infections, liver cancer, and even death. Even before liver deterioration, those with Hepatitis C can suffer other health issues including a higher risk of heart attack, fatigue, joint pain, depression, sore muscles, arthritis, and jaundice. Centers for Disease Control and Prevention statistics reveal that up to 70% of those with Hepatitis C will develop chronic liver disease, 20% will develop cirrhosis, and 5% will develop liver cancer.

39. Hepatitis C also leads to liver fibrosis, which is the first stage of liver scarring. The degree of fibrosis varies and is described in several stages from F0 to F4. A normal liver is designated as stages F0 or F1. Someone in stage F3 suffers from severe fibrosis and stage F4 indicates cirrhosis. But cirrhosis—stage 4—is largely irreversible and has debilitating symptoms, including dementia. Thus, even if Harvoni cures a patient's Hepatitis C, that patient can remain very sick if they wait to cure their Hepatitis C until they have cirrhosis.

C. The standard of care in the medical community to treat Hepatitis C in 2012

40. In January 2001, Jane found Steven-Huy Han, MD of UCLA's Pfleger Liver Institute. Dr. Han is board-certified in transplant hepatology and gastroenterology with a focus on treating viral hepatitis and preventing hepatitis C recurrence in post-liver transplant patients.

41. Jane first saw Dr. Han on February 1, 2001. At that time, Dr. Han prescribed quarterly blood tests for Jane to monitor her liver function and related organs. In 2002, Dr. Han reduced the frequency of the testing to semi-annually and in 2003 the

frequency was further reduced to once annually. Jane has continued to receive annual blood tests since 2003 to monitor her liver function and related organs.

42. By 2012, the FDA had approved a three-drug treatment containing boceprevir, interferon, and ribavirin. In 2012, the standard of care in the medical community for treating Hepatitis C patients was this three-drug treatment program. The overall cost of the three-drug treatment program was $170,000 and only provided a 70% cure rate. It came with tremendous adverse side effects, including anemia, insomnia, depression, diarrhea, and memory loss.

43. Consistent with the standard of care in the medical community at the time, Dr. Han prescribed the three-drug treatment for Jane and requested pre-authorization from Blue Cross. Blue Cross approved the treatment as medically necessary and Jane began this regimen in hopes for a cure despite the unbearable side effects. After eight weeks of treatment, Jane's viral load was drastically reduced from 12.8 million to 1,590. But because the virus was still detectable in her blood after eight weeks, she was forced to terminate the medication under the governing medical standards.

44. The eight weeks of this three-drug treatment was the most debilitating experience of Jane's life. For fifty-six days she experienced devastating side effects including anemia, severe depression, headaches, dizziness, and nausea. The severe depression and total depletion of energy (from a previously very high energy person) prevented her from doing almost any task. She was extremely tired, dizzy, and nauseous all of the time and frequently could only sit in a chair and read or watch movies for the entire day, dozing off and on and unable to move. She often did not have enough energy to even take a daily shower.

45. Jane experienced persistent and constant headaches, which were not relieved by aspirin or any other available product. After doing any activity for only a few minutes, she immediately became dizzy and nauseous. She had no appetite and was unable to eat most food; she began making protein smoothies in order to get

protein in her system. She could no longer continue her exercise program of daily aerobics and weight machines at the gym.

46. Jane ultimately joined a "hepatitis C triple drug therapy support group" set up by Dr. Han's office and run by Val Peacock, a social worker. The group exchanged information, particularly about foods, activities, and successful means people had found to cope with the severe effects of the medicines.

47. Jane also experienced pain in her eye at one point, which was especially difficult because she has keratoconus, a condition which requires that she wear contact lenses in order to see. Jane's vision is nearly 20/20 with two contact lenses in each eye, but can see almost nothing without the contact lenses. She cannot see with eye glasses, owns no eyeglasses, and therefore has no alternative to contact lenses. She was unable to wear her contact lenses for several days during this period, and even visited an urgent care facility at one point. Without contact lenses, Jane was unable to drive or do nearly anything else and was confined to her home.

48. During this treatment regimen, Jane experienced constant joint pain, particularly in her fingers and hands. After several weeks of the drugs, she discussed her symptoms with Ms. Peacock, who suggested taking a mood elevator. Dr. Han prescribed such a drug, which, after several weeks, began to alleviate some of the symptoms.

49. Following the three-drug therapy, Jane's viral load severely increased—from 1,590 to 38.5 million. Jane was living with daily pain and anxiety, and desperate for a cure.

D. The FDA approves a new cure for Hepatitis C—changing the standard of care in the medical community

50. In October 2014, the FDA approved Harvoni, a prescription drug that dramatically changes the lives of those infected with Hepatitis C. Harvoni is a once daily tablet that contains two drugs, ledipasvir and sofosbuvir, and can completely cure

the disease in just eight to twelve weeks. The length of the treatment depends on a patient's condition, particularly their viral load. If a patient has a viral load of more than 6 million, then they will remain on Harvoni for twelve weeks. If they have a viral load of less than 6 million, then they will remain on Harvoni for eight weeks. Harvoni has proven highly successful for those with Jane's genotype, genotype 1.

51. Since the FDA approval in 2014, the standard of care in the medical community for treating Hepatitis C patients is Harvoni, which provides a cure rate of 95%-99% at a cost of $99,000 for a 12-week treatment with little to no harmful side effects.

52. Harvoni's efficacy has been tested in three clinical trials consisting of more than 1,500 participants. In these trials, Harvoni cured 95-99% of patients within twelve weeks. In one study of 865 patients with genotype 1, 99% of individuals who received a twelve-week Harvoni regimen were "cured" and study participants were considered "cured" if the virus was not detected in the patients' blood three months after the conclusion of the last Harvoni treatment. Another study concerning an additional 440 Hepatitis C patients with genotype 1 who had failed prior treatments produced astounding results: within twelve weeks Harvoni cured 95% of patients without cirrhosis and after 24 weeks 100% of those with cirrhosis.

53. This revolutionary cure is not only far more effective than other treatment options, but eliminates the harmful side effects associated with other available treatments, such as the three-drug treatment regimen of boceprevir, interferon, and ribavirin, or the treatment regimen of Sovaldi, a prescription medication utilized in combination with ribavirin. Other treatment options result in severe, unbearable side effects such as nausea, fatigue, anemia, insomnia, anxiety, diarrhea, low red blood cell count, depression, memory loss, and muscle, joint, or bone pain. In contrast, the most severe common side effects associated with Harvoni are tiredness and headaches.

54. In light of its high success rate and minimal side effects, in 2014 Harvoni was designated by the FDA as a "breakthrough therapy." This designation is reserved

for drugs that have proven to provide "substantial improvement over available therapies for patients with serious or life-threatening diseases."

55. "The American Association for the Study of Liver Diseases (AASLD) is the leading organization of scientists and health care professionals committed to preventing and curing liver disease, and to promoting liver health and quality patient care." (A true and correct copy of an AASLD webpage printout regarding Hepatitis C is attached as Exhibit 2.) The AASLD adamantly disagrees with insurers', such as Blue Cross, decisions deny treatment when a treating physician has prescribed it on the basis that only patients suffering from Hepatitis C with fibrosis stages 3 or 4 are eligible. (Exhibit 2.)

56. Hepatitis C is only the second disease or condition for which a cure has been discovered in a single lifespan from the discovery of the disease or condition. Hepatitis C was discovered in 1990 and the cure arrived in 2014. Hepatitis C could be completely eradicated in the coming few years as a result of Harvoni, assuming patients, such as Jane, have access to this incredible cure.

E. Jane's treating doctor recommends that she begin Harvoni treatment immediately, but Blue Cross refuses to provide coverage for the cure

57. Jane's chronic fatigue and joint pain have persisted and worsened. Dr. Han believes that Jane can avoid future liver damage by undergoing a 12-week course of Harvoni treatment. Thus, on October 13, 2014, Dr. Han prescribed Harvoni for Jane and requested pre-authorization from Blue Cross.

58. In a letter dated October 20, 2014, Blue Cross denied coverage for Harvoni claiming the medication was "not medically necessary" for Jane. A true and correct copy of the October 20, 2014 denial letter is attached as Exhibit 3. Within this letter, Blue Cross stated that it needed additional information in order to approve Dr. Han's request for Harvoni for Jane, including, if she currently has scarring in her liver. (Exhibit 3, pg. 1.) The review was completed by Don Wentzel, M.D.

59. On information and belief, plaintiff alleges that Blue Cross's reviewers, such as Dr. Wentzel, receive approximately $45 per case reviewed regardless of the time spent investigating the claim or conducting the review. Thus, Blue Cross incentivizes the reviewers to complete the investigation and review claims as quickly as possible.

60. On information and belief, plaintiff further alleges that Dr. Wentzel, and all other Blue Cross reviewers, individually review approximately 550 cases per month. Thus, they review approximately 27.5 cases per day and spend approximately 17 minutes reviewing each case. (If they work 5 days per week for four weeks in a month (550 cases/20 days = 27.5 cases per day per month) and spend approximately 17 minutes reviewing each case (8 hours x 60 minutes = 480 minutes per day; 480 minutes per day/ 27.5 cases = 17.45 minutes per case).) Plaintiff also alleges on information and belief that Blue Cross pays the reviewers approximately $25,000 per month to conduct these cursory reviews.

61. Blue Cross's reviewers, such as Dr. Wentzel, routinely deny the majority of the claims that they review. Based on information and belief, the reviewers average a denial rating of 90% or higher.

F. Dr. Han appeals the denial, but Blue Cross refuses to overturn its decision

62. Jane and Dr. Han were shocked by the denial, and could not understand why Blue Cross would deny her access to a proven cure. They would later learn that Blue Cross only approves Harvoni for those with severe liver deterioration. Although Harvoni is a proven cure for those in all stages of fibrosis, Blue Cross, without explanation or medical support, has restricted access to the cure to only those in stages 3 and 4 fibrosis.

63. Jane and Dr. Han's office appealed Blue Cross' denial. In response, Blue Cross sent Jane a letter dated November 19, 2014, and copied Dr. Han's office, asking that she have Dr. Han's office send Blue Cross further extensive documentation. A true and correct copy of Blue Cross' letter is attached as Exhibit 4. Blue Cross claimed that it

did not have enough clinical information regarding Jane's health status to determine the medical necessity of Harvoni for her.

> In order to process your request, please ask your provider to send us documentation supporting the need for the medication because some or all of the information is lacking: specific diagnosis; documentation supporting the diagnosis and genotype; test results [genotype; baseline quantitative hepatitis C virus RNA; severity of fibrosis on liver biopsy or medical imaging and scale used; complete blood count, international normalized ratio, hepatic function panel, and glomerular filtration rate within 6 weeks of starting treatment with this drug; previously treatments and response (including SVR and/or relapse)]; concomitant medications used for this condition; if the liver disease is compensated or decompensated; kidney function; if current or illicit drug abuse is present and being treated to facilitate cessation; if highest risk for complications from hepatitis C; liver transplant recipient; type 2 or 3 essential cryoglobulinemia with end-organ manifestations; or glomerular kidney disease with proteinuria greater than 300 mg per day, nephritic syndrome, or membranoproliferative glomerulonephritis. Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.
> (Exhibit 4, p. 1.)

64. Notably Blue Cross' November 19, 2014 letter is not signed by an individual. Instead, the signature block states "Utilization Management." And it does not list anyone involved in the review process that determined that more information was necessary following the initial October 20, 2014 denial.

65. Next, Blue Cross issued a second denial letter dated December 3, 2014. A true and correct copy of this denial letter is attached as Exhibit 5. This time the review was completed by Dr. Harry Weisman.

> Coverage for the requested medication is denied because the medication does not meet the criteria of "medical necessity" under your description of benefits.
>
> . . .
>
> Our clinical reviewer concluded the following: because of details we received about your liver illness (Hepatitis C) We may approve HARVONI when the liver has a certain amount of scarring (advanced fibrosis of stage F3 or greater) on a liver biopsy. Records we received do

not show that your liver has this amount of scarring on a liver biopsy or FIBROSCAN. We did not receive a copy of the liver biopsy results or FIBROSCAN. We based this decision on your health plan's prior authorization criteria for HARVONIi (sic).
This review was completed by: Harry Weisman MD."
(Exhibit 5, p. 1.)

66. Jane was again upset with the denial. She and Dr. Han's office appealed Blue Cross' second denial. On December 24, 2014, Blue Cross acknowledged receipt of the grievance for the second appeal. A true and correct copy of this letter is attached as Exhibit 6. A couple of days later, on December 26, 2014, Blue Cross denied Jane and Dr. Han's request for an expedited appeal on the basis that the request did not pose a serious threat to Jane's health. A true and correct copy of this letter is attached as Exhibit 7.

67. A couple of weeks later, in a letter dated January 8, 2015, Blue Cross again upheld its denial of Harvoni on appeal. A true and correct copy of this letter is attached as Exhibit 8. According to the letter, an unidentified reviewer who was board certified in Gastroenterology and Dr. Wilson Fung who is board certified in Family Medicine, reviewed Jane's appeal and concluded Harvoni was not medically necessary for her. (Exhibit 8, p. 1.)

> After further review of your medical records, your request cannot be approved. You are being treated for a liver infection (Hepatitis C). We may approve your request if records show that you have advanced scarring in your liver (liver biopsy showing fibrosis score of F3 or higher on the IASL, Batts-Ludwig, or Metavir scales OR fibrosis score of F3 or higher on the Ishak scale OR mean FibroScan elastrography score of 9.5 kPa or higher). We cannot approve your request because records show you do not have advanced scarring in your liver. We based this decision on your health plan's prior authorization criteria for Harvoni.
> (*Id.*)

68. On March 3, 2015, Dr. Han wrote to Blue Cross requesting that it reconsider its denial of coverage. A true and correct copy of the March 3, 2015 letter is attached as Exhibit 9. Dr. Han explained why the treatment was medically necessary for Jane under Blue Cross's own EOC:

I have treated and monitored Ms. Blumenfeld's condition since 2001.
Though asymptomatic at this time, Ms. Blumenfeld has a viral load of 11,800,000 IU/ml with slight liver damage but could avoid future liver damage with treatment by the FDA approved medication Harvoni. Her maternal grandmother died of liver cancer and Ms. Blumenfeld did not respond to treatment with Boceprevir, interferon, and ribavirin in 2012. Ms. Blumenfeld is certainly an excellent candidate for treatment. . .

Prescribing Harvoni for Ms. Blumenfeld clearly meets all of the criteria for medical necessity, as defined in Anthem's Evidence of Coverage (pages 119 and 120 dated January 1, 2014) as follows:

Medically necessary procedures, supplies, equipment, or services are those determined to be:
1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Provided for the diagnosis or direct care and treatment of the medical condition;
3. Within standards of good medical practice within the organized medical community;
4. No primarily for Ms. Blumenfeld's convenience, or for my convenience as her physician, or for the convenience of another provider; and
5. Harvoni is the most appropriate treatment which can safely be provided.

Furthermore, Harvoni is the most appropriate treatment because it satisfies **all** of Anthem's requirements as follows:

a. There is valid and widely accepted scientific evidence that the expected health benefits from Harvoni are clinically significant and produce a greater likelihood of benefit, without disproportionately greater risk of harm or complications for Ms. Blumenfeld's hepatitis C than all other possible alternatives; and
b. Generally, accepted forms of treatment have been tried and found to be ineffective or are otherwise unsuitable.

Harvoni is medically necessary for Ms. Blumenfeld:

- It meets all of Anthem's criteria for medical necessity.

- It provides the most effective treatment known for Ms. Blumenfeld's chronic Hepatitis C genotype 1.
- It provides the most cost effective treatment for chronic Hepatitis C known today.
- It prevents the dangerous and precarious situation of waiting for the development of a severely damaged liver before administering a known and highly effective treatment.

Given Ms. Blumenfeld's family history and previous drug therapy, it is not prudent for her to wait for evidence of stage 3 liver disease before receiving treatment for Hepatitis C as she is already at greater risk for hepatocellular carcinoma.

(Exhibit 9, pp. 1-2.)

69. On March 12, 2015, Jane wrote to Blue Cross, also requesting that it expeditiously overturn its denial. A true and correct copy of her March 12, 2015 letter is attached as Exhibit 10. Jane explained to Blue Cross that living with chronic Hepatitis C "means living with the daily fear and anxiety that results from never knowing if today will be the day that asymptomatic Hepatitis C turns into a catastrophic illness that might be too late to treat." (Exhibit 10, pg. 1.)

70. On March 18, 2015, Blue Cross confirmed receipt of Dr. Han and Jane's grievance. A true and correct copy of Blue Cross' March 18, 2015 letter is attached as Exhibit 11.

71. In a letter dated April 15, 2015, Blue Cross refused to reconsider its decision, claiming that despite receiving the letter of medical necessity from Dr. Han, which explained why Harvoni is medically necessary for Jane, there was no new pertinent medical information to review:

> Your health plan has received your request for reconsideration (re-review) of the appeal decision regarding the denial of the above provider claim or service. However, no new pertinent medical information was submitted with your request for an appeal re-review. As there is no new medical information to review that would change the original appeal determination, your plan will not re-open your appeal file at this time.
> (Exhibit 12, pp. 1.)

72. To date, Blue Cross continues to deny Jane access to the cure. Instead, Jane, someone with an increased risk of developing liver cancer, must wait and allow her medical condition to significantly deteriorate before Blue Cross will provide coverage for Harvoni.

G. Blue Cross engages in a pattern and practice of unreasonably denying subscribers' claims, including plaintiff's, based on guidelines and criteria not disclosed and markedly different from the EOC

73. Jane's EOC provides coverage for medically necessary care. The EOC contains a definition of medical necessity, which is the only criteria Blue Cross subscribers, such as Jane, are aware of before receiving a denial letter.

74. According to Jane's EOC, in order for medication such as Harvoni to be medically necessary, it must be a drug that is appropriate and necessary for the treatment of the medical condition, provided for the treatment of the medical condition, within standards of good medical practice, not primarily for Jane's or her providers' convenience, and the most appropriate procedure, supply, equipment or service which can be safely provided. (Exhibit 1, p. 119.) Harvoni meets all of these requirements. Nothing requires that a member allow his or her medical condition to deteriorate to severe fibrosis or liver damage in order for their care to be considered "Medically Necessary."

75. Applying an objective standard, Jane was reasonably entitled to assume that her EOC would be consulted and interpreted to determine whether she was afforded a certain benefit. In fact, the first few pages of Jane's EOC expressly states:

> The benefits of this plan are provided only for those services that we determine to be medically necessary.
>
> 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.

> For your convenience, this summary provides a brief outline of your benefits. You need to refer to the entire Combined Evidence of Coverage and Disclosure (Evidence of Coverage) Form for more complete information, and you must consult your employer's health plan contract with us to determine the exact terms and conditions of your coverage. (Exhibit 1, p. 6.)

76. By the express terms of Jane's agreement with Blue Cross, whether a claim is covered is to be determined by the benefits described in the EOC, and particularly the definition of "Medically Necessary" contained in the EOC.

77. But the definition of "Medical Necessity" is not the test that Blue Cross used to deny Jane's claim for Harvoni. Rather, it applied a more restrictive test created by Blue Cross in an effort to increase company profits by limiting the number of patients who would qualify for this life-saving medication. Blue Cross's denial letter states: "We need to know if you have scarring in your liver (fibrosis score by liver biopsy or results of FibrosScan elastography)." (See Exhibit 3.) In other words, Blue Cross only approves Harvoni for patients with Stage 3 or 4 fibrosis. (See also Exhibits 5 and 8.) Notably, Blue Cross does not cite to any provision of the EOC in support of this standard. An online search of Blue Cross guidelines and medical policies fails to turn up any guidelines for Harvoni.

78. Blue Cross's requirement of severe fibrosis before treatment severely limits insureds' access to medically necessary treatment and places restrictions on treatment that are not disclosed in the EOC. Jane had no notice before receiving the denial letter that coverage could be determined by anything outside of her EOC, or that Blue Cross would place arbitrary restrictions on who can access medically necessary treatment.

79. Despite the plain language of Jane's EOC, Blue Cross did not rely on it to determine if Harvoni was covered. Instead, Blue Cross used unenforceable, undisclosed medical criteria, only created to elevate profits over concerns for the health of its insureds.

80. By using this restrictive medical criteria as a barrier to access Harvoni, Blue Cross is breaching its contract with its members whose EOCs contain the entirety of the terms of the agreement.

I. Blue Cross's investigation of the medical necessity of Harvoni was conducted by unqualified reviewers in violation of California Health and Safety Code § 1367.01, and at odds with the EOC

81. Subdivision (e) of California Health & Safety Code § 1367.01 provides, in relevant part, the following:

> [N]o individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity.

82. Jane's EOC states that the case will be sent to a "Peer Clinical Reviewer" if it does not satisfy the pre-established criteria or Blue Cross' medical policies. (Exhibit 1, pp. 75.) "Peer Clinical Reviewers" are "health professionals clinically competent to evaluate the specific clinical aspects of the request and render an opinion specific to the medical condition, procedure and/or treatment under review." (*Id.*) The EOC further claims that "Peer Clinical Reviewers are licensed in California with the same license category as the requesting provider." (*Id.*)

83. Yet, Blue Cross has utilized unqualified reviewers in Jane's case in violation of California Health and Safety Code §1367.01 and the EOC. For example, Dr. Don Wentzel was identified in Blue Cross' October 20, 2014 letter. (Exhibit 3.) Upon information and belief, plaintiff asserts that Dr. Wentzel is a board certified internal medicine physician with little to no experience treating Hepatitis C patients. Upon information and belief, plaintiff asserts that Dr. Wentzel has no experience with hematology or gastroenterology.

84. Similarly, Dr. Wilson Fung was identified as the reviewer in Blue Cross' January 8, 2015 denial letter on appeal. (Exhibit 8.) Upon information and belief,

plaintiff asserts that Dr. Fung is a family medicine physician with little to no experience treating Hepatitis C patients, or with hematology or gastroenterology.

J. Jane has been left without a cure and continues to suffer on a daily basis due to Blue Cross's unreasonable conduct

85. Each day since October 20, 2014 Jane remains at risk and her health condition continues to deteriorate.

86. Despite knowing that Harvoni provides Jane with a 95-99% chance of curing her deadly disease, Blue Cross refuses to provide coverage for the treatment.

87. Jane has endured and continues to endure stress, grief, anxiety, dread, fear, anger, hopelessness and worry concerning her medical condition. She spends many sleepless nights worried about her future, her mind racing with questions—whether she will develop liver cancer or some other catastrophic illness caused by Hepatitis C before she is given access to the cure.

88. Jane's maternal grandmother died of liver cancer. In light of this family history and her previous treatment failure, she has a greater risk of developing liver cancer than the average Hepatitis C patient.

89. As a result of Blue Cross's unreasonable denials, Jane awakens every morning with the stress of not knowing what her future holds. Blue Cross's refusal to provide a known cure for Hepatitis C only reinforces Jane's sense of hopelessness in having this deadly disease.

FIRST CAUSE OF ACTION

(Breach of the Implied Covenant of Good Faith and Fair Dealing)

PLAINTIFF, FOR A FIRST CAUSE OF ACTION AGAINST BLUE CROSS OF CALIFORNIA, dba ANTHEM BLUE CROSS; ANTHEM HOLDING CORP., FORMERLY KNOWN AS WELLPOINT HEALTH NETWORKS, INC.; ANTHEM UM SERVICES, INC.; ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, FORMERLY KNOWN AS BC LIFE & HEALTH INSURANCE COMPANY; AND DOES 1 THROUGH 100, INCLUSIVE, FOR BREACH OF THE COVENANT OF GOOD FAITH AND FAIR DEALING, ALLEGES:

90. Plaintiff refers to each and every paragraph above and incorporates those paragraphs as though set forth in full in this cause of action.

91. Defendants, and each of them, breached their duty of good faith and fair dealing owed to Plaintiff in the following respects:

a. Unreasonably delaying and denying coverage for Jane's medically necessary treatment;

b. Unreasonably denying Jane coverage for Harvoni before conducting a reasonable investigation of her provider's request for the medication;

c. Unreasonably failing to give at least as much consideration to Jane's interests and welfare in the investigation and handling of her claim as it gave to its own interests;

d. Unreasonably engaging in a pattern and practice of failing to give at least as much consideration to the interests and welfare of its insureds in the investigation and handling of their claims as it gives to its own interests;

e. Unreasonably requiring Jane's health to deteriorate before providing coverage for medically necessary treatment;

f. Unreasonably compelling Jane to institute this litigation to obtain benefits due under the Plan;

g. Unreasonably failing to conduct a thorough, fair, and balanced investigation in evaluating the medical necessity of Jane's claims for benefits and services under her EOC;

h. Unreasonably engaging in a pattern and practice of failing to conduct a thorough, fair, and balanced investigation in evaluating the medical necessity of benefits and services for its members under their EOC;

i. Unreasonably failing to have qualified reviewing physicians conduct a thorough, fair, and balanced investigation of Jane's claim for benefits and/or services;

j. Unreasonably engaging in a pattern and practice of failing to have qualified reviewing physicians to conduct a thorough, fair, and balanced investigation of its members' claim for benefits and/or services;

k. Unreasonably failing to diligently search for and consider evidence that supported the medical necessity of Jane's claim for benefits and services; and

l. Unreasonably engaging in a pattern and practice of failing to diligently search for and consider evidence that supports the medical necessity of its members' claim for benefits and services.

92. Plaintiff is informed and believes and thereon alleges that defendants, and each of them, have breached their duty of good faith and fair dealing owed to plaintiff by other acts or omission of which plaintiff is presently unaware and which will be shown according to proof at the time of trial.

93. Defendants furthermore have committed institutional bad faith. Defendants' institutional bad faith amounts to reprehensible conduct because the conduct is part of a repeated pattern of unfair practices and not an isolated occurrence. The pattern of unfair practices constitutes a conscious course of wrongful conduct that is firmly grounded in the established company policies of defendants. Plaintiff is

informed and believes and thereon alleges that defendants have engaged in similar wrongful conduct as to individuals other than plaintiff and that defendants have substantially increased their profits as a result of causing similar harm to others.

94. As a proximate result of the aforementioned unreasonable and bad faith conduct of defendants, plaintiff has suffered, and will continue to suffer in the future, damages under the Plan, plus interest and other economic and consequential damages, including personal physical injuries, physical sickness, and physical disability, for a total amount to be shown at the time of trial.

95. As a further proximate result of the unreasonable and bad faith conduct of defendants, and each of them, plaintiff has suffered anxiety, worry, and mental and emotional distress, all to her general damages in a sum to be determined at the time of trial.

96. As a further proximate result of the aforementioned wrongful conduct of defendants, plaintiff was compelled to retain legal counsel to obtain the benefits due under the Plan. Therefore, defendants are liable to plaintiff for those attorneys' fees reasonably necessary and incurred by plaintiff in order to obtain the benefits under the Plan in a sum to be determined at the time of trial.

97. The defendants' conduct described herein was intended by defendants to cause injury to plaintiff, or was despicable conduct carried on by the defendants with a willful and conscious disregard of the rights of plaintiff or subjected plaintiff to cruel and unjust hardship in conscious disregard of the plaintiff's rights, or was an intentional misrepresentation, deceit, or concealment of a material fact known to the defendants with the intention to deprive plaintiff of property or legal rights or to otherwise cause injury, such as to constitute malice, oppression or fraud under California Civil Code section 3294, thereby entitling plaintiff to punitive damages in an amount appropriate to punish or set an example of defendants.

98. Defendants' conduct described herein was undertaken by the corporate defendants' officers or managing agents, identified herein as DOES 1 through 100, who

were responsible for claims supervision and operations, underwriting, communications, and/or decisions. The aforementioned conduct of said managing agents and individuals was therefore undertaken on behalf of the corporate defendant. Further, said corporate defendant had advance knowledge of the actions and conduct of said individuals whose actions and conduct were ratified, authorized and approved by managing agents whose precise identities are unknown to plaintiff at this time and are therefore identified and designated herein as DOES 1 through 100, inclusive.

SECOND CAUSE OF ACTION

(Breach of Contract)

PLAINTIFF, FOR A SECOND CAUSE OF ACTION AGAINST BLUE CROSS OF CALIFORNIA, dba ANTHEM BLUE CROSS; ANTHEM HOLDING CORP., FORMERLY KNOWN AS WELLPOINT HEALTH NETWORKS, INC.; ANTHEM UM SERVICES, INC.; ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, FORMERLY KNOWN AS BC LIFE & HEALTH INSURANCE COMPANY; AND DOES 1 THROUGH 100, INCLUSIVE, FOR BREACH OF CONTRACT, ALLEGES:

99. Plaintiff refers to each and every paragraph above and incorporates those paragraphs as though set forth in full in this cause of action.

100. Defendants, and each of them, breached the terms of the Plan by failing to provide benefits Jane was entitled to under the Plan. Specifically, defendants breached the terms of the Plan in the following respects:

a. Denying coverage for medically necessary treatment for Jane;

b. Requiring that Jane's medical condition deteriorate before providing medically necessary treatment under the Plan;

c. Failing and refusing to provide Jane coverage for Harvoni with knowledge that the medication was medically necessary and with knowledge that Jane's claims were valid under her EOC; and

d. Failing to evaluate the claim for benefits based on the definition of "Medical Necessity" in the EOC.

101. Plaintiff is informed and believes and thereon alleges that defendants have breached the terms and provisions of the Plan by other acts or omissions of which plaintiff is presently unaware and which will be shown according to proof at the time of trial.

102. As a direct and proximate result of defendants' conduct and breach of their contractual obligations, plaintiff has suffered damages under the Plan in an amount to be determined according to proof at the time of trial, plus interest and other foreseeable and incidental damages, including personal physical injuries, physical sickness, and physical disability, according to proof, and in amounts to be determined at the time of trial.

THIRD CAUSE OF ACTION

(Negligent Infliction of Emotional Distress)

PLAINTIFF, FOR A THIRD CAUSE OF ACTION AGAINST BLUE CROSS OF CALIFORNIA, dba ANTHEM BLUE CROSS; ANTHEM HOLDING CORP., FORMERLY KNOWN AS WELLPOINT HEALTH NETWORKS, INC.; ANTHEM UM SERVICES, INC.; ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, FORMERLY KNOWN AS BC LIFE & HEALTH INSURANCE COMPANY; AND DOES 1 THROUGH 100, INCLUSIVE, FOR NEGLIGENT INFLICTION OF EMOTIONAL DISTRESS, ALLEGES:

103. Plaintiff refers to each and every paragraph above and incorporates those paragraphs as though set forth in full in this cause of action.

104. Since her diagnosis in December 2000 or January 2001, Jane has desperately sought a cure for this deadly disease. She lives each day with anxiety, heightened by her family history of liver cancer—the same cancer she remains at an increased risk of developing with Hepatitis C. Despite knowing that Harvoni provides

Jane with a 95-99% chance of curing her deadly disease, Blue Cross refuses to provide coverage for the treatment. Instead Blue Cross claims that it will only provide coverage for Harvoni once Jane's medical condition significantly deteriorates.

105. Jane has endured and continues to endure stress, grief, anger, fear, hopelessness and worry concerning her ongoing medical condition for which a cure exists. As a result of Blue Cross's unreasonable denials, Jane awakens every morning with stress not knowing what her future holds.

106. At all relevant times, defendants owed plaintiff a duty of due care, which they breached.

107. Defendants, and each of them, knew, or with any exercise of reasonable care should have known, the potential seriousness of Jane's medical condition and that her treating physician felt strongly that she required Harvoni, that their aforementioned wrongful conduct would result in the delay and denial of benefits that Jane was entitled to under the Plan, and would cause her severe emotional distress. Despite this knowledge, defendants, and each of them, negligently and without exercising reasonable care, processed, reviewed, and made recommendations and decisions contrary to Jane's treating provider, and otherwise engaged in conduct that directly caused benefits to be denied under the Plan.

108. Plaintiff is informed and believes and thereon alleges that defendants, and each of them, have been negligent by other acts or omissions of which plaintiff is presently unaware, and which will be shown according to proof at time of trial.

109. As a direct and proximate result of the negligent conduct of defendants, and each of them, as alleged above, Jane has suffered severe physical, mental, and emotional distress and discomfort, including, but not limited to, suffering, anguish, fright, horror, nervousness, grief, anxiety, worry, shock, humiliation, and shame, all to her detriment and damage in an amount to be shown according to proof at the time of trial.

110. Defendants' conduct described herein was undertaken by the corporate defendants' officers, managing agents, or employees identified herein as DOES 1 through 100, inclusive, who were responsible for claims handling and/or decisions. The aforementioned conduct of said managing agents and individuals was therefore undertaken on behalf of the corporate defendants. Said corporate defendants further had advance knowledge of the actions and conduct of said individuals whose actions and conduct were ratified, authorized, and approved by managing agents and by other corporate officers, directors, or managing agents whose precise identities are unknown to plaintiff at this time and are therefore identified and designated herein as DOES 1 through 100, inclusive.

FOURTH CAUSE OF ACTION

(Intentional Infliction of Emotional Distress)

PLAINTIFF, FOR A FOURTH CAUSE OF ACTION AGAINST BLUE CROSS OF CALIFORNIA, dba ANTHEM BLUE CROSS; ANTHEM HOLDING CORP., FORMERLY KNOWN AS WELLPOINT HEALTH NETWORKS, INC.; ANTHEM UM SERVICES, INC.; ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, FORMERLY KNOWN AS BC LIFE & HEALTH INSURANCE COMPANY; AND DOES 1 THROUGH 100, INCLUSIVE, FOR INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS, ALLEGES:

111. Plaintiff refers to each and every paragraph above and incorporates those paragraphs as though set forth in full in this cause of action.

112. Defendants endangered Jane's health, safety, and wellbeing when they denied a medically necessary cure requested by her treating provider, even though defendants knew, or should have known, that the medication was medically necessary covered under the EOC and 95-99% effective with few side effects. Defendants knew, or should have known, that their refusal to approve Jane's medically necessary care caused her to suffer stress, grief, worry, and anxiety.

113. Defendants, knowing the seriousness of Jane's medical condition, knowing the physical damage that could result from denying the care, knowing that it held a position of authority which gave it power to affect the plaintiff's interests, and knowing that plaintiff would be forced to deal with the emotional, physical, and financial implications of the denial of care, intentionally, unreasonably, and unfairly refused to provide Jane with the requested medically necessary care, thereby placing Jane's safety and life in jeopardy.

114. In light of Jane's condition, the defendants' improper and unreasonable delays and denials constitute extreme and outrageous conduct.

115. Defendants, and each of them, intentionally and with malicious motive engaged in said conduct. Defendants' conduct was directed at and was calculated to cause, and did cause, Jane to suffer humiliation, mental anguish, and severe emotional distress, in an attempt to gain an advantage over Jane, and deprive Jane of the entitlement to the full benefits under her EOC.

116. As a direct and proximate result of the aforementioned acts of defendants, Jane suffered severe emotional distress including suffering, anguish, fright, horror, nervousness, grief, anxiety, worry, shock, humiliation, and shame. This emotional distress was beyond what a reasonable person in a civilized society should be expected to bear.

117. Defendants' conduct described herein was intended by said defendants to cause injury to Jane, or was despicable conduct carried on by said defendants with a willful and conscious disregard of the rights, health, and safety of Jane, subjected her to cruel and unjust hardship in conscious disregard of her rights, and was an intentional misrepresentation, deceit, or concealment of a material fact known to defendants with the intention to deprive Jane of property, legal rights, or to otherwise cause injury, such as to constitute malice, oppression, or fraud under California Civil Code § 3294, thereby entitling plaintiff to punitive damages in an amount appropriate to punish or set an example of defendants.

118. Defendants' conduct described herein was undertaken by the corporate defendants' officers, managing agents, or employees identified herein as DOES 1 through 100, inclusive, who were responsible for claims handling and/or decisions. The aforedescribed conduct of said managing agents and individuals was therefore undertaken on behalf of the corporate defendants. Said corporate defendants further had advance knowledge of the actions and conduct of said individuals whose actions and conduct were ratified, authorized, and approved by managing agents and by other corporate officers, directors, or managing agents whose precise identities are unknown to plaintiff at this time and are therefore identified and designated herein as DOES 1 through 100, inclusive.

FIFTH CAUSE OF ACTION

(Violations of California Business & Professions Code §§ 17200 et seq.)

PLAINTIFF FOR A FIFTH CAUSE OF ACTION AGAINST BLUE CROSS OF CALIFORNIA, dba ANTHEM BLUE CROSS; ANTHEM HOLDING CORP., FORMERLY KNOWN AS WELLPOINT HEALTH NETWORKS, INC.; ANTHEM UM SERVICES, INC.; ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, FORMERLY KNOWN AS BC LIFE & HEALTH INSURANCE COMPANY; AND DOES 1 THROUGH 100, INCLUSIVE, FOR VIOLATION OF CALIFORNIA BUSINESS & PROFESSIONS CODE §§ 17200 *ET SEQ.*, BY THEIR UNLAWFUL, UNFAIR, AND FRAUDULENT CONDUCT ALLEGES:

119. Plaintiff refers to each and every paragraph of the Complaint and incorporates those paragraphs as though set forth in full in this cause of action.

120. California Business and Professions Code §§ 17200 *et seq.* precludes a person or entity from engaging in unfair competition, defined as business practices which are unlawful, unfair, and fraudulent. Business and Professions Code § 17203 permits the court in an action based on allegations of unfair competition to issue injunctive, restitutionary or other equitable relief, and any person who meets the

standing requirements of California Business and Professions Code § 17204 and complies with California Code of Civil Procedure § 382 may pursue a representative action.

121. California Business & Professions Code § 17204 permits individuals, such as plaintiff, to institute an action to obtain injunctive and restitutionary relief against persons and entities that engage in unfair business practices and/or unfair competition.

122. Plaintiff has suffered injury in fact as a result of Blue Cross's unlawful, unfair, and fraudulent business practices. Blue Cross's unlawful, unfair, and fraudulent business practice in not paying for the Harvoni cure for Hepatitis C patients suffering from stages F0, F1 or F2 has caused plaintiff to suffer economic and consequential damages, plus interest, for a total amount to be proven at the time of trial.

123. Plaintiff has suffered a loss of money or property as a result of the Blue Cross' unlawful, unfair and fraudulent business practices. Plaintiff has been denied her legal rights to a full, complete, and fair handling of her claims in violation of well-established principals of insurance claims handling set forth in statutory and case law.

124. Defendant has committed acts of unfair competition as defined by California Business and Professions Code §§ 17200 *et seq.* by engaging in the following acts:

a. Unlawfully violating California Health & Safety Code § 1367.01 by utilizing unqualified reviewers who are neither experienced nor specialize in treating Hepatitis C patients;
b. Unlawfully and unfairly engaging in unfair claims settlement practices in violation of California Insurance Code § 790.03(h);
c. Unfairly delaying medically necessary care causing their insureds to first suffer significant symptoms and liver damage before approving coverage for a proven cure;
d. Fraudulently attempting to apply undisclosed criteria contrary to the definition of Medically Necessary contained in insureds' EOCs; and

e. Other acts of unfair competition of which plaintiff is presently unaware, and which may be determined through discovery in this action.

125. Plaintiff respectfully requests an injunction be issued against defendants, and each of them, to enjoin them from continuing to engage in the unfair, unlawful, and fraudulent conduct alleged herein.

126. Plaintiff respectfully requests an award of attorneys' fees upon prevailing in the request for injunctive relief pursuant to California Code of Civil Procedure § 1021.5.

PRAYER FOR RELIEF

WHEREFORE, plaintiff prays for judgment against defendants, and each of them, as follows:

AS TO THE FIRST CAUSE OF ACTION AGAINST DEFENDANTS BLUE CROSS OF CALIFORNIA, dba ANTHEM BLUE CROSS; ANTHEM HOLDING CORP., FORMERLY KNOWN AS WELLPOINT HEALTH NETWORKS, INC.; ANTHEM UM SERVICES, INC.; ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, FORMERLY KNOWN AS BC LIFE & HEALTH INSURANCE COMPANY; AND DOES 1 THROUGH 100, INCLUSIVE, FOR BREACH OF THE IMPLIED COVENANT OF GOOD FAITH AND FAIR DEALING:

1. Damages for failure to provide benefits under the Plan, plus interest, in a sum to be determined at the time of trial;

2. For prejudgment interest on all damages awarded to plaintiff in accordance with California Civil Code section 3287;

3. For attorneys' fees, witness fees and costs of litigation incurred by plaintiff to obtain the Plan benefits, in an amount to be determined at trial;

4. For economic and consequential damages arising out of the defendants' unreasonable failure to provide benefits under the Plan;

5. For general damages for mental and emotional distress in a sum to be determined at the time of trial;

6. For punitive and exemplary damages in an amount appropriate to punish or set an example of defendants;

7. For costs of suit herein; and

8. For such other relief as the Court deems just and proper.

AS TO THE SECOND CAUSE OF ACTION AGAINST DEFENDANTS BLUE CROSS OF CALIFORNIA, dba ANTHEM BLUE CROSS; ANTHEM HOLDING CORP., FORMERLY KNOWN AS WELLPOINT HEALTH NETWORKS, INC.; ANTHEM UM SERVICES, INC.; ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, FORMERLY KNOWN AS BC LIFE & HEALTH INSURANCE COMPANY; AND DOES 1 THROUGH 100, INCLUSIVE, FOR BREACH OF CONTRACT:

9. Damages under the Plan, plus interest, and other economic and consequential damages, in an amount to be determined according to proof at the time of trial;

10. For prejudgment interest on all damages awarded to plaintiff in accordance with California Civil Code section 3287;

11. For costs of suit herein; and

12. For such other relief as the Court deems just and proper.

AS TO THE THIRD CAUSE OF ACTION AGAINST DEFENDANTS BLUE CROSS OF CALIFORNIA, dba ANTHEM BLUE CROSS; ANTHEM HOLDING CORP., FORMERLY KNOWN AS WELLPOINT HEALTH NETWORKS, INC.; ANTHEM UM SERVICES, INC.; ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, FORMERLY KNOWN AS BC LIFE & HEALTH INSURANCE COMPANY; AND DOES 1 THROUGH 100, INCLUSIVE, FOR NEGLIGENT INFLICTION OF EMOTIONAL DISTRESS:

13. For general damages for mental and emotional distress in a sum to be determined at the time of trial;

14. For non-economic damages for pain and suffering; and

15. For such other and further relief as the Court deems just and proper.

AS TO THE FOURTH CAUSE OF ACTION AGAINST DEFENDANTS BLUE CROSS OF CALIFORNIA, dba ANTHEM BLUE CROSS; ANTHEM HOLDING CORP., FORMERLY KNOWN AS WELLPOINT HEALTH NETWORKS, INC.; ANTHEM UM SERVICES, INC.; ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, FORMERLY KNOWN AS BC LIFE & HEALTH INSURANCE COMPANY; AND DOES 1 THROUGH 100, INCLUSIVE, FOR INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS:

16. For general damages for mental and emotional distress in a sum to be determined at the time of trial;

17. Punitive and exemplary damages in an amount appropriate to punish or set an example of defendants;

18. For non-economic damages for pain and suffering; and

19. For such other and further relief as the Court deems just and proper.

AS TO THE FIFTH CAUSE OF ACTION AGAINST DEFENDANTS BLUE CROSS OF CALIFORNIA, dba ANTHEM BLUE CROSS; ANTHEM HOLDING CORP., FORMERLY KNOWN AS WELLPOINT HEALTH NETWORKS, INC.; ANTHEM UM SERVICES, INC.; ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, FORMERLY KNOWN AS BC LIFE & HEALTH INSURANCE COMPANY; AND DOES 1 THROUGH 100, INCLUSIVE, FOR INJUNCTIVE AND RESTITUTIONARY RELIEF UNDER CALIFORNIA BUSINESS AND PROFESSIONS CODE §§ 17200, *ET. SEQ:*

20. For a permanent injunction against defendants restraining and enjoining them from engaging in the unfair, unlawful or fraudulent business practices alleged herein;

21. For an order requiring defendants to properly re-adjust all of Jane's claims to restore to her the benefits owed under the Plan;

23. For the attorneys fees incurred to obtain the equitable relief requested, including the re-adjusted claims;

24. For costs of suit incurred herein; and

25. For such other and further relief as the Court may deem just and proper.

Dated: May 18, 2015

SHERNOFF BIDART
ECHEVERRIA BENTLEY LLP

By: _____
MICHAEL J. BIDART
RICARDO ECHEVERRIA
DANICA DOUGHERTY
CLARE H. LUCICH
Attorneys for Plaintiff

JURY DEMAND

Plaintiff hereby demands a jury trial.

Dated: May 18, 2015

SHERNOFF BIDART
ECHEVERRIA BENTLEY LLP

By: _____
MICHAEL J. BIDART
RICARDO ECHEVERRIA
DANICA DOUGHERTY
CLARE H. LUCICH
Attorneys for Plaintiff

EXHIBIT 1

LOS ANGELES CITY EMPLOYEES' RETIREMENT SYSTEM

January 1, 2014

CA PPO - Member under age 65

Prudent Buyer ®

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

Anthem Blue Cross
21555 Oxnard Street
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. If you have special health care needs, you should read those sections of the Evidence of Coverage that apply to those needs. Your employer will provide you with a copy of the health plan contract upon request.

TABLE OF CONTENTS

TYPES OF PROVIDERS

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

Participating Providers in California. We have established a network of various types of "Participating Providers". These providers are called "participating" because they have agreed to participate in our preferred provider organization program (PPO), which we call the Prudent Buyer Plan. *Participating providers* have agreed to a rate they will accept as reimbursement for covered services. The amount of benefits payable under this *plan* will be different for *non-participating providers* than for *participating providers*. See the definition of "Participating Providers" in the DEFINITIONS section for a complete list of the types of providers which may be *participating providers*.

We publish a directory of Participating Providers. You can get a directory from your plan administrator (usually your employer) or from us. The directory lists all *participating providers* in your area, including health care facilities such as *hospitals* and *skilled nursing facilities*, *physicians*, laboratories, and diagnostic x-ray and imaging providers. You may call us at the customer service number listed on your ID card or you may write to us and ask us to send you a directory. You may also search for a *participating provider* using the "Provider Finder" function on our website at **www.anthemcom/ca**. The listings include the credentials of our *participating providers* such as specialty designations and board certification.

How to Access Primary and Specialty Care Services

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

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

• Tell them you are a Prudent Buyer Plan *member*.

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

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

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

Participating Providers Outside of California

If you are outside of our California service areas, please call the toll-free BlueCard Provider Access number on your ID card to find a *participating provider* in the area you are in. A directory of PPO Providers for outside of California is available. You can get a directory from your plan administrator (usually your employer).

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

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

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

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

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

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

"Non-Participating Pharmacies" have not agreed to the *prescription drug maximum allowed amount*. The amount that will be covered as *prescription drug covered expense* is significantly lower than what these providers customarily charge.

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

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

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

Care Outside the United States—BlueCard Worldwide

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

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

Payment Information

- **Participating BlueCard Worldwide hospitals.** In most cases, you should not have to pay upfront for inpatient care at participating BlueCard Worldwide *hospitals* except for the out-of-pocket costs you normally pay (noncovered services, deductible, copays, and coinsurance). The *hospital* should submit your claim on your behalf.
- **Doctors and/or non-participating hospitals.** You will have to pay upfront for outpatient services, care received from a *physician*, and inpatient care from a *hospital* that is not a participating BlueCard

Worldwide *hospital*. Then you can complete a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim Filing

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

Additional Information About BlueCard Worldwide Claims.

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

Claim Forms

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

  www.bcbs.com/bluecardworldwide.

  The address for submitting claims is on the form.

SUMMARY OF BENEFITS

THE BENEFITS OF THIS PLAN ARE PROVIDED ONLY FOR THOSE 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 COVERED UNDER THIS PLAN. 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" AND "MAXIMUM ALLOWED AMOUNT ") THAT ARE DEFINED IN THE DEFINITIONS SECTION. WHEN READING THROUGH THIS BOOKLET, CONSULT THE DEFINITIONS SECTION TO BE SURE THAT YOU UNDERSTAND THE MEANINGS OF THESE ITALICIZED WORDS.

For your convenience, this summary provides a brief outline of your benefits. You need to refer to the entire Combined Evidence of Coverage and Disclosure (Evidence of Coverage) Form for more complete information, and you must consult your employer's health plan contract with us to determine the exact terms and conditions of your coverage.

Second Opinions. If you have a question about your condition or about a plan of treatment which your *physician* has recommended, you may receive a second medical opinion from another *physician.* This second opinion visit will be provided according to the benefits, limitations, and exclusions of this *plan.* If you wish to receive a second medical opinion, remember that greater benefits are provided when you choose a *participating provider.* You may also ask your *physician* to refer you to a *participating provider* to receive a second opinion.

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

After Hours Care. After hours care is provided by your *physician* who may have a variety of ways of addressing your needs. You should call your *physician* for instructions on how to receive medical care after their normal business hours, on weekends and holidays, or to receive non-

emergency care and non-*urgent care* within the service area for a condition that is not life threatening but that requires prompt medical attention. If you have an *emergency*, call 911 or go to the nearest emergency room.

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

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

The benefits of this *plan* are subject to the REIMBURSEMENT FOR ACTS OF THIRD PARTIES section.

MEDICAL BENEFITS

DEDUCTIBLES

Calendar Year Deductibles

- Member Deductible..... **$750**
- Family Deductible **$1,500**

Additional Deductibles

- Non-Certification Deductible..... **$300**

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

- The Calendar Year Deductible will not apply to the following services: (a) *physician's* services for routine examinations and immunizations under the Routine Physical Exam benefit; (b) *physician's* services under the Well Baby and Well Child Care benefit; and (b) Hepatitis B and Varicella Zoster immunizations for dependent children.
- The Calendar Year Deductible will not apply to office visits to a *physician* who is a *participating provider.*

  Note: This exception only applies to the charge for the visit itself. It does not apply to any other charges made during that visit, such as for testing procedures, surgery, etc.
- The Calendar Year Deductible will not apply to diabetes education program services provided by a *physician* who is a *participating provider.*
- The Calendar Year Deductible will not apply to hearing aids.
- The Calendar Year Deductible will not apply to colonoscopies, sigmoidoscopies and other colorectal cancer screenings.
- The Calendar Year Deductible will not apply to transplant travel expenses in connection with an authorized transplant procedure provided at an approved COE.
- The Non-Certification Deductible will not apply to *emergency* admissions or services, nor to the services provided by a *participating provider.* See UTILIZATION REVIEW PROGRAM.

CO-PAYMENTS

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

- *Participating Providers*.....**10%**
- *Other Health Care Providers*.....**20%**
- *Non-Participating Providers*.....**30%**

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

***Exceptions:**

- Your Co-Payment for inpatient hospital benefits provided by *non-participating providers* will be **20%**. You will be responsible for charges which exceed the *maximum allowed amount*.
- Your Co-Payment for *non-participating providers* will be the same as for *participating providers* for the following services. You will be responsible for charges which exceed the *maximum allowed amount*.
  a. *Emergency services* provided by other than a *hospital;*
  b. The first 48 hours of *emergency services* provided by a *hospital* (the *participating provider* Co-Payment will continue to apply to a *non-participating provider* beyond the first 48 hours if you, in our judgment, cannot be safely moved);
  c. An *authorized referral* from a *physician* who is a *participating provider* to a *non-participating provider*; or
  d. Charges by a type of *physician* not represented in the Prudent Buyer Plan network (for example, an audiologist).
  e. Cancer Clinical Trials.
- Your Co-Payment for office visits to a *physician* who is a *participating provider* will be **$20**. This Co-Payment will not apply toward the satisfaction of any deductible.

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

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

- Your Co-Payment for specified organ transplants (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures) determined to be *medically necessary* and performed at a designated *COE* will be the same as for *participating providers.* **Services for specified organ transplants are not covered when performed at other than a designated *COE*.** See UTILIZATION REVIEW PROGRAM.

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

- No Co-Payment will be required under the Well Baby and Well Child Care or Routine Physical Exam benefits.

- No Co-Payment will be required for hearing aids.

- No Co-Payment will be required for services of a *participating provider* for prostate cancer screening, cervical cancer screening and breast cancer.

- Your Co-Payment for office visits to a *Prudent Buyer Plan provider physician* for chiropractic services will be **$20**.

Out-of-Pocket Amount*. After each *member* has made a total of **$5,000** in out-of-pocket payments for covered charges incurred during a *calendar year,* each *member* will no longer be required to pay a Co-Payment for the remainder of that *year,* but will remain responsible for costs in excess of the *maximum allowed amount.*

***Exception:**

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

MEDICAL BENEFIT MAXIMUMS

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

Skilled Nursing Facility

- For covered *skilled nursing facility* care..... **100 days**
  per *calendar year*

Home Health Care

- For covered home health services ..... **60 visits**
  per *calendar year*

Home Infusion Therapy

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

  **Non-participating providers* only

Chiropractic Services

- For all covered services..... **30**
  visits per *calendar year*

Christian Science Benefit

- For services of practitioners **$25**
  per visit, for up to 70 visits
  per *calendar year*

- For nursing care..... **$20**
  per visit, for up to 70 visits
  per *calendar year*

- Sanatorium ..... **70 days**
  per *calendar year*

Acupuncture

- For all covered services..... **$30**
  per visit, for up to 12 visits
  per *calendar year*

Hearing Aids

- For all covered services..... **$2,000**
  per ear, every three years

Transplant Travel Expense

- For the Recipient and One Companion per Transplant Episode (limited to 6 trips per episode)
  - For transportation to the *COE*..... **$250**
    per trip for each person
    for round trip coach airfare
  - For hotel accommodations..... **$100**
    per day, for up to 21 days per trip,
    limited to one room,
    double occupancy
  - For other reasonable expenses
    (excluding, tobacco, alcohol, drug
    and meal expenses)..... **$25**
    per day for each person,
    for up to 21 days per trip
- For the Donor per Transplant Episode (limited to one trip per episode)
  - For transportation to the *COE*..... **$250**
    for round trip coach airfare
  - For hotel accommodations..... **$100**
    per day, for up to 7 days
  - For other reasonable expenses
    (excluding, tobacco, alcohol, drug
    and meal expenses)..... **$25**
    per day, up to 7 days

Lifetime Maximum

- For all medical benefits..... **$2,000,000**
  during your lifetime

PRESCRIPTION DRUG BENEFITS

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

Retail Pharmacies: The following co-payments apply for a 30-day supply of medication.

Participating Pharmacies

- *Generic Drugs*..... **$5**
- *Brand Name Drugs*:*
  - *Formulary brand name drugs* when no *generic drug* equivalent is available, or the prescriber has specified "dispense as written"..... **$25**
  - *Non-Formulary brand name drugs*** when no *generic drug* equivalent is available..... **$50**
- Non-*formulary brand name drugs***..... **$50**

* **Note Regarding Brand Name Drugs:** When the prescriber has not specified "dispense as written", you will pay the co-payment plus the difference of the *prescription drug covered expense* between the *generic drug* and the *brand name drug*.

****Note Regarding Brand Name Non-Formulary Drugs:** When the prescriber has specified "dispense as written", the co-payment for *formulary brand name drugs* will apply. When the member's *physician* has not specified "dispense as written", the **$50** co-payment will apply.

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

Non-Participating Pharmacies***

- *Generic Drugs*.....**20%** of *prescription drug covered expense*
- *Brand Name Drugs**:
  - *Formulary brand name drugs* when no *generic drug* equivalent is available, or the prescriber has specified "dispense as written".....**20%** of *prescription drug covered expense*
  - *Non-Formulary brand name drugs*** when no *generic drug* equivalent is available.....**20%** of *prescription drug covered expense*
- Non-*formulary brand name drugs***.....**20%** of *prescription drug covered expense*

* **Note Regarding Brand Name Drugs:** When the prescriber has not specified "dispense as written", you will pay the co-payment plus the difference of the *prescription drug covered expense* between the *generic drug* and the *brand name drug*.

Note Regarding Brand Name Non-Formulary Drugs: When the prescriber has specified "dispense as written", the co-payment for *formulary brand name drugs* will apply. When the member's *physician* has not specified "dispense as written", the co-payment for non-*formulary brand name drugs* will apply.

Home Delivery Prescriptions: The following co-payments apply for a 90-day supply of medication.

- *Generic Drugs*..... **$10**
- *Brand Name Drugs*:*
  - *Formulary brand name drugs* when no *generic drug* equivalent is available, or the prescriber has specified "dispense as written"..... **$50**
  - *Non-Formulary brand name drugs*** when no *generic drug* equivalent is available..... **$100**
- *Non-formulary brand name drugs***..... **$100**

* **Note Regarding Brand Name Drugs:** When the prescriber has not specified "dispense as written", you will pay the co-payment plus the difference of the *prescription drug covered expense* between the *generic drug* and the *brand name drug*.

****Note Regarding Brand Name Non-Formulary Drugs:** When the prescriber has specified "dispense as written", the co-payment for *formulary brand name drugs* will apply. When the member's *physician* has not specified "dispense as written", the **$100** co-payment will apply.

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

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

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

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

YOUR MEDICAL BENEFITS

MAXIMUM ALLOWED AMOUNT

General

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

We have provided two examples below, which illustrate how the *maximum allowed amount* works. These examples are for illustration purposes only.

Example: The plan has a *member* Co-Payment of 30% for *participating provider* services after the Deductible has been met.

- The *member* receives services from a *participating* surgeon. The charge is $2,000. The *maximum allowed amount* under the plan for the surgery is $1,000. The *member's* Co-Payment responsibility when a *participating* surgeon is used is 30% of $1,000, or $300. This is what the *member* pays. We pay 70% of $1,000, or $700. The *participating* surgeon accepts the total of $1,000 as reimbursement for the surgery regardless of the charges.

Example: The plan has a *member* Co-Payment of 50% for *non-participating provider* services after the Deductible has been met.

- The *member* receives services from a *non-participating* surgeon. The charge is $2,000. The *maximum allowed amount* under the plan for the surgery is $1,000. The *member's* Co-Payment responsibility when a *non-participating* surgeon is used is 50% of $1,000, or $500. We pay the remaining 50% of $1,000, or $500. In addition, the *non-participating* surgeon could bill the *member* the difference between $2,000 and $1,000. So the *member's* total out-of-pocket charge would be $500 plus an additional $1,000, for a total of $1,500.

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

Provider Network Status

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

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

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

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

Non-Participating Providers and Other Health Care Providers.*

Providers who are not in our Prudent Buyer network are *non-participating providers* or *other health care providers,* subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers. For covered services you receive from a *non-participating provider* or *other health care provider* the *maximum allowed amount* will be based on the applicable Anthem Blue Cross *non-participating provider* rate or fee schedule for this plan, an amount negotiated by us or a third party vendor which has been agreed to by the *non-participating provider,* an amount derived from the total charges billed by the *non-participating provider,* an amount based on information provided by a third party vendor, or an amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the *maximum allowed amount* upon the level or method of reimbursement used by CMS, Anthem Blue Cross will update such information, which is unadjusted for geographic locality, no less than annually.

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

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

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

***Exceptions:**

- **Emergency Services Provided by Non-Participating Providers**

  For *emergency services* provided by *non-participating providers* or at *non-contracting hospitals,* reimbursement is based on the *reasonable and customary value.* You will not be responsible for any amounts in excess of the *reasonable and customary value* for *emergency services rendered within California.*

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

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

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

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

Member Cost Share

For certain covered services, and depending on your plan design, you may be required to pay all or a part of the *maximum allowed amount* as your cost share amount (Deductibles or Co-Payments). Your cost share amount and the Out-Of-Pocket Amounts may be different depending on whether you received covered services from a *participating provider* or *non-participating provider.* Specifically, you may be required to pay higher cost-sharing amounts or may have limits on your benefits when

using *non-participating providers*. Please see the SUMMARY OF BENEFITS section for your cost share responsibilities and limitations, or call the customer service telephone number on your ID card to learn how this *plan's* benefits or cost share amount may vary by the type of provider you use.

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

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

Authorized Referrals

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

DEDUCTIBLES, CO-PAYMENTS, OUT-OF-POCKET AMOUNTS AND MEDICAL BENEFIT MAXIMUMS

After we subtract any applicable deductible and your Co-Payment, we will pay benefits up to the *maximum allowed amount*, (or the *reasonable and customary value* for *emergency services* provided by a *non-participating provider*), not to exceed any applicable Medical Benefit Maximum. The Deductible amounts, Co-Payments, Out-Of-Pocket Amounts and Medical Benefit Maximums are set forth in the SUMMARY OF BENEFITS.

DEDUCTIBLES

Each deductible under this *plan* is separate and distinct from the other. Only the covered charges that make up the *maximum allowed amount* (or the *reasonable and customary value* for *emergency services* provided by a *non-participating provider*) will apply toward the satisfaction of any deductible except as specifically indicated in this booklet.

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

Prior Plan Calendar Year Deductibles. If you were covered under the *prior plan* any amount paid during the same *calendar year* toward your calendar year deductible under the *prior plan,* will be applied toward your Calendar Year Deductible under this *plan;* provided that, such payments were for charges that would be covered under this *plan.*

Additional Deductible

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

CO-PAYMENTS

After you have satisfied any applicable deductible, we will subtract your Co-Payment from the *maximum allowed amount* remaining (or from the amount of *reasonable and customary value* remaining for *emergency services* provided by a *non-participating provider*).

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

OUT-OF-POCKET AMOUNTS

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

Participating Providers, COEs and Other Health Care Providers. Only covered charges up to the *maximum allowed amount* for the services of a *participating provider*, *COE* or *other health care provider* will be applied to the *participating provider* and *other health care provider* Out-of-Pocket Amount.

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

Non-Participating Providers. Only covered charges up to the *maximum allowed amount* for the services of a *non-participating provider* will be applied to the *non-participating provider* Out-of-Pocket Amount. After this Out-of-Pocket Amount per *member* has been satisfied during a *calendar year*, you will no longer be required to make any Co-Payment for the covered services provided by a *non-participating provider* for the remainder of that *year*.

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

- Charges for services or supplies not covered under this plan;
- Charges which exceed the *maximum allowed amount;* and
- Any expense applied to a deductible.

MEDICAL BENEFIT MAXIMUMS

We do not make benefit payments for any *member* in excess of any of the Medical Benefit Maximums. Your Lifetime Maximum under this *plan* will be reduced by any benefits we paid to you or on your behalf under any other health plan provided by Anthem, or any of its affiliates, which is sponsored by the *group*.

Prior Plan Maximum Benefits. If you were covered under the *prior plan,* any benefits paid to you under the *prior plan* will reduce any maximum amounts you are eligible for under this *plan* which apply to the same benefit.

CONDITIONS OF COVERAGE

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

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

MEDICAL CARE THAT IS COVERED

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

Hospital

1. Inpatient services and supplies*, provided by a *hospital.* The *maximum allowed amount* will not include charges in excess of the *hospital's* prevailing two-bed room rate unless there is a negotiated per diem rate between us and the *hospital,* or unless your *physician* orders, and we authorize, a private room as *medically necessary.*

   *Including 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.*

2. Services in *special care units.*

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

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

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

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

*Including 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.*

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

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

In no event will benefits exceed 60 visits during a *calendar year.* A visit of four hours or less by a home health aide shall be considered as one home health visit.

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

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

Hospice Care. The services and supplies listed below are covered when provided by a *hospice* for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care is care that controls pain and relieves symptoms but is not intended to cure the illness. You must be suffering from a terminal illness for which the prognosis of life expectancy is one year or less, as certified by your *physician* and submitted to us. Covered services are available on a 24-hour basis for the management of your condition.

1. Interdisciplinary team care with the development and maintenance of an appropriate plan of care.
2. Short-term inpatient *hospital* care when required in periods of crisis or as respite care. Coverage of inpatient respite care is provided on an occasional basis and is limited to a maximum of five consecutive days per admission.

3. Skilled nursing services provided by or under the supervision of a registered nurse. Certified home health aide services and homemaker services provided under the supervision of a registered nurse.

4. Social services and counseling services provided by a qualified social worker.

5. Dietary and nutritional guidance. Nutritional support such as intravenous feeding or hyperalimentation.

6. Physical therapy, occupational therapy, speech therapy, and respiratory therapy provided by a licensed therapist.

7. Volunteer services provided by trained *hospice* volunteers under the direction of a *hospice* staff member.

8. Pharmaceuticals, medical equipment, and supplies necessary for the management of your condition. Oxygen and related respiratory therapy supplies.

9. Bereavement services, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following the *subscriber's* or the *family member's* death. Bereavement services are available to surviving members of the immediate family for a period of one year after the death. Your immediate family means your spouse, children, step-children, parents, and siblings.

10. Palliative care (care which controls pain and relieves symptoms, but does not cure) which is appropriate for the illness.

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

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

1. Medication, ancillary medical supplies and supply delivery, (not to exceed a 14-day supply); however, medication which is delivered but not administered is not covered;

2. Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications;

3. *Hospital* and home clinical visits related to the administration of infusion therapy, including skilled nursing services including those provided for: (a) patient or alternative caregiver training; and (b) visits to monitor the therapy;

4. Rental and purchase charges for durable medical equipment (as shown below); maintenance and repair charges for such equipment;

5. Laboratory services to monitor the patient's response to therapy regimen.

Our maximum payment will not exceed **$600** for the services or supplies received during any one day when provided by a *home infusion therapy provider* which is not a *participating provider*.

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

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

Professional Services

1. Services of a *physician*.

2. Services of an anesthetist (M.D. or C.R.N.A.).

Reconstructive Surgery. Reconstructive surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or creating a normal appearance. This includes *medically necessary* dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. "Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

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

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

Ambulance services are subject to medical necessity reviews.

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

Coverage includes *medically necessary* treatment of an illness or injury by medical professionals from an ambulance service, even if you are not transported to a *hospital*. If provided through the 911 emergency response system*, ambulance services are covered if you reasonably believed that a medical *emergency* existed even if you are not transported to a *hospital*.

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

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

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

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

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

Radiation Therapy

Chemotherapy

Hemodialysis Treatment

Prosthetic Devices

1. Breast prostheses following a mastectomy.
2. *Prosthetic devices* to restore a method of speaking when required as a result of a covered *medically necessary* laryngectomy.
3. We will pay for other *medically necessary prosthetic devices*, including:
   a. Surgical implants;
   b. Artificial limbs or eyes;

c. The first pair of contact lenses or eye glasses when required as a result of a covered *medically necessary* eye surgery;

d. Therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications; and

e. Orthopedic footwear used as an integral part of a brace; shoe inserts that are custom molded to the patient.

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

1. Of no further use when medical needs end (but not disposable);
2. For the exclusive use of the patient;
3. Not primarily for comfort or hygiene;
4. Not for environmental control or for exercise; and
5. Manufactured specifically for medical use.

We will determine whether the item satisfies the conditions above.

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

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

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

Dental Care

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

2. **General Anesthesia.** General anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a *hospital* or *ambulatory surgical center*. This applies only if (a) the *member* is less than seven years old, (b) the *member* is developmentally disabled, or (c) the *member's* health is compromised and general anesthesia is *medically necessary*. Charges for the dental procedure itself, including professional fees of a dentist, are not covered.

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

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

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 customer service telephone number listed on your ID card. To fully understand your coverage under this *plan*, please carefully review this Evidence of Coverage document.

Pregnancy and Maternity Care

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

   a. Prenatal and postnatal care;

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

   c. Involuntary complications of pregnancy;

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

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

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

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

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

1. The organ or tissue recipient; or

2. The organ or tissue donor.

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

The *maximum allowed amount* does not include charges for services received without first obtaining our prior authorization, or which are provided at a facility other than a transplant center approved by us. See UTILIZATION REVIEW PROGRAM for details.

You must obtain our prior authorization for all services related to specified organ transplants (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures)

including, but not limited to preoperative tests and postoperative care. Specified organ transplants must be performed at a *Center of Expertise (COE)*. **Charges for services provided for or in connection with a specified organ transplant performed at a facility other than a *COE* will not be considered covered charges.** See UTILIZATION REVIEW PROGRAM for details.

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

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

Mental or Nervous Disorders or Substance Abuse. Covered services shown below for the *medically necessary* treatment of *mental or nervous disorders* or substance abuse, or to prevent the deterioration of chronic conditions.

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

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

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

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

1. A *physician's* services for routine physical examinations.
2. Immunizations given as standard medical practice for children.
3. Radiology and laboratory services in connection with routine physical examinations.

Routine Physical Exam (Members Age 7 and Over). We will for the following services:

1. A physician's services for routine physical examinations.
2. Radiology and laboratory services and tests ordered by the examining physician in connection with a routine physical examination.
3. Vision and hearing examinations.
4. Immunizations.

Hearing Aids. Hearing aids. Hearing aids are limited to one pair every three years, up to **$2,000** per ear.

Allergy. Allergy testing and treatment, including allergy serum.

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

Hepatitis B and Varicella Zoster Immunizations. Hepatitis B and Varicella Zoster (chickenpox) immunizations for dependent children.

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

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

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

1. Routine and diagnostic mammogram examinations.
2. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.
3. Reconstructive surgery of both breasts performed to restore and achieve symmetry following a *medically necessary* mastectomy.
4. Breast prostheses following a mastectomy (see "Prosthetic Devices").

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

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

1. The treatment provided in a clinical trial must either:
    a. Involve a *drug* that is exempt under federal regulations from a new drug application, or
    b. Be approved by (i) one of the National Institutes of Health, (ii) the federal Food and Drug Administration in the form of an investigational new drug application, (iii) the United States Department of Defense, or (iv) the United States Veteran's Administration.
2. You must be diagnosed with cancer to be eligible for participation in these clinical trials.
3. Participation in such clinical trials must be recommended by your *physician* after determining participation has a meaningful potential to benefit the *member*.

4. For the purpose of this provision, a clinical trial must have a therapeutic intent. Clinical trials to just test toxicity are not included in this coverage.

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

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

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

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

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

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

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

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

2. Occupational therapy provided on an outpatient basis when the ability to perform daily life tasks has been lost or reduced by, or has not been developed due to, illness or injury including programs which are designed to rehabilitate mentally, physically or emotionally handicapped persons. Occupational therapy programs are designed to maximize or improve a patient's upper extremity function, perceptual motor skills and ability to function in daily living activities.

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

Chiropractic Services. Spinal manipulation or adjustment, limited to 30 visits per calendar year.

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

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

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

HIV Testing. Human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis. This coverage is provided according to the terms and conditions of this *plan* that apply to all other medical conditions.

Outpatient Speech Therapy. Outpatient speech therapy following injury or organic disease.

Acupuncture. The services of a *physician* for acupuncture treatment to treat a disease, illness or injury, including a patient history visit, physical examination, treatment planning and treatment evaluation, electroacupuncture, cupping and moxibustion. We will pay for up to 12 visits during a *calendar year,* and for up to a maximum of **$30** for all covered services rendered during each visit.

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

1. The following equipment and supplies:

    a. Blood glucose monitors, including monitors designed to assist the visually impaired, and blood glucose testing strips.

    b. Insulin pumps.

    c. Pen delivery systems for insulin administration (non-disposable).

    d. Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin.

    e. Podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes-related complications.

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

2. Diabetes education program which:

    a. Is designed to teach a *member* who is a patient and covered members of the patient's family about the disease process and the daily management of diabetic therapy;

    b. Includes self-management training, education, and medical nutrition therapy to enable the *member* to properly use the equipment, supplies, and medications necessary to manage the disease; and

    c. Is supervised by a *physician.*

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

3. The following items are covered under your *prescription drug* benefits:

   a. Insulin, glucagon, and other *prescription drugs* for the treatment of diabetes.

   b. Insulin syringes, disposable pen delivery systems for insulin administration.

   c. Testing strips, lancets, and alcohol swabs.

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

Christian Science Benefit. Benefits for the following services will be provided when a *member* manifests symptoms of a covered illness or injury and receives Christian Science treatment for such symptoms.

Christian Science Sanatorium. Services provided by a Christian Science sanatorium, and other nursing homes which may be approved by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc., if the *member* is admitted for active care of an illness or injury. Services are limited to 70 days per *calendar year*.

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

1. Services of a Christian Science Practitioner, other than a nurse, are limited to one visit per day, not to exceed a maximum payment of **$25** per day and 70 visits per *calendar year*.

2. Services of a Christian Science nurse who is authorized by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. and who is not a part of the *member's* family, are limited to one visit per day, not to exceed a maximum payment of **$20** per day and 70 visits per *calendar year*.

A Christian Science sanatorium will be considered a *hospital* under the *plan* if it is accredited by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.

The term *physician* includes a Christian Science practitioner approved and accredited by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.

NO BENEFITS ARE AVAILABLE FOR TELEPHONE CONSULTATIONS OR SPIRITUAL REFRESHMENT. All other provisions of MEDICAL CARE THAT IS NOT COVERED apply equally to Christian Science benefits as to all other benefits and providers of care.

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

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

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

MEDICAL CARE THAT IS NOT COVERED

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

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

Experimental or Investigative. Any *experimental* or *investigative* procedure or medication. But, if you are denied benefits because it is determined that the requested treatment is *experimental* or *investigative*, you may request an independent medical review as described in GRIEVANCE PROCEDURES.

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

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

Not Covered. Services received before your *effective date* or after your coverage ends, 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. This exclusion does not apply to the *medically necessary* treatment of pervasive developmental disorder or autism, to the extent stated in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.

Excess Amounts. Any amounts in excess of *maximum allowed amounts* or the Lifetime Maximum.

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

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

Government Treatment. Any services 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*. This will not apply to services provided by a Veterans Administration Medical Center or a Military Treatment Facility for *emergency services* or for care that is related to a non-service connected condition.

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

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

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

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

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

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

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

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

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth, or treatment to the teeth or gums, or treatment to or for any disorders for the jaw joint, except as specifically stated in the "Reconstructive Surgery", "Dental Care" or "Jaw Joint Disorders"

provisions of MEDICAL CARE THAT IS COVERED. Cosmetic dental surgery or other dental services for beautification.

Hearing Aids or Tests. Hearing aids. Routine hearing tests, except as specifically provided under the "Routine Physical Exam" and "Hearing Aids" provisions of MEDICAL CARE THAT IS COVERED.

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

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

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

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

Weight Alteration Programs (Inpatient and Outpatient). Weight loss or weight gain programs including, but not limited to, dietary evaluations and counseling, exercise programs, behavioral modification programs, surgery, laboratory tests, food and food supplements, vitamins and other nutritional supplements associated with weight loss or weight gain. Dietary evaluations and counseling, and behavioral modification programs are covered for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity will be covered only when criteria are met as recommended by our Medical Policy.

Sterilization Reversal. Reversal of sterilization.

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

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

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

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

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.

Educational or Academic Services. This plan does not cover:

1. Educational or academic counseling, remediation, or other services that are designed to increase academic knowledge or skills.

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

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

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

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

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

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

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

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

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

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

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

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

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

BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM

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

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

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

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

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

DEFINITIONS

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

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

Intensive Behavioral Intervention means any form of Applied Behavioral Analysis that is comprehensive, designed to address all domains of functioning, and provided in multiple settings for no more than 40 hours per week, across all settings, depending on the individual's needs and progress. Interventions can be delivered in a one-to-one ratio or small group format, as appropriate.

Qualified Autism Service Provider is either of the following:

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

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

Our network of *participating providers* is limited to licensed Qualified Autism Service Providers who contract with us and who may supervise and employ Qualified Autism Service Professionals or Qualified Autism Service Paraprofessionals who provide and administer Behavioral Health Treatment.

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

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

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

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

BEHAVIORAL HEALTH TREATMENT SERVICES COVERED

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

- The treatment must be prescribed by a licensed physician and surgeon (an M.D. or D.O.) or developed by a licensed clinical psychologist,
- The treatment must be provided under a treatment plan prescribed by a Qualified Autism Service Provider and administered by one of the following: (a) Qualified Autism Service Provider, (b) Qualified Autism Service Professional supervised and employed by the Qualified Autism Service Provider, or (c) Qualified Autism Service Paraprofessional supervised and employed by a Qualified Autism Service provider, and
- The treatment plan must have measurable goals over a specific timeline and be developed and approved by the Qualified Autism Service Provider for the specific patient being treated. The treatment plan must be reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate, and must be consistent with applicable state law that imposes requirements on the provision of Applied Behavioral Analysis services and Intensive Behavioral Intervention services to certain persons pursuant to which the Qualified Autism Service Provider does all of the following:
    - Describes the patient's behavioral health impairments to be treated,
    - Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the intervention plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported,
    - Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Pervasive Developmental Disorder or autism,
    - Discontinues Intensive Behavioral Intervention services when the treatment goals and objectives are achieved or no longer appropriate, and

- The treatment plan is not used for purposes of providing or for the reimbursement of respite care, day care, or educational services, and is not used to reimburse a parent for participating in the treatment program. No coverage will be provided for any of these services or costs. The treatment plan must be made available to us upon request.

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.

    - If we paid the provider other than on a capitated basis, our lien will not be more than amount we paid for those services.
    - If we paid the provider on a capitated basis, our lien will not be more than 80% of the usual and customary charges for those services in the geographic area in which they were given.
    - If you hired an attorney to gain your recovery from the third party, our lien will not be for more than one-third of the money due you under any final judgment, compromise, or settlement agreement.
    - If you did not hire an attorney, our lien will not be for more than one-half of the money due you under any final judgment, compromise or settlement agreement.
    - If a final judgment includes a special finding by a judge, jury, or arbitrator that you were partially at fault, our lien will be reduced by the same comparative fault percentage by which your recovery was reduced.
    - Our lien is subject to a pro rata reduction equal to your reasonable attorney's fees and costs in line with the common fund doctrine.

2. You must advise us in writing, within 60 days of filing a claim against the third party and take necessary action, furnish such information and assistance, and execute such papers as we may require to facilitate enforcement of our rights. You must not take action which

may prejudice our rights or interests under your *plan*. Failure to give us such notice or to cooperate with us, or actions that prejudice our rights or interests will be a material breach of this *plan* and will result in your being personally responsible for reimbursing us.

3. We will be entitled to collect on our lien even if the amount you or anyone recovered for you (or your estate, parent or legal guardian) from or for the account of such third party as compensation for the injury, illness or condition is less than the actual loss you suffered.

YOUR PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG COVERED EXPENSE

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

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

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

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

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

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

PRESCRIPTION DRUG CO-PAYMENTS

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

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

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

HOW TO USE YOUR PRESCRIPTION DRUG BENEFITS

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

Generic drugs will be dispensed by *participating pharmacies* when the *prescription* indicates a *generic drug*. When a *brand name drug* is specified, but a *generic drug* equivalent exists, the *generic drug* will be substituted. *Brand name drugs* will be dispensed by *participating pharmacies* when the *prescription* specifies a *brand name* and states "dispense as written" or no *generic drug* equivalent exists.

Many *participating pharmacies* display an "Rx" decal with our logo in their window. For information on how to locate a *participating pharmacy* in your area, call 1-800-700-2541 (or TTY/TDD 1-800-905-9821).

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

Prescription Drug Program
ATTN: Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872

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

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

Prescription Drug Program
ATTN: Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872

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

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

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

When You Order Your Prescription Through the Home Delivery Program. You can order your *prescription* through the home delivery *prescription drug* program. Not all medications are available through the home delivery pharmacy.

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

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

Order forms can be obtained by contacting us at 1-800-700-2541 (or TTY/TDD 1-800-905-9821) to request one. The form is also available on-line at www.anthem.com/ca.

PRESCRIPTION DRUG UTILIZATION REVIEW

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

PRESCRIPTION DRUG FORMULARY

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

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

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

other than the one you are currently taking.) If approved, *drugs* requiring prior authorization for benefits will be provided to you after you make the required co-payment.

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

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

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

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

- Based on your medical condition, as medically necessary, we will review it and decide if we will approve benefits within 5-business days or a shorter period as applicable by state or federal law. We will tell you and your *physician* what we have decided in writing - by fax to your *physician*, and by mail, to you.
- If more information is needed to make a decision, we will tell your *physician* in writing within 5-business days or a shorter period as

applicable by state or federal law after we get the request what information is missing, and why we cannot make a decision. If, for reasons beyond our control, we cannot tell your *physician* what information is missing within 5-business days, we will tell your *physician* that there is a problem as soon as we know that we cannot respond within 5-business days. In any event, we will tell you and your *physician* that there is a problem in writing by facsimile, and when appropriate, by telephone to your *physician*, and in writing to you by mail.

- As soon as we can, based on your medical condition, as *medically necessary*, within 5-business days or a shorter period as applicable by state or federal law, and after we have all the information we need to decide if we will approve benefits, we will tell you and your *physician* what we have decided in writing - by fax to your *physician* and by mail to you.

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

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

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

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

- Your coverage under this *plan* ends;
- The *agreement* with the *group* terminates;
- You reach a benefit maximum that applies to *prescription drugs*, if the *plan* includes such a maximum;

- Your *prescription drug* benefits under the *plan* change so that *prescription drugs* are no longer covered or are covered in a different way.

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

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

PRESCRIPTION DRUG CONDITIONS OF SERVICE

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

1. It must be prescribed by a licensed prescriber and be dispensed within one year of being prescribed, subject to federal and state laws.

2. It must be approved for general use by the Food and Drug Administration (FDA).

3. It must be for the direct care and treatment of your illness, injury or condition. Dietary supplements, health aids or drugs prescribed for cosmetic purposes are not included. However formulas prescribed by a *physician* for the treatment of phenylketonuria are covered.

4. It must be dispensed from a licensed retail *pharmacy*, or through your home delivery program.

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

6. For a retail *pharmacy*, the *prescription* must not exceed a 30-day supply.

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

7. Certain *drugs* have specific quantity supply limits based on our analysis of prescription dispensing trends and the Food and Drug Administration dosing recommendations.

8. For the home delivery program, the *prescription* must not exceed a 90-day supply.

9. The *drug* will be covered under YOUR PRESCRIPTION DRUG BENEFITS only if it is not covered under another benefit of your *plan*.

10. *Drugs* for the treatment of impotence and/or sexual dysfunction are limited to six tablets/units for a 30-day period and are available at retail *pharmacies* only. Documented evidence of contributing medical condition must be submitted to us for review.

PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED

1. Outpatient *drugs* and medications which the law restricts to sale by *prescription*. Formulas prescribed by a *physician* for the treatment of phenylketonuria. These formulas are subject to the copayment for *brand name drugs*.

2. Insulin.

3. Syringes when dispensed for use with insulin and other self-injectable *drugs* or medications.

4. *Prescription* oral contraceptives; contraceptive diaphragms. Contraceptive diaphragms are limited to one per *year* and are subject to the copayment for *brand name drugs*.

5. Injectable *drugs* which are self-administered by the subcutaneous route (under the skin) by the patient or *family member*. *Drugs* with Food and Drug Administration (FDA) labeling for self-administration.

6. All compound *prescription drugs* which contain at least one covered *prescription* ingredient.

7. Diabetic supplies (i.e. test strips and lancets).

8. Inhaler spacers and peak flow meters for the treatment of pediatric asthma. These items are subject to the copayment for *brand name drugs*.

9. *Prescription drugs* for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.

PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED

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

1. Immunizing agents, biological sera, blood, blood products or blood plasma. While not covered under this *prescription drug* benefit, these items are covered under the "Blood," "Well Baby and Well Child Care," "Routine Physical Exam," and "Hepatitis B and Varicella Zoster Immunizations" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

2. Hypodermic syringes and/or needles except when dispensed for use with insulin and other self-injectable *drugs* or medications. While not covered under this *prescription drug* benefit, these items are covered under the "Home Health Care," "Hospice Care," "Home Infusion Therapy," and "Diabetes" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

3. *Drugs* and medications used to induce spontaneous and non-spontaneous abortions. While not covered under this *prescription drug* benefit, FDA approved medications that may only be dispensed by or under direct supervision of a *physician*, such as *drugs* and medications used to induce non-spontaneous abortions, are covered as specifically stated in the "Prescription Drug for Abortion" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to the benefit.

4. *Drugs* and medications dispensed or administered in an outpatient setting; including, but not limited to, outpatient *hospital* facilities and *physicians'* offices. While not covered under this *prescription drug* benefit, these services are covered as specified under the "Hospital," "Home Health Care," "Hospice Care," and "Home Infusion Therapy" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

5. Professional charges in connection with administering, injecting or dispensing of *drugs.* While not covered under this *prescription drug* benefit, these services are covered as specified under the "Professional Services" and "Home Infusion Therapy" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

6. *Drugs* and medications which may be obtained without a *physician's* written prescription, except insulin or niacin for cholesterol lowering.

7. *Drugs* and medications dispensed by or while you are confined in a *hospital*, *skilled nursing facility,* rest home, sanitorium, convalescent hospital, or similar facility. While not covered under this *prescription drug* benefit, such *drugs* are covered as specified under the "Hospital", "Skilled Nursing Facility", and "Hospice Care", provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits. While you are confined in a rest home, sanitarium, convalescent hospital or similar facility, *drugs* and medications supplied and administered by your *physician* are covered as specified under the "Professional Services" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to the benefit. Other *drugs* that may be prescribed by your *physician* while you are confined in a rest home, sanitarium, convalescent hospital or similar facility, may be purchased at a *pharmacy* by the *member*, or a friend, relative or care giver on your behalf, and are covered under this *prescription drug* benefit.

8. Durable medical equipment, devices, appliances and supplies, even if prescribed by a *physician*, except *prescription* contraceptive diaphragms as specified under PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED. While not covered under this *prescription drug* benefit, these items are covered as specified under the "Durable Medical Equipment", "Hearing Aid Services", and "Diabetes" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

9. Services or supplies for which you are not charged.

10. Oxygen. While not covered under this *prescription drug* benefit, oxygen is covered as specified under the "Hospital", "Skilled Nursing Facility", "Home Health Care" and "Hospice Care" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

11. Cosmetics and health or beauty aids. However, health aids that are *medically necessary* and meet the requirements for durable medical equipment as specified under the "Durable Medical Equipment" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), are covered, subject to all terms of this *plan* that apply to that benefit.

12. *Drugs* labeled "Caution, Limited by Federal Law to Investigational Use" or Non-FDA approved investigational *drugs*. Any *drugs* or medications prescribed for *experimental* indications. If you are denied a *drug* because we determine that the *drug* is *experimental* or *investigative*, you may ask that the denial be reviewed by an external independent medical review organization. (See the section "Independent Medical Review of Denials of Experimental or Investigative Treatment" (see Table of Contents) for how to ask for a review of your *drug* denial.)

13. Any expense incurred for a *drug* or medication in excess of: *prescription drug maximum allowed amount*.

14. *Drugs* which have not been approved for general use by the State of California Department of Health Services or the Food and Drug Administration. This does not apply to *drugs* that are *medically necessary* for a covered condition.

15. Over-the-counter smoking cessation *drugs*. This does not apply to *medically necessary drugs* that you can only get with a *prescription* under state and federal law.

16. *Drugs* used primarily for cosmetic purposes (e.g., Retin-A for wrinkles). However, this will not apply to the use of this type of *drug* for *medically necessary* treatment of a medical condition other than one that is cosmetic.

17. *Drugs* used primarily for the purpose of treating infertility, unless *medically necessary* for another covered condition.

18. Anorexiants and drugs used for weight loss except when used to treat morbid obesity (e.g., diet pills and appetite suppressants).

19. *Drugs* obtained outside of the United States unless they are furnished in connection with *urgent care* or an *emergency*.

20. Allergy desensitization products or allergy serum. While not covered under this *prescription drug* benefit, such *drugs* are covered as specified under the "Hospital", "Skilled Nursing Facility", and "Professional Services" provisions of YOUR MEDICAL BENEFITS:

MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

21. Infusion *drugs*, except *drugs* that are self-administered subcutaneously. While not covered under this *prescription drug* benefit, infusion *drugs* are covered as specified under the "Professional Services" and "Home Infusion Therapy" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.

22. Herbal supplements, nutritional and dietary supplements. However, formulas prescribed by a *physician* for the treatment of phenylketonuria that are obtained from a *pharmacy* are covered as specified under PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED. Special food products that are not available from a *pharmacy* are covered as specified under the "Special Food Products" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to the benefit.

23. *Prescription drugs* with a non-prescription (over-the-counter) chemical and dose equivalent except insulin. This does not apply if an over-the-counter equivalent was tried and was ineffective.

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 at least one Other Plan covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

Other Plan is any of the following:

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

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

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

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

EFFECT ON BENEFITS

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

1. If This Plan is the Principal Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan.

2. If This Plan is not the Principal Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed Allowable Expense.

3. The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if you were covered under This Plan only.

ORDER OF BENEFITS DETERMINATION

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

1. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision. This would include Medicare in all cases, except when the law requires that This Plan pays before Medicare.

2. A plan which covers you as a *subscriber* pays before a plan which covers you as a dependent. But, if you are retired and eligible for Medicare, Medicare pays (a) after the plan which covers you as a dependent of an active employee, but (b) before the plan which covers you as a retired *subscriber*.

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

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

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

a. If the parent with custody of that *child* for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that *child* as a dependent pays first.

b. If the parent with custody of that *child* for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:

   i. The plan which covers that *child* as a dependent of the parent with custody.

   ii. The plan which covers that *child* as a dependent of the stepparent (married to the parent with custody).

   iii. The plan which covers that *child* as a dependent of the parent without custody.

   iv. The plan which covers that *child* as a dependent of the stepparent (married to the parent without custody).

c. Regardless of a and b above, if there is a court decree which establishes a parent's financial responsibility for that *child's* health care coverage, a plan which covers that *child* as a dependent of that parent pays first.

4. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But, if either plan does not have a provision regarding laid-off or retired employees, provision 6 applies.

5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan do not agree under these circumstances with the order of benefit determination provisions of This Plan, this rule will not apply.

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

OUR RIGHTS UNDER THIS PROVISION

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

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

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

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

BENEFITS FOR MEDICARE ELIGIBLE MEMBERS

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

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

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

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

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

UTILIZATION REVIEW PROGRAM

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

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

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

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

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

UTILIZATION REVIEW REQUIREMENTS

Utilization reviews are conducted for the following services:

- All inpatient *hospital stays* and *residential treatment center* admissions.
- *Facility-based care* for the treatment of *mental or nervous disorders* and substance abuse.
- Organ and tissue transplants.
- Home infusion therapy.
- Home health care.
- Admissions to a *skilled nursing facility*.

- Select imaging procedures, including but not limited to: Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scan), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and Nuclear Cardiac Imaging. You may call the toll-free customer service telephone number on your identification card to find out if an imaging procedure requires pre-service review.

- Behavioral health treatment for pervasive developmental disorder or autism, as specified in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.

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

- Maternity care of 48 hours or less following a normal delivery or 96 hours or less following a cesarean section; and

- Mastectomy and lymph node dissection.

The stages of utilization review are:

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

    - Scheduled, non-emergency inpatient *hospital stays* and *residential treatment center* admissions (except inpatient *stays* for maternity care or mastectomy and lymph node dissection).

    - *Facility-based care* for the treatment of *mental or nervous disorders* and substance abuse.

    - Organ and tissue transplants.

    - Home infusion therapy.

    - Home health care.

    - Admissions to a *skilled nursing facility*.

    - Select imaging procedures, including but not limited to: Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scan), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and Nuclear Cardiac Imaging.

- Behavioral health treatment for pervasive developmental disorder or autism, as specified in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.

2. **Concurrent review** determines whether services are *medically necessary* and appropriate when we are notified while service is ongoing, for example, an emergency admission to the hospital.

3. **Retrospective review** for medical necessity is performed to review services that have already been provided. This applies in cases when pre-service or concurrent review was not completed, or in order to evaluate and audit medical documentation subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified.

EFFECT ON BENEFITS

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

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

2. When pre-service review is performed and the admission, procedure or service is determined to be *medically necessary* and appropriate, benefits will be provided for the following:

   - Organ and tissue transplants as follows:

     a. For kidney, bone, skin or cornea transplants if the *physicians* on the surgical team and the facility in which the transplant is to take place are approved for the transplant requested.

     b. For transplantation of liver, heart, heart-lung, lung, kidney-pancreas or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures if the providers of the related preoperative and postoperative services are approved and the transplant will be performed at a *Centers of Expertise (COE)* facility.

   - Services of a home infusion therapy provider if the attending *physician* has submitted both a prescription and a plan of treatment before services are rendered.

   - Home health care services if:

a. The services can be safely provided in your home, as certified by your attending *physician*;

b. Your attending *physician* manages and directs your medical care at home; and

c. Your attending *physician* has established a definitive treatment plan which must be consistent with your medical needs and lists the services to be provided by the *home health agency*.

- Services provided in a *skilled nursing facility* if you require daily skilled nursing or rehabilitation, as certified by your attending *physician*.

- Select imaging procedures, including, but not limited to: Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and nuclear cardiac imaging.

- Behavioral health treatment for pervasive developmental disorder or autism, as specified in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.

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

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

HOW TO OBTAIN UTILIZATION REVIEWS

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

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

1. For all scheduled services that are subject to utilization review, you or your *physician* must initiate the pre-service review at least three working days prior to when you are scheduled to receive services.

2. You must tell your *physician* that this *plan* requires pre-service review. *Physicians* who are *participating providers* will initiate the review on your behalf. A *non-participating provider* may initiate the review for you, or you may call us directly. The toll-free number for pre-service review is printed on your identification card.

3. If you do not receive the reviewed service within 60 days of the certification, or if the nature of the service changes, a new pre-service review must be obtained.

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

Concurrent Reviews

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

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

3. When we determine that the service is *medically necessary* and appropriate, we will, depending upon the type of treatment or procedure, specify the period of time for which the service is medically appropriate. We will also determine the medically appropriate setting.

4. If we determine that the service is not *medically necessary* and appropriate, your *physician* will be notified by telephone no later than 24 hours following our decision. We will send written notice to you and your *physician* within two business days following our decision. However, care will not be discontinued until your *physician* has been notified and a plan of care that is appropriate for your needs has been agreed upon.

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

Retrospective Reviews

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

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

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

THE MEDICAL NECESSITY REVIEW PROCESS

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

1. A decision on the medical necessity of a pre-service request will be made no later than 5 business days from receipt of the information reasonably necessary to make the decision, and based on the nature of your medical condition.

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

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

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

4. If we do not have the information we need, we will make every attempt to obtain that information from you or your *physician*. If we are unsuccessful, and a delay is anticipated, we will notify you and your *physician* of the delay and what we need to make a decision. We will also inform you of when a decision can be expected following receipt of the needed information.

5. All pre-service, concurrent and retrospective reviews for medical necessity are screened by clinically experienced, licensed personnel (called "Review Coordinators") using pre-established criteria and our medical policy. These criteria and policies are developed and approved by practicing providers not employed by us, and are evaluated at least annually and updated as standards of practice or technology change. Requests satisfying these criteria are certified as *medically necessary*. Review Coordinators are able to approve most requests.

6. A written confirmation including the specific service determined to be *medically necessary* will be sent to you and your provider no later than 2 business days after the decision, and your provider will be initially notified by telephone within 24 hours of the decision for pre-service and concurrent reviews.

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

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

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

9. Reviewers may be plan employees or an independent third party we choose at our sole and absolute discretion.

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

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

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

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

- Your coverage under this *plan* ends;
- The *agreement* with the *group* terminates;

- You reach a benefit maximum that applies to the services in question;
- Your benefits under the *plan* change so that the services in question are no longer covered or are covered in a different way.

PERSONAL CASE MANAGEMENT

The personal case management program enables us to authorize you to obtain medically appropriate care in a more economical, cost-effective and coordinated manner during prolonged periods of intensive medical care. Through a case manager, we have the right to recommend an alternative plan of treatment which may include services not covered under this *plan*. It is not your right to receive personal case management, nor do we have an obligation to provide it; we provide these services at our sole and absolute discretion.

HOW PERSONAL CASE MANAGEMENT WORKS

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

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

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

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

We make treatment recommendations only; any decision regarding treatment belong to you and your *physician*. The *group* will, in no way, compromise your freedom to make such decisions.

EFFECT ON BENEFITS

1. Any alternative benefits are accumulated toward the Lifetime Maximum.

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

3. Our authorization of services in lieu of benefits in a particular case in no way commits us to do so in another case or for another *member.*

4. The personal case management program does not prevent us from strictly applying the expressed benefits, exclusions and limitations of this *plan* at any other time or for any other *member.*

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

DISAGREEMENTS WITH MEDICAL MANAGEMENT DECISIONS

1. If you or your *physician* disagree with a decision, or question how it was reached, you or your *physician* may request reconsideration. Requests for reconsideration (either by telephone or in writing) must be directed to the reviewer making the determination. The address and the telephone number of the reviewer are included on your written notice of determination. Written requests must include medical information that supports the medical necessity of the services.

2. If you, your representative, or your *physician* acting on your behalf find the reconsidered decision still unsatisfactory, a request for an appeal of a reconsidered decision may be submitted in writing to us.

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

QUALITY ASSURANCE

Utilization review programs are monitored, evaluated, and improved on an ongoing basis to ensure consistency of application of screening criteria and medical policy, consistency and reliability of decisions by

reviewers, and compliance with policy and procedure including but not limited to timeframes for decision making, notification and written confirmation. Our Board of Directors is responsible for medical necessity review processes through its oversight committees including the Strategic Planning Committee, Quality Management Committee, and Physician Relations Committee. Oversight includes approval of policies and procedures, review and approval of self-audit tools, procedures, and results. Monthly process audits measure the performance of reviewers and Peer Clinical Reviewers against approved written policies, procedures, and timeframes. Quarterly reports of audit results and, when needed, corrective action plans are reviewed and approved through the committee structure.

HOW COVERAGE BEGINS AND ENDS

HOW COVERAGE BEGINS

ELIGIBLE STATUS

1. **Subscribers.** You are in an eligible status if you are a *retired employee*. A *retired employee* is retired from active full-time or part time employment, under the age of 65, and eligible to receive health plan benefits as part of the *group's* pension plan.

2. **Family Members.** The following are eligible to enroll as *family members:* (a) Either the *subscriber's spouse* or *domestic partner;* and (b) An unmarried *child.*

Definition of Family Member

1. **Spouse** is the *subscriber*'s spouse under a legally valid marriage. Spouse does not include any person who is: (a) covered as a *subscriber* or *domestic partner*, or (b) in active service in the armed forces.

2. **Domestic partner** is the *subscriber*'s domestic partner under a legally registered and valid domestic partnership. Domestic partner does not include any person who is: (a) covered as a *subscriber*, or (b) in active service in the armed forces.

   For a domestic partnership, other than one that is legally registered and valid, in order for the *subscriber* to include their domestic partner as a *family member*, the *subscriber* and domestic partner must provide the *group* with a signed, notarized, LACERS domestic partnership affidavit.

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

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

   b. The unmarried child is under 19 years of age, or if age 19 or over, that child is eligible until his or her 25th birthday, provided he or she is enrolled as a full-time student (for 12 or more units or credits) in a properly accredited secondary or post-secondary educational or vocational institution (a college, university, or trade or technical school). Any break in the school calendar will not disqualify a child from coverage under this provision. An unmarried child 19 years of age, but, less than 25 years of age who enters or returns to an eligible status will become eligible for coverage on the first day of the month following the date an enrollment application is filed on their behalf.

   c. The unmarried child is 19 years of age, or more and: (i) was covered under the *prior plan*, or has six or more months of *creditable coverage*, (ii) is chiefly dependent on the *subscriber, spouse or domestic partner* for support and maintenance, and (iii) is incapable of self-sustaining employment due to a physical or mental condition. A *physician* must certify in writing that the child is incapable of self-sustaining employment due to a physical or mental condition. We must receive the certification, at no expense to us, within 60-days of the date the *subscriber* receives our request. We may request proof of continuing dependency and that a physical or mental condition still exists, but not more often than once each year after the initial certification. This exception will last until the child is no longer chiefly dependent on the *subscriber, spouse* or *domestic partner* for support and maintenance due to a continuing physical or mental condition. A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

   d. A child who is in the process of being adopted is considered a legally adopted child if we receive legal evidence of both: (i) the intent to adopt; and (ii) that the *subscriber, spouse* or *domestic*

partner have either: (a) the right to control the health care of the child; or (b) assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption. Legal evidence to control the health care of the child means a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or relinquishment form, signed by the child's birth parent, or other appropriate authority, or in the absence of a written document, other evidence of the *subscriber*'s, *spouse*'s or the *domestic partner's* right to control the health care of the child.

e. A child for whom the *subscriber, spouse* or *domestic partner* is a legal guardian is considered eligible on the date of the court decree (the "eligibility date"). We must receive legal evidence of the decree.

f. The term "child" does not include any person who is: (i) covered as a *subscriber*; or (ii) in active service in the armed forces.

g. If both parents are covered as *subscribers*, their children may be covered as the *family members* of either, but not of both.

ELIGIBILITY DATE

1. For *subscribers,* you become eligible for coverage on the first day of the month coinciding with or following the date you retire.

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

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 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

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

1. **Timely Enrollment:** If you enroll for coverage before, on, or within 60 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,* provided the enrollment application is on time and in order.

2. **Late Enrollment.** If you fail to enroll within 60 days after your eligibility date, you must wait until the *group's* next Open Enrollment Period to enroll.

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

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

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

In both cases, coverage will be in effect for 31 days. For the *child's* enrollment to continue beyond this 31-day period, the *subscriber* or *domestic partner* must submit a membership change form to the *group* within the 31-day period. We must then receive the form from the *group* within 90 days.

Special Enrollment Periods

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

1. You have met all of the following requirements:

    a. You were covered as an individual or dependent under either:

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

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

    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 wait until the *group's* next open enrollment 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 or CalCOBRA continuation, coverage ended because you lost eligibility under the other plan, your coverage under a COBRA or CalCOBRA continuation was exhausted, or employer contributions toward coverage under the other plan terminated. You must properly file an application with the *group* within 60 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. A court has ordered coverage be provided for a *spouse, domestic partner* or dependent *child* under your employee health plan and an application is filed within 60 days from the date the court order is issued.

3. 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 60 days after your eligibility date, or if you disenroll, and later file an enrollment application, your coverage may not begin until the first day of the month following the end of the *group's* next open enrollment period.

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

   a. If you are enrolling following marriage or domestic partnership, you and your new *spouse* or *domestic partner* must enroll within 31 days of the date of marriage or domestic partnership. Your *domestic partner* must meet the *plan*'s eligibility requirements for *domestic partners* as outlined under HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE BEGINS. Your new *spouse* or *domestic partner's* children may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above.

   b. If you are enrolling following the birth, adoption, or placement for adoption of a *child*, your *spouse* (if you are already married) or *domestic partner*, who is eligible but not enrolled, may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above. Application must be made within 31 days of the birth or date of adoption or placement for adoption.

5. 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.

6. The date the *subscriber* reaches the age of 55.

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, except as specified below:

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

2. For enrollments following the birth, adoption, or placement for adoption of a *child*, coverage will be effective as of the date of birth, adoption, or placement for adoption.

OPEN ENROLLMENT PERIOD

The *group* has an open enrollment period once each *year*, during the month of October. During that time, an individual who meets the eligibility requirements as a *subscriber* under this *plan* may enroll. A *subscriber* may also enroll any eligible *family members* at that time. Persons eligible to enroll as *family members* may enroll only under the *subscriber's plan*.

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

HOW COVERAGE ENDS

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 this *agreement* is amended to delete coverage for *family members,* a *family member*'s coverage ends on the effective date of that change.

3. Coverage for *family members* ends when *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.

   Exceptions to item 6:

   a. **Leave of Absence.** If you are a *subscriber* and the *group* pays subscription charges to us on your behalf, your coverage may continue for up to six months during a temporary leave of absence approved by the *group*. This time period may be extended if required by law.

   b. **Handicapped Children:** If a *child* reaches the age limits shown in the "Eligible Status" provision of this section, the *child* will continue to qualify as a *family member* if he or she is (i) covered under this *plan,* (ii) still chiefly dependent on the *subscriber, spouse* or *domestic partner* for support and maintenance, and (iii) incapable of self-sustaining employment due to a physical or mental condition. A *physician* must certify in writing that the *child* has a physical or mental condition that makes the *child* incapable of obtaining self-sustaining employment. We will notify the *subscriber* that the *child's* coverage will end when the *child* reaches the *plan's* upper age limit at least 90-days prior to the date the *child* reaches that age. The *subscriber* must send proof of the *child's* physical or mental condition within 60-days of the

date the *subscriber* receives our request. If we do not complete our determination of the *child's* continuing eligibility by the date the *child* reaches the *plan's* upper age limit, the *child* will remain covered pending our determination. When a period of two years has passed, we may request proof of continuing dependency due to a continuing physical or mental condition, but not more often than once each year. This exception will last until the *child* is no longer chiefly dependent on the *subscriber*, *spouse* or *domestic partner* for support and maintenance or a physical or mental condition no longer exists. A *child* is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

c. **Full time students taking a medical leave of absence from school:** If a *child* who is 19 years of age or more, enrolled as a full-time student (for 12 or more units or credits) in a properly accredited secondary or post-secondary educational or vocational institution (a college, university, or trade or technical school), and covered under this *plan* in accordance with the "Eligible Status" provision of this section, the *child* may remain covered under this *plan* for a period not to exceed 12 months or until the date the *child's* coverage would normally end in accordance with the terms and conditions of this *plan*, whichever comes first, during a medical leave of absence from school. This provision applies if the nature of the *child's* health condition does not meet the requirements of the "Handicapped Children" provision, above. The period of coverage during this medical leave of absence will begin on the first day of the leave or on the date a *physician* determines the child's illness, injury, or condition prevented the *child* from attending school, whichever comes first. Any break in the school calendar will not disqualify the *child* from maintaining coverage under this provision. A *physician* must certify in writing that the leave of absence from school is medically necessary. This certification must be submitted to us at least 30 days prior to the date the leave begins if the medical reason for the leave and the leave itself are foreseeable. If the medical reason for the leave and the leave itself are not foreseeable, the certification must be submitted to us within 30 days after the date the leave begins.

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*, and their dependent *children*, 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* and the children of the *spouse* or *domestic partner*, if any, immediately upon termination of the *subscriber's* marriage or domestic partnership, such notice will be considered compliance with the requirements of this provision.

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

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

Most employers who employ 20 or more people on a typical business day are subject to The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If the employer who provides coverage under the *agreement* is subject to the federal law which governs this provision (Title X of P. L. 99-272), you may be entitled to a period of continuation of coverage. Check with your employer for details. Your employer must provide you with the name of your Health Plan Administrator. Your Health Plan Administrator will give you notice of your right to continue coverage after certain "Qualifying Events". You must notify your health Plan Administrator of the occurrence of any subsequent Qualifying Events. (See the "Terms of COBRA Continuation" provision 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 appear in capital letters. When you see these capitalized words, you should refer to this "Definitions" provision.

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

Qualified Beneficiary means: (a) a person enrolled for this COBRA continuation coverage who, on the day before the Qualifying Event, was covered under this *agreement* as either a *subscriber* or *family member;* and (b) a *child* who is born to or placed for adoption with the *subscriber* during the COBRA continuation period. Qualified Beneficiary does not include any person who was not enrolled during the Initial Enrollment Period, including any *family members* acquired during the COBRA continuation period, with the exception of newborns and adoptees as specified above.

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

1. **For Subscribers and Family Members:**
    a. The *subscriber's* termination of employment, for any reason other than gross misconduct; or
    b. A reduction in the *subscriber's* work hours.
2. **For Retired Employees and their Family Members.** Cancellation or a substantial reduction of retiree benefits under the *plan* due to the *group's* filing for Chapter 11 bankruptcy, provided that:
    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.
3. **For Family Members:**
    a. The death of the *subscriber;*
    b. The *spouse's* divorce or legal separation from the *subscriber;*
    c. The end of a *domestic partner's* partnership with the *subscriber*;

d. The end of a *child's* status as a dependent *child,* as defined by the *agreement;* or

e. The *subscriber's* entitlement to Medicare.

ELIGIBILITY FOR COBRA CONTINUATION

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

TERMS OF COBRA CONTINUATION

Notice. The Health Plan Administrator (we are not the administrator) will notify either the *subscriber* or *family member* of the right to continue coverage under COBRA, as provided below:

1. For Qualifying Events 1 or 2 above, the *subscriber* will be notified of the continuation right.
2. For Qualifying Events 3(a) or 3(d) above, a *family member* will be notified of the continuation right.
3. For Qualifying Events 3(b) or 3(c) above, you must inform the Health Plan Administrator within 60 days of the Qualifying Event if you wish to continue coverage. The Health Plan Administrator, in turn, will promptly give you official notice of the continuation right.

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

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

You must remit the initial subscription charge to us within 45 days after you elect COBRA continuation coverage.

Additional Family Members. A *spouse, domestic partner* or *child* acquired during the COBRA continuation period is eligible to be enrolled as a *family member.* The standard enrollment provisions of the *agreement* apply to enrollees during the COBRA continuation period.

Cost of Coverage. You are required to pay the entire cost of your COBRA continuation coverage. You must remit this cost (called the "subscription charge") to us each month during the COBRA continuation period. In addition to the subscription charge, we will add a monthly administrative fee equal to two percent of that charge. We must receive payment of the subscription charge and administrative fee each month in order to maintain the coverage in force.

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

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

Payment Dates. The first payment is due along with your enrollment form within 45 days after you elect continuation coverage. We will bill you for any retroactive charges which may be due. Succeeding subscription charges are due on the first day of each following month (the Subscription Charge Due Date).

Grace Period. For every Subscription Charge Due Date, except the first, there is a 31-day grace period in which to pay subscription charges. If subscription charges are not received by the end of the grace period, your coverage will be canceled at the end of the period for which subscription charges are last paid.

Change of Subscription Charge. The amounts of the subscription charges may be changed by us as of any Subscription Charge Due Date. Your Health Plan Administrator agrees to provide you with written notice at least 60 days prior to the date any subscription charge increase goes into effect.

Accuracy of Information. You are responsible for supplying up-to-date eligibility information. We shall rely upon the latest information received as correct without verification; but we maintain the right to verify any eligibility information you provide.

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

For example, a *child* may have been originally eligible for this COBRA continuation due to termination of the *subscriber's* employment, and enrolled for this COBRA continuation as a Qualified Beneficiary. If, during the COBRA continuation period, the *child* reaches the upper age limit of the *plan,* the *child* is eligible for an extended continuation period

which would end no later than 36 months from the date of the original Qualifying Event (the termination of employment).

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

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

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

1. The end of 18 months from the Qualifying Event, if the Qualifying Event was termination of employment or reduction in work hours;*
2. The end of 36 months from the Qualifying Event, if the Qualifying Event was the death of the *subscriber,* divorce or legal separation, the end of a domestic partnership or the end of dependent *child* status;*
3. The end of 36 months from the date the *subscriber* became entitled to Medicare, if the Qualifying Event was the *subscriber's* entitlement to Medicare. If entitlement to Medicare does not result in coverage terminating and Qualifying Event 1 occurs within 18 months after Medicare entitlement, coverage for Qualified Beneficiaries other than the *subscriber* will end 36 months from the date the *subscriber* became entitled to Medicare;
4. The date the *agreement* terminates;
5. The end of the period for which subscription charges are last paid;
6. 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; or
7. The date, following the election of COBRA, the *member* first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

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

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

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 covered *family members* may continue coverage for 36 months after the *subscriber's* death. But coverage could terminate prior to such time for either the *subscriber* or *family member* in accordance with items 4, 5 or 6 above.

If your COBRA continuation under this *plan* ends in accordance with items 1, 2 or 3, you may be eligible for medical conversion coverage. If your COBRA continuation under this *plan* ends in accordance with items 1, 2, 3, or 4 you may be eligible for HIPAA coverage. The *group* will provide notice of these options within 180 days prior to your COBRA termination date. Please see HIPAA COVERAGE AND CONVERSION in this booklet for more information.

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 us 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, you must remit to us the cost for the extended continuation coverage. 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. You are required to pay the entire cost of your extended continuation coverage.

3. You must remit the cost for extended continuation coverage to us each month. We must receive your timely payment of the subscription charge each month in order to maintain the coverage in force.

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; or

6. The date, following the election of COBRA, the *member* first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

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

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

CALCOBRA CONTINUATION OF COVERAGE

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

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

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

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

TERMS OF CALCOBRA CONTINUATION

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

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

Additional Family Members. A dependent acquired during the CalCOBRA continuation period is eligible to be enrolled as a *family member*. The standard enrollment provisions of the *agreement* apply to enrollees during the CalCOBRA continuation period.

Cost of Coverage. You will be required to pay the entire cost of your CalCOBRA continuation coverage (this is the "subscription charge"). This cost will be:

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

You must make payment to us within the timeframes specified below. We must receive payment of your subscription charge each month to maintain your coverage in force.

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

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

Change of Subscription Charge. The amounts of the subscription charges may be changed by us as of any subscription charge due date. We will provide you with written notice at least 60 days prior to the date any subscription charge increase goes into effect.

Accuracy of Information. You are responsible for supplying up-to-date eligibility information. We shall rely upon the latest information received as correct without verification; but we maintain the right to verify any eligibility information you provide.

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

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

For *family members* properly enrolled during the CalCOBRA continuation, coverage begins according to the enrollment provisions of the *agreement*.

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

1. The date that is 36 months after the date of your qualifying event under federal COBRA*;
2. The date the *agreement* terminates;

3. The date the *group* no longer provides coverage to the class of *members* to which you belong;

4. The end of the period for which subscription charges are last paid (your coverage will be cancelled upon written notification, as explained under "Payment Dates", above);

5. The date you become covered under any other health plan, unless the other health plan contains an exclusion or limitation relating to a pre-existing condition that you have. In this case, this continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied;

6. The date you become entitled to Medicare; or

7. The date you become covered under a federal COBRA continuation.

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

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

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

COVERAGE FOR SURVIVING FAMILY MEMBERS

If the *retired employee* dies while covered under this *plan*, coverage continues for enrolled *family members* until one of the following occurs:

1. The surviving *spouse* remarries*, or
2. Premium is not paid to us on the *member's* behalf, or
3. The *group* cancels coverage for the class of *subscribers* to which the *member* belongs, or
4. The *policy* between the *group* and us terminates, or
5. The *child* no longer meets all of the conditions of coverage in HOW COVERAGE BEGINS AND ENDS.

***Exception:** Coverage continues for the surviving *spouse* of a certificated *full-time employee* or a certificated *retired employee*. Coverage does not continue for *children*.

Note: The cost of continuing coverage under this provision may be more than the cost of coverage the *group* provides to its *subscribers* or their *family members*. The *member* may be responsible for all or part of the subscription charges.

EXTENSION OF BENEFITS

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

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

HIPAA COVERAGE AND CONVERSION

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

HIPAA Coverage

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

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

You must apply for HIPAA coverage within 63 days of the date your coverage under the employer's *plan* ends. Any carrier or health plan that offers individual medical coverage must make HIPAA coverage available to qualified persons without regard to health status. If you decide to enroll in HIPAA coverage, you will no longer qualify for conversion coverage.

Conversion Coverage

To apply for a conversion plan, you must submit an application to us and make the first subscription charge payment within 63 days of the date your coverage under the employer's *plan* ends. Under certain circumstances you are not eligible for a conversion plan. They are:

1. You are not eligible if your coverage under this *plan* ends because the *agreement* between the *group* and us terminates and is replaced by another group plan within 15 days.

2. You are not eligible if your coverage under this *plan* ends because subscription charges are not paid when due because you (or the *subscriber* who enrolled you as a dependent) did not contribute your part, if any.

3. You are not eligible for a conversion plan if you are eligible for health coverage under another group plan when your coverage ends.

4. You are not eligible for a conversion plan if you are eligible for Medicare coverage when your coverage under this *plan* ends, whether or not you have actually enrolled in Medicare.

5. You are not eligible for a conversion plan if you are covered under an individual health plan.

6. You are not eligible for a conversion plan if you were not covered for medical benefits under the *plan* for three consecutive months immediately prior to the termination of your coverage.

If you decide to enroll in a conversion plan, you will no longer qualify for HIPAA coverage.

Important: The intention of conversion coverage is not to replace the coverage you have under this *plan,* but to make available to you a specified amount of coverage for medical benefits until you can find a replacement. The conversion plan provides lesser benefits than this *plan* and the provisions and rates differ.

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

GENERAL PROVISIONS

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

Independent Contractors. Our relationship with providers is that of an independent contractor. *Physicians,* and other health care professionals, *hospitals, skilled nursing facilities* and other community agencies are not 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.*

Out-of-Area Services. We have a variety of relationships with other Blue Cross and/or Blue Shield licensees referred to generally as "Inter-Plan Programs." Whenever you obtain health care services outside of California, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard® Program and may include negotiated National Account arrangements available between us and other Blue Cross and Blue Shield licensees.

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

BlueCard® Program. Under the BlueCard® Program, when you access covered health care services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating health care providers.

- Whenever you access covered healthcare services outside of California, and the claim is processed through the BlueCard Program, the amount you pay for covered health care services is calculated based on the lower of: The billed covered charges for your covered services, or
- The negotiated price that the Host Blue makes available to us.

Often, this "negotiated price" will consist of a simple discount, which reflects the actual price paid by the Host Blue to your health care provider. But sometimes it is an estimated price that takes into account

special arrangements with your health care provider or provider group that may include types of settlements, incentive payments, and other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care providers after taking into account the same types of transactions as with an estimated price.

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

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

Non-Participating Health Care Providers Outside Our Service Area

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

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

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

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

Terms of Coverage

1. In order for you to be entitled to benefits under the *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.

Protection of Coverage. We do not have the right to cancel your coverage under this *plan* while: (1) this *plan* is in effect; (2) you are eligible; and (3) your 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*). *Hospitals* and other health care facilities may be paid either a fixed fee or on a discounted fee-for-service basis.

Availability of Care. If there is an epidemic or public disaster and you cannot obtain care for covered services, 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 we determine to be *medically necessary*. The services must be ordered by the attending *physician* for the direct care and treatment of a covered condition. They must be standard medical practice where received for the condition being treated and must be legal in the United States. The process used to authorize or deny health care services under this *plan* is available to you upon request.

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

Benefits Not Transferable. Only the *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 12 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 customer service 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*, *COE* and medical transportation providers. If you or one of your *family members* receives services from *non-contracting hospitals* or *non-participating providers*, payment will be made directly to the *subscriber* and you will be responsible for payment to the provider. Any assignment of benefits, even if assignment includes the providers right to receive payment, is void unless an *authorized referral* has been approved by us. We will pay *non-contracting hospitals* and other providers of service directly when *emergency services* and care are provided to you or one of your *family members*. We will continue such direct payment until the emergency care results in stabilization. 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.

Right of Recovery. Whenever payment has been made in error, we will have the right to recover such payment from you or, if applicable, the provider, in accordance with applicable laws and regulations. In the event we recover 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.

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

Prepayment Fees. Your employer is responsible for paying subscription charges to us for all coverage provided to you and your *family members*. Your employer may require that you contribute all or part of the costs of these subscription charges. Please consult your employer for details.

Liability of Subscriber to Pay Providers. In accordance with California law, you will not be required to pay any *participating provider* or *other health care 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* any amounts not paid to them by us.

Renewal Provisions. Your employer'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.

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 applicable to Anthem or its affiliates' agreements for insured group accounts.

Under arrangements with some health care providers and suppliers (hereafter referred to together as "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.

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

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

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

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

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

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

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

6. Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the time you enroll with Anthem.

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

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

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

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

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

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

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

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

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

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

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

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

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

We will notify you by telephone, and the provider by telephone and fax, as to whether or not your request for continuity of care is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the *plan*. Financial arrangements with terminated providers are negotiated on a case-by-case basis. We will request that the terminated provider agree to accept reimbursement and contractual requirements that apply to *participating providers*, including payment terms. If the terminated provider does not agree to accept the same reimbursement and contractual requirements, we are not required to continue that provider's services. If you disagree with our determination regarding continuity of care, you may file a grievance with us by following the procedures described in the section entitled GRIEVANCE PROCEDURES.

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 Customer Service Department listed on your identification card.

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

Creditable coverage is any individual or group plan that provides medical, hospital and surgical coverage, including continuation or conversion coverage, coverage under Medicare or Medicaid, TRICARE, the Federal Employees Health Benefits Program, programs of the Indian Health Service or of a tribal organization, a state health benefits risk pool, coverage through the Peace Corps, the State Children's Health Insurance Program, or a public health plan established or maintained by a state, the United States government, or a foreign country. Creditable coverage does not include accident only, credit, coverage for on-site medical clinics, disability income, coverage only for a specified disease or condition, hospital indemnity or other fixed indemnity insurance, Medicare supplement, long-term care insurance, dental, vision, workers'

compensation insurance, automobile insurance, no-fault insurance, or any medical coverage designed to supplement other private or governmental plans. Creditable coverage is used to set up eligibility rules for children who cannot get a self-sustaining job due to a physical or mental condition.

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

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

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

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

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

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

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

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

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

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

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

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

Family member meets the *plan's* eligibility requirements for family members as outlined under HOW COVERAGE BEGINS AND ENDS.

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

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

Group refers to the business entity to which we have issued this *agreement*. The name of the group is LOS ANGELES CITY EMPLOYEES' RETIREMENT SYSTEM (LACERS).

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

Home infusion therapy provider is a provider licensed according to state and local laws as a pharmacy, and must be either certified as a home health care provider by Medicare, or accredited as a home pharmacy by the Joint Commission on Accreditation of Health Care Organizations.

Hospice is an agency or organization providing a specialized form of interdisciplinary health care that provides palliative care (pain control and symptom relief) and alleviates the physical, emotional, social, and spiritual discomforts of a terminally ill person, as well as providing supportive care to the primary caregiver and the patient's family. A

hospice must be: currently licensed as a hospice pursuant to Health and Safety Code section 1747 or a licensed *home health agency* with federal Medicare certification pursuant to Health and Safety Code sections 1726 and 1747.1. A list of hospices meeting these criteria is available upon request.

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

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

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

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

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

Medically necessary procedures, supplies equipment or services are those we determine to be:

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Provided for the diagnosis or direct care and treatment of the medical condition;
3. Within standards of good medical practice within the organized medical community;
4. Not primarily for your convenience, or for the convenience of your *physician* or another provider; and
5. The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:

a. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and

b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and

c. For *hospital stays*, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received by you as an outpatient or in a less intensified medical setting.

Member is the *subscriber* or *family member.*

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

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

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

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

1. A *hospital;*
2. A *physician;*
3. An *ambulatory surgical center;*
4. A *home health agency;*

5. A facility which provides diagnostic imaging services;
6. A durable medical equipment outlet;
7. A *skilled nursing facility*;
8. A clinical laboratory;
9. A *home infusion therapy provider*; or
10. A licensed qualified autism service provider

Remember that the *maximum allowed amount* may only represent a portion of the amount which a *non-participating provider* charges for services. See YOUR MEDICAL BENEFITS: MAXIMUM ALLOWED AMOUNT.

Other health care provider is one of the following providers:

1. A certified registered nurse anesthetist;
2. A blood bank;
3. A Christian Science practitioner/sanatorium;
4. A licensed ambulance company; or
5. A *hospice*.

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

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

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

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

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

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

Pharmacy means a licensed retail pharmacy.

Pharmacy and Therapeutics Process is a process in which health care professionals including nurses, pharmacists, and *physicians* determine the clinical appropriateness of *drugs* and promote access to quality medications. The process also reviews *drugs* to determine the most cost effective use of benefits and advise on programs to help improve care. Our programs include, but are not limited to, *drug* utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and *drug* profiling initiatives.

Pharmacy Benefits Manager (PBM) is the entity with which Anthem has contracted with to administer its prescription drug benefits. The PBM is an independent contractor and not affiliated with Anthem.

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 licensed educational psychologist for the provision of behavioral health treatment services for the treatment of pervasive developmental disorder or autism only
    - A chiropractor (D.C.)
    - An acupuncturist (A.C.)
    - A licensed clinical social worker (L.C.S.W.)
    - A marriage and family therapist (M.F.T.)
    - A licensed professional clinical counselor (L.P.C.C.)*

- A physical therapist (P.T. or R.P.T.)*
- A speech pathologist*
- An audiologist*
- An occupational therapist (O.T.R.)*
- A respiratory care practitioner (R.C.P.)*
- A nurse midwife**
- A nurse practitioner
- A physician assistant
- A *psychiatric mental health nurse* (R.N.)*
- A registered dietitian (R.D.)* for the provision of diabetic medical nutrition therapy only

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

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

Plan is the set of benefits described in this 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 covered expense is the expense you incur for a covered *prescription drug*, but not more than the *prescription drug maximum allowed amount*. Expense is incurred on the date you receive the service or supply.

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

Prescription drug maximum allowed amount is the maximum amount we will allow for any *drug*. The amount is determined by us using prescription drug cost information provided to us by the *pharmacy benefits manager*. The amount is subject to change. You may determine

the prescription drug maximum allowed amount of a particular drug by calling 1-800-700-2541 (or TTY/TDD 1-800-905-9821).

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.

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

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

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

1. Licensed by the California Department of Health Services;
2. Qualified to provide short-term inpatient treatment according to 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 and customary value is (1) for professional *non-participating providers*, the reasonable and customary value is determined by using a percentile of billed charges from a database of a third-party that takes into consideration various factors, such as the amounts billed for same or similar services, and the geographic locations in which the services were rendered; and (2) for facility *non-participating providers* and *non-contracting hospitals*, the reasonable and customary value is determined by using a percentile of billed charges from a database of Anthem's actual claims experience, subject to certain

thresholds based on each provider's cost-to-charge ratio as reported by the provider to a California governmental agency and the actual claim submitted to us.

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.

Retired employee is a former full-time employee or part 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 inpatient confinement which begins when you are admitted to a facility and ends when you are discharged from that facility.

Subscriber is the person who, by meeting the *plan's* eligibility requirements for 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 retired employee is a *retired employee* who is unable to perform all activities usual for persons of that age.

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

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

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

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

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

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

GRIEVANCE PROCEDURES

If you have a question about your eligibility, (including if you believe your coverage under this *plan* has been or will be improperly terminated), your benefits under this *plan*, or concerning a claim, 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 Customer Service Department listed on your identification card). Our customer service 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 customer service representative. You may complete and return the form to us, or ask the customer service 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 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 Customer Service 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, P.O. Box 4310, Woodland Hills, CA 91365-4310. 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 customer service 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

Your Rights and Responsibilities as an Anthem Blue Cross Member

As an Anthem Blue Cross *member* you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, we're committed to making sure your rights are respected while providing your health benefits. That also means giving you access to our network providers and the information you need to make the best decisions for your health and welfare.

These are your rights and responsibilities:

You have the right to:

- Speak freely and privately with your doctors and other health providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it's covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect us to keep your personal health information private. This is as long as it follows state and Federal laws, and our privacy policies.
- Get the information you need to help make sure you get the most from your health plan, and share your feedback. This includes information on:
    - Our company and services
    - Our network of doctors and other health care providers
    - Your rights and responsibilities
    - The rules of your health care plan
    - The way your health plan works
- Make a complaint or file an appeal about:
    - Your health care plan
    - Any care you get
    - Any covered service or benefit ruling that your health care plan makes
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your doctor tell you how that may affect your health now and in the future.

- Get all of the most up-to-date information from a doctor or other health care professional about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose another person to be with you to help you to understand.

You have the responsibility to:

- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- Follow all health care plan rules and policies.
- Choose any primary care physician (doctor), also called a PCP, who is in our network if your health care plan requires it.
- Treat all doctors, health care providers, and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers and call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your doctors or other health care providers to make a treatment plan that you all agree on.
- Follow the care plan that you have agreed on with your doctors or health care providers.
- Give us, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health care plans and insurance benefits you have in addition to your coverage with us.
- Let our Customer Service department know if you have any changes to your name, address or family members covered under your plan.

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

We are committed to providing quality benefits and customer service to our *members.* Benefits and coverage for services provided under the benefit program are governed by the Evidence of Coverage and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact us, please go to **www.anthem.com/ca** and select "Customer Support>Contact Us", or you may call the customer service number on your ID card.

ORGAN DONATION

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

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

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

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

www.donatelifecalifornia.org/

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

ANTHEM BLUE CROSS WEB SITE

Information specific to your benefits and claims history are available by calling the 800 number on your identification card or on the Anthem Blue Cross web site at **www.anthem.com/ca**. To access benefit information, claims payment status, benefit maximum status, participating providers or to order an ID card, simply log on to the web site, select "Member", and click the "Register" button on your first visit to establish a User ID and Password to access the personalized and secure MemberAccess Web site. Once registered, simply click the "Login" button and enter your User ID and Password to access the MemberAccess Web site. Our privacy statement can also be viewed on our website. You may also submit a grievance online or print the Plan Grievance form through the website.

LANGUAGE ASSISTANCE PROGRAM

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

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

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

- Spanish
- Chinese
- Vietnamese
- Korean
- Tagalog

Oral interpretation services are available in additional languages.

Requesting a written or oral translation is easy. Just contact Member Services by calling the 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.

STATEMENT OF RIGHTS UNDER THE NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

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

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

In addition, a plan or issuer may not, under federal law, require that a *physician* or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, please call us at the customer service telephone number listed on your ID card.

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

This *plan*, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). If you have any questions about this coverage, please call us at the customer service telephone number listed on your ID card.

EXHIBIT 2

AASLD Position on Treating Patients with Chronic HCV

AASLD Position on Treating Patients with Chronic Hepatitis C Virus
HCV Guidance FAQ

The American Association for the Study of Liver Diseases (AASLD) is the leading organization of scientists and health care professionals committed to preventing and curing liver disease, and to promoting liver health and quality patient care. AASLD has always put the patient first by providing clinicians with the latest rigorous data on the best treatments for patients with liver diseases, including hepatitis C.

Our recent addition to the Guidance prepared by a committee of leading liver experts from AASLD and The Infectious Diseases Society of America (IDSA) proposed that the sickest patients be treated first, but all patients who receive advice from their doctor to take newest medications should not be denied. The decision across the board should be in the hands of the clinician and the patient to make the decision. Unfortunately payers across America are denying treatment when a doctor has prescribed it for their patient. We adamantly disagree with this decision.

Our Guidance is not intended to be used by payers to deny access to treatment. In no way does this position contradict the evidence evaluated to produce the Guidance and the recommendation made in the Guidance to treat the sickest first, but recognizes need to treat all.

Some confusion exists about our process of advising physicians. The Guidance committee relied on the best available published evidence and expert opinion.

HCV Guidance FAQ

Chronic hepatitis C virus (HCV) infection affects more than 3 million Americans and is a major cause of liver disease, cirrhosis, and liver cancer. Although several new drugs have now made it possible to cure almost all individuals with this infection, several obstacles remain. Read the FAQs.

AASLD has produced numerous Practice Guidelines, which require a tremendous amount of time and level of evidence. The Guidance was released based on a thorough review of current scientific evidence along with expert opinion. To wait for further evidence to appear in the literature as opposed to assessing what currently exists and relying on expert opinion -- which is what the committee did -- would be irresponsible to patients and clinicians.

AASLD remains committed to its partnership with IDSA and to continuing to fund and write the practice Guidance. As the only organization solely dedicated to the prevention and cure of liver disease, we applaud the seminal research of our members who made recent treatment options possible. We are concerned about cost, but we also recognize the value of this drug to patients with hepatitis C. It's a one-time treatment, with minimal side effects and a great cure rate.
Treatments currently available and those we are confident will soon receive FDA-approval should be heralded as remarkable advances in curing a disease that was once fatal.

Background on the Development of the Guidance

On September 24, 2014, AASLD and IDSA published online one of the final two sections of their practice Guidance for hepatitis C -- *Monitoring Patients Who Are Starting Hepatitis C Treatment, Are in Treatment, or Have Completed Therapy.* The other section, *Management of HCV Infection*, has been approved and will be released in the next few weeks. The Guidance is now complete; however, it will be updated regularly. The online, easily updateable format was created to allow for us to change the Guidance as new drugs are approved by the Food and Drug Administration.

AASLD and IDSA recognized there was a need for clinical guidance. Our Federal partners such as the National Institutes of Health, Centers for Disease Control and Prevention, and the US Department of Health and Human Services were also aware of this need and supported the creation of a practice Guidance to help clinicians who treat patients with hepatitis C. AASLD and IDSA stepped forward to fund and create this Guidance independent of any industry financial support.

1001 North Fairfax Street | Suite 400 | Alexandria, Virginia 22314
Phone:703-299-9766

EXHIBIT 3

Anthem UM Services, Inc.
c/o 8640 Evans Road, Mail Stop B401-03
St. Louis, MO 63134

Anthem UM Services, Inc.

October 20, 2014

2014186455 - 11508 CID PCM-UMCPA
JANE BLUMENFELD
969 HILGARD AVE #1109
LOS ANGELES, CA 90024

Date Created: 10/16/2014
Reference Number: 26141823
Member Name: JANE BLUMENFELD
Medication: Harvoni Tablet
Provider: Dr. STEVEN HAN
Denial Reason: MEDICAL NECESSITY

Dear JANE BLUMENFELD:

Anthem UM Services, Inc. provides utilization management services for Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance. We want you to understand how your health plan works so you can get the most from your health plan benefits. Certain medications within your health plan require review to see if they are covered under your description of benefits. Coverage for the requested medication is denied because the medication does not meet the criteria of "medical necessity" under your description of benefits. Medications that are considered not medically necessary are not covered according to your description of benefits. To assist our medical director in making this decision, we have put a process in place to send all information about the service to a clinical reviewer with appropriate credentials.

Based on their opinion, we have determined that coverage for the requested medication is denied.

Our clinical reviewer concluded the following because we do not have enough information, your request for Harvoni cannot be approved at this time. You are being treated for a liver infection (Hepatitis C; genotype 1). We need to know if you have scarring in your liver (fibrosis score by liver biopsy or results of FibroScan elastography). We need to know what other drugs, if any, you will be treated with for your infection. We cannot approve your request without this information. We based this decision on your plan's prior authorization criteria for HARVONI 90MG-400MG TABLET.

This review was completed by: Don Wentzel MD

In making medical necessity determinations that are consistent with our contract language, medical reviewers follow established criteria and guidelines when available and applicable to the member's situation, including the health plan's guidelines and/or other available information such as peer reviewed or evidence based literature. Guidelines are available on our website at www.anthem.com/pharmacyinformation. To request prior authorization guidelines or the applicable criteria used in this case, diagnosis and description when available, and/or to request an explanation of the clinical judgment for this determination or any other documents related to this determination, please call Customer Service at: 866 297-1013 and it will be provided free of charge. Refer to the subscriber's description of benefits under the section marked exclusions for information on not medically necessary services.

The materials provided to you are guidelines used by this plan to authorize, modify, or deny health care benefits for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract.

Member: Your provider will receive a copy of this letter. If you have questions about this determination you may call customer service at the number on your health plan identification card. Please see the attached for your additional member rights.

Provider: If you have not already done so and would like to discuss this determination with our clinical reviewer, please contact us at 800-794-0838 before all applicable appeals have been completed. At the time of your call, please provide the following:

- Member Name
- Reference Number (from top of this letter)
- Requested Medication
- Member Policy ID Number
- Date of Service

This decision doesn't mean that you can't or shouldn't receive this medication. Only you and your health care providers can decide whether you need it. But, this decision means that if you do receive the medication, it won't be covered by your plan.

If you or your provider disagrees with this decision, please see the attached information for additional rights.

Sincerely,

Michael M. Su, MD, MBA
Medical Director
Utilization Management

cc: Dr. STEVEN HAN

Rights Available to Members

If you don't agree with this decision, you have the right to ask for a grievance (also known as an appeal). Unless your benefits booklet states otherwise, you must ask for a grievance within 180 calendar days from the date you get this letter. Your provider, or any other person you choose (authorized representative), may ask for a grievance on your behalf. A person of your choice may also help you during the grievance process. You need to let us know, in writing, if you want someone to help or represent you.

How do I ask for an urgent (expedited) grievance?

An urgent grievance is available if you haven't had services (pre-service) or if you are currently getting services (concurrent care) and you, or your health care provider, believe that your condition could involve an imminent and serious threat to your health, including, but not limited to, severe pain or potential loss of life, limb or major bodily function.

We will let you know the decision within 72 hours after we get a qualifying urgent grievance. We will let you know the decision by phone. We will also send you the decision in writing.

You, or any person you choose, can ask for an urgent grievance in writing or by phone:

In writing: **Overnight mail**
Grievances and Appeals
21555 Oxnard Street
Woodland Hills, CA 91367
By phone: **800-365-0609** or **866-333-4823** (TDD line if you have hearing or speech loss)

How do I ask for a standard (not expedited) grievance?

You, or any person you choose, can ask for a standard grievance in writing, by phone or online.

In writing: **Grievances and Appeals**
P.O. Box 4310
Woodland Hills, CA 91365-4310
By phone: **800-365-0609** or **866-333-4823** (TDD line for the hearing and speech impaired)
Online: **www.anthem.com/ca**

We will send a written decision within 30 calendar days from the date we get the grievance. Our response will have reasons for the decision and references to the plan provisions on which the decision was based. However, grievances received over the phone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, will not receive a written response.

What should my grievance include?

Include, if available, the following information:

- The member's name and ID number;
- The name of the provider who will or has provided care;
- The date(s) of service;

- The claim or reference number for the specific decision with which you don't agree; and

- The specific reason(s) why you don't agree with the decision.

You have the right, and we encourage you, to give us written comments, documents and other relevant information with your grievance.

How will my grievance be handled?

The appropriate administrative and/or clinical specialists will review your grievance. All relevant information submitted by you or on your behalf will be reviewed regardless of whether it was considered at the time the initial decision was made. We may contact any providers who may have additional information to support your grievance. The reviewers will not have been involved in the initial decision. They also will not be a subordinate of the person who made the initial decision.

If I don't agree with the decision on my grievance, what other rights do I have?

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 **1-800-365-0609** or **1-866-333-4823** for the hearing and speech impaired 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 website, **http://www.hmohelp.ca.gov**, has complaint forms, IMR application forms, and instructions online. You may also contact the department by writing to the following address: 980 9th Street, Suite 500, Sacramento, CA 95814 or by e-mail at **helpline@dmhc.ca.gov**.

IMR may be available to you immediately without going through your health plan's grievance process if the department determines that an earlier review is warranted or if there is imminent or serious threat to your health that requires an urgent (expedited) review of your case. We will help you with the application process if an urgent review of your case is warranted. You can find the application and instructions on the department's website (**http://www.hmohelp.ca.gov**).

If we deny your grievance, we will give you more details about dispute resolution options available to you. You may also refer to your benefits booklet or call Member Services at the phone number on your member ID card for details about the entire grievance process

ERISA Plan Members

If your health benefit plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), and you have exhausted all mandatory appeal rights, you have the right to bring a civil action in federal court under section 502(a) (1) (B) of ERISA.

Non-ERISA Plan Members

In addition to the rights described in this letter, you have the right to appeal any decision by your plan regarding coverage or payment of claims. If you are dissatisfied with our decision and wish to pursue further action, your plan may have a mandatory dispute resolution provision. Please refer to your benefits booklet for information concerning your specific plan. You may also call Member Services at the phone number on your Member ID card.

Other helpful resources:

Whether or not you use the grievance rights available to you, you may contact the California Consumer Assistance Program operated by the California Department of Managed Health Care and Department of Insurance at any time:

California Consumer Assistance Program
980 9th St, Suite #500
Sacramento, CA 95814
888-466-2219
http://www.HealthHelp.ca.gov

EXHIBIT 4

Anthem Blue Cross
c/o 8640 Evans Road, Mail Stop B401-03
St. Louis, MO 63134

Anthem BlueCross

November 19, 2014

2014206566 - 13125 CID PCM-UMCPA
JANE BLUMENFELD
969 HILGARD AVE #1109
LOS ANGELES, CA 90024

Date Created: 11/18/2014
Reference Number: 26523186
Member Name: JANE BLUMENFELD
Medication: Harvoni Tablet
Provider: Dr. STEVEN HAN

Dear JANE BLUMENFELD:

We want you to understand how your health plan works so you can get the most from your health plan benefits. Certain medications within your health plan require review to see if they are covered under your description of benefits. We have received a request to review the medication identified above. However, at this time we do not have enough clinical information regarding your health status to determine medical necessity.

If you and your provider decide to continue with the treatment, we cannot guarantee benefits will be covered.

In order to process your request, please ask your provider to send us documentation supporting the need for the medication because some or all of the following information is lacking: specific diagnosis; documentation supporting the diagnosis and genotype; test results [genotype; baseline quantitative hepatitis C virus RNA; severity of fibrosis on liver biopsy or medical imaging and scale used; complete blood count, international normalized ratio, hepatic function panel, and glomerular filtration rate within 6 weeks of starting treatment with this drug; previous treatments and response (including SVR and/or relapse)]; concomitant medications used for this condition; if the liver disease is compensated or decompensated; kidney function; if current alcohol or illicit drug abuse is present and being treated to facilitate cessation; if highest risk for complications from hepatitis C: liver transplant recipient; type 2 or 3 essential cryoglobulinemia with end-organ manifestations; or glomerular kidney disease with proteinuria greater than 300 mg per day, nephrotic syndrome, or membranoproliferative glomerulonephritis. Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.

NOTE: Utilization management reviews are conducted by Express Scripts Utilization Management Company, under a delegation agreement with the following entity. Express Scripts, Inc. is a separate company that provides pharmacy services and pharmacy benefit management services for health plan members.

Please ask your provider to provide the missing information by calling 800 417-8164 or faxing 877 526-2307.

For Urgent Requests: If we receive the necessary information within the next 48 hours, we will review this request for benefits. If we do not receive the information within 48 hours, we will make a determination based solely on the information that we have available.

For Non Urgent Requests: Additional information requested must be provided to the Health Plan within 45 days of request. If the requested information is not provided within 45 days, a determination will be made based upon the information available. If the requested information is received within the required timeframe, review of your case will be completed within five (5) business days of the receipt of information. You will be notified in writing of the outcome of the completed review process. If we do not receive the information needed to complete the review, your coverage may be affected. Please refer to your description of benefits for details.

You have the right to appeal any decision regarding coverage or payment of claims. Please see the attachment to this letter for information on the appeals process.

Thank you for choosing us for your health care coverage needs. Please take some time now to review your description of benefits. If you have any questions about your health plan, such as eligibility or financial responsibility, you may call your customer service phone number listed on your health plan identification card.

Sincerely,

Utilization Management

cc: Dr. STEVEN HAN

EXHIBIT 5

Anthem UM Services, Inc.
c/o 8640 Evans Road, Mail Stop B401-03
St. Louis, MO 63134

Anthem UM Services, Inc.

December 3, 2014

20142159961 - 10964 CID PCM-UMCPA
JANE BLUMENFELD
969 HILGARD AVE #1109
LOS ANGELES, CA 90024

Date Created: 11/18/2014
Reference Number: 26523186
Member Name: JANE BLUMENFELD
Medication: Harvoni Tablet
Provider: Dr. STEVEN HAN
Denial Reason: MEDICAL NECESSITY

Dear JANE BLUMENFELD:

Anthem UM Services, Inc. provides utilization management services for Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance. We want you to understand how your health plan works so you can get the most from your health plan benefits. Certain medications within your health plan require review to see if they are covered under your description of benefits. Coverage for the requested medication is denied because the medication does not meet the criteria of "medical necessity" under your description of benefits. Medications that are considered not medically necessary are not covered according to your description of benefits. To assist our medical director in making this decision, we have put a process in place to send all information about the service to a clinical reviewer with appropriate credentials.

Based on their opinion, we have determined that coverage for the requested medication is denied.

Our clinical reviewer concluded the following: because of details we received about your liver illness (hepatitis C). We may approve HARVONI when the liver has a certain amount of scarring (advanced fibrosis of stage F3 or greater) on a liver biopsy. Records we received do not show that your liver has this amount of scarring on a liver biopsy or FIBROSCAN. We did not receive a copy of the liver biopsy results or FIBROSCAN. We based this decision on your health plan's prior authorization criteria for HARVONIi.

This review was completed by: Harry Weisman MD

In making medical necessity determinations that are consistent with our contract language, medical reviewers follow established criteria and guidelines when available and applicable to the member's situation, including the health plan's medical policies, clinical guidelines, and/or

other available information such as peer reviewed or evidence based literature. Medical policies are available on our website at www.anthem.com/pharmacyinformation. To request the applicable criteria used in this case, or to request an explanation of the clinical judgment for this determination, or diagnosis and description when available, or any other documents related to this determination, please call Customer Service at 866 297-1013 and it will be provided free of charge. Refer to the subscriber's description of benefits under the section marked exclusions for information on medication.

Member: Your provider will receive a copy of this letter. If you have questions about this determination you may call customer service at the number on your health plan identification card. Please see the attached for your additional member rights.

Provider: If you have not already done so and would like to discuss this determination with our clinical reviewer, please contact us at 800-794-0838 before all applicable appeals have been completed. At the time of your call, please provide the following:

- Member Name
- Reference Number (from top of this letter)
- Requested Medication
- Member Policy ID Number
- Date of Service

This decision doesn't mean that you can't or shouldn't receive this medication. Only you and your health care providers can decide whether you need it. But, this decision means that if you do receive the medication, it won't be covered by your plan.

If you or your provider disagrees with this decision, please see the attached information for additional rights.

Sincerely,

Michael M. Su, MD, MBA
Medical Director
Utilization Management

cc: Dr. STEVEN HAN

EXHIBIT 6

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

Anthem

00000020201

**********SCH 5-DIGIT 90001
1826 1 AV 0.381 11
JANE BLUMENFELD
969 HILGARD AVE APT 1109
LOS ANGELES CA 90024-3079

Date: 12/24/14

Subscriber: Jane Blumenfeld
Id No: 461A62239
Group Number: 1349UA

Dear Member:

Thank you for your recent grievance that Anthem Blue Cross received on 12/24/14. Your questions and concerns are important to us, and responding promptly is part of our commitment to meet your overall healthcare needs.

We are currently reviewing your grievance and will resolve your concern or answer your question within 30 calendar days.

While we are researching your request, should you wish to submit additional written comments, documents or other information, have any questions or if we can be of further assistance you may call me, Gina Rodriguez. I can be reached at 1-800-365-0609. You may also visit www.anthem.com/ca/ for details on your health plan benefits, view current claims status, download forms and more.

Thank you again for taking the time to contact us. We are committed to serving you and ensuring that your relationship with Anthem Blue Cross is consistently positive.

Sincerely,

Gina Rodriguez
Grievance/Appeals Associate I

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 **1-866-940-8303** or on the TDD line at 1-866-333-4823 for the speech and hearing impaired, 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 calendar days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

2014358571025/S-75DMHC

TAGACK

CALTL006 BOWE 20141229800 J0D6
20141225 000002 Env [1 826] 1 of 2

English: If you need assistance in Spanish to understand this document, you may request it for free by calling customer service at the number on your identification card or in your enrollment booklet.

Spanish: Si usted necesita ayuda en espa¦ol para entender éste documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en su folleto de inscripción.

2014358571025/S-75DMHC

EXHIBIT 7

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

Anthem Blue Cross

**********SCH 5-DIGIT 90001
1478 1 AV 0.381

JANE BLUMENFELD
969 HILGARD AVE APT 1109
LOS ANGELES CA 90024-3079

00000401010 1

Date: 12/26/14

Member: Jane Blumenfeld
Id Number: 461A62239
Group No.: 1349UA
PMG: N/A

Dear Jane Blumenfeld:

Anthem Blue Cross has received your request for an expedited grievance/appeal on 12/26/14. Grievances/appeals are expedited when it is determined that the standard review process timeframe (30 calendar days) might pose an imminent and serious threat to your health. A serious threat to your health may include, but is not limited to, severe pain, or potential loss of life, limb, or major bodily function.

We have reviewed your request. Based on the information available at the time of our review, we have determined that your request does not meet the criteria for an expedited review, as described above. However, your grievance/appeal will be processed as expeditiously as possible through our standard review process. We will send you written notification of resolution no later than 30 calendar days from the date Anthem Blue Cross received your appeal.

We appreciate your taking the time to communicate your concerns to us. Should you wish to submit additional comments, documents or other information related to your appeal, or if you have any questions, please do not hesitate to call us at **1-800-365-0609**.

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 **1(800)365-0609** or on the TDD line at **1-866-333-4823** for the speech and hearing impaired, 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 calendar days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

Sincerely yours,

JUDY MAYFIELD

2014360451204/S-145DMHC

CA:TL001 BOWE 20141230800.J1AC
20141227 000004 Env [1 478] 1 of 1

TAGACK

GRIEVANCES AND APPEALS ANALYST
Grievance & Appeals Department

2014360451204/S-145DMHC

EXHIBIT 8

Anthem UM Services, Inc.
Grievances and Appeals
P.O. Box 4310
Woodland Hills, CA 91365

Anthem UM Services, Inc.

January 8, 2015

Jane Blumenfeld
969 Hilgard Ave #1109
Los Angeles, CA 90024

Case number:	Magi Case #58582
Member name:	Jane Blumenfeld
Member ID number:	461A62239
Date grievance received:	December 24, 2014

Dear Ms. Blumenfeld:

Anthem UM Services, Inc., provides utilization management services for Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company. Your plan has completed its review of the appeal that your physician, Dr. Steven-Huy Han, MD, has requested on your behalf concerning the denial of your request for Harvoni.

Your plan has reviewed your specific circumstances and health condition as documented in the medical records provided by Dr. Steven-Huy Han, MD. The reviewers included a health plan consultant who is board-certified in Gastroenterology and a health plan Medical Director, Dr. Wilson Fung, MD, who is Board Certified in Family Medicine. After review of the available clinical information, the recommendation is to uphold the initial denial as not medically necessary based on the following review.

After further review of your medical records, your request cannot be approved. You are being treated for a liver infection (Hepatitis C). We may approve your request if records show you have advanced scarring in your liver (liver biopsy showing fibrosis score of F3 or higher on the IASL, Batts-Ludwig, or Metavir scales OR fibrosis score of F4 or higher on the Ishak scale OR mean FibroScan elastography score of 9.5 kPa or higher). We cannot approve your request because records show you do not have advanced scarring in your liver. We based this decision on your health plan's prior authorization criteria for Harvoni.

As stated in your Evidence of Coverage (EOC) on pages 119 and 120 dated January 1, 2014, medically necessary is defined as follows:
Medically necessary procedures, supplies equipment or services are those we determine to be:
1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Provided for the diagnosis or direct care and treatment of the medical condition;
3. Within standards of good medical practice within the organized medical community;
4. Not primarily for your convenience, or for the convenience of your physician or another provider; and

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

Binding Arbitration

If you don't agree with the way this case was handled, please refer to your policy for further instructions on resolving disputes. Your complaint may be subject to binding arbitration in accordance with the terms of your policy.

This is our final decision. Your grievance rights with us are exhausted. If you don't agree with this decision, you may have more rights. We've included details with this letter. If you have any questions about this letter, call customer service toll-free at **1-800-365-0609** or **1-866-333-4823** for the hearing and speech impaired. If you prefer, write to **Grievances and Appeals, P.O. Box 4310, Woodland Hills CA 91365**.

Sincerely,

Wilson Fung MD

Wilson Fung, M.D.
Medical Director
Grievances and Appeals

WF:cl

Enclosures:
DMHC IMR Application and Instructions
Authorized Assistant form
DMHC envelope

EXHIBIT 9

UCLA

Steven-Huy B. Han, M.D., A.G.A.F.
Professor of Medicine and Surgery
Director, Hepatology Clinical Research Center
Assistant Director, UCLA Asian Liver Center
David Geffen School of Medicine at UCLA

Pfleger Liver Institute
200 UCLA Medical Plaza
Suite 214
Box 957302
Los Angeles, California 90095-7302

March 3, 2015

Dr. Wilson Fung,
Medical Director
Grievances and Appeals
Anthem UM Services, Inc.
P.O. Box 4310
Woodland Hills, CA 91365

Dear Dr. Fung:

I am writing to request approval of Harvoni for the treatment of my patient Jane Blumenfeld, who suffers from hepatitis C, genotype 1. A hepatologist with UCLA's Pfleger Liver Institute, I am Board Certified in transplant hepatology and gastroenterology with a focus on treating viral hepatitis and preventing hepatitis C recurrence in post liver transplant patients. I have treated and monitored Ms. Blumenfeld's condition since 2001.

Though asymptomatic at this time, Ms. Blumenfeld has a viral load of 11,800,000 IU/ml with slight liver damage but could avoid future liver damage with treatment by the FDA approved medication Harvoni. Her maternal grandmother died of liver cancer and Ms Blumenfeld did not respond to treatment with Boceprevir, interferon, and ribavirin in 2012. Given her family history and past treatment experience, Ms. Blumenfeld is certainly an excellent candidate for treatment.

Harvoni is indicated for patients with genotype 1 chronic hepatitis, including those who have failed prior therapy with an interferon-based regimen, as Ms. Blumenfeld has. With her level of liver damage and treatment experience, the American Association for the Study of Liver Diseases guidelines recommend 12 weeks of treatment with Harvoni.

Prescribing Harvoni for Ms. Blumenfeld clearly meets ***all*** of the criteria for medical necessity, as defined in Anthem's Evidence of Coverage (pages 119 and 120 dated January 1, 2014) as follows:

Medically necessary procedures, supplies, equipment, or services are those determined to be:

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Provided for the diagnosis or direct care and treatment of the medical condition;

Appointments
Tel (310) 794-7788
Fax (310) 794-3296

Administrative
Tel (310) 794-5970
Fax (310) 206-4197

Research Center
Tel (310) 794-6067
Fax (310) 794-3296

E-Mail
sbhan@mednet.ucla.edu

3. Within standards of good medical practice within the organized medical community;
4. Not primarily for Ms. Blumenfeld's convenience, or for my convenience as her physician, or for the convenience of another provider; and
5. Harvoni is the most appropriate treatment which can safely be provided.

Furthermore, Harvoni is the most appropriate treatment because it satisfies ***all*** of Anthem's requirements, as follows:

a. There is valid and widely accepted scientific evidence that the expected health benefits from Harvoni are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications for Ms. Blumenfeld' hepatitis C than all other possible alternatives; and
b. Generally accepted forms of treatment have been tried and found to be ineffective or are otherwise unsuitable.

Harvoni is medically necessary for Ms. Blumenfeld:

- It meets all of Anthem's criteria for medical necessity.
- It provides the most effective treatment known today for Ms. Blumenfeld's chronic hepatitis C genotype 1
- It provides the most cost effective treatment for chronic hepatitis C known today.
- It prevents the dangerous and precarious situation of waiting for the development of a severely damaged liver before administering a known and highly effective treatment.

Given Ms. Blumenfeld's family history and previous drug therapy, it is not prudent for her to wait for evidence of stage 3 liver disease before receiving treatment for hepatitis C as she is already at greater risk for hepatocellular carcinoma.

I request that you reconsider your denial of coverage, recognize that this treatment meets all of Anthem's requirements for "medical necessity," and approve coverage of Harvoni for my patient Jane Blumenfeld as soon as possible.

Sincerely,

Steven-Huy Han, MD, AGAF
Director, Hepatology Clinical Research Center
Assistant Director, UCLA Asian Liver Center

EXHIBIT 10

Jane Blumenfeld
969 Hilgard Avenue #1109
Los Angeles, CA 90024
janeblumenfeld@gmail.com

March 12, 2015

Wilson Fung, M.D.
Medical Director
Grievances and Appeals
P.O. Box 4310
Woodland Hills, CA 91365

Dear Dr. Fung:

I am writing as a follow-up to Dr. Steven-Huy Han's letter to you, dated March 3, 2015 (copy attached). Dr. Han's letter describes my medical situation and delineates the rationale for his professional determination that the drug, Harvoni, is medically necessary to treat my chronic Hepatitis C. His determination is based on treating me and monitoring my medical condition for 14 years, the details of my specific situation, my past treatment history, and my family history. His conclusion regarding the medical necessity of Harvoni is contrary to the determination you have reached as Anthem's Medical Director and arbiter of grievances and appeals.

I hope Dr. Han's input has provided relevant information that demonstrates the medical necessity of Harvoni, the FDA-approved permanent cure for Hepatitis C, genotype 1. And, most importantly, I hope that you will reconsider your determination and approve coverage of Harvoni for me. As you are aware, without insurance coverage, the cost of a 12-week course of Harvoni is $94,500, an unaffordable expense for a retired public employee living on a fixed income. Thus, I am very anxious to hear from you in light of the information Dr. Han has provided.

I hope you will respond expeditiously. Living with chronic Hepatitis C means living with the daily fear and anxiety that results from never knowing if today will be the day that asymptomatic Hepatitis C turns into a catastrophic illness that might be too late to treat.

Please let me know your decision as soon as possible. For me, time is of the essence.

Thank you for your attention to this matter.

Sincerely,

Jane Blumenfeld

Jane Blumenfeld

Cc: Michael M. Su, MD, MBA; Medical Director, Utilization Management; Anthem

Attachment: Dr. Han letter 3/3/15

EXHIBIT 11

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

Anthem

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**********SCH 3-DIGIT 900
10371 1 AT 0.406 32
JANE BLUMENFELD
969 HILGARD AVE APT 1109
LOS ANGELES CA 90024-3079

Date: 03/18/15

Subscriber: Jane Blumenfeld
Id No: 461A62239
Group Number: 1349UA

Dear Member:

We wanted to take this opportunity to acknowledge the receipt of your recent grievance to us. Your grievance has been directed to an associate for research and response. We will take the necessary steps to address your grievance and will respond to you within 30 calendar days.

For your convenience you may also access the Internet for secured information about your claims, eligibility, contracted benefits, to order an identification card, or to simply contact us. Please feel free to visit our site at www.anthem.com/ca/. If you want to pursue personal information you will need to secure a pin number.

While we are researching your grievance, should you wish to submit additional written comments, documents or other information, have any questions or if we can be of further assistance you may call our Customer Care Department Monday through Friday. The toll free number is 1-866-940-8303.

We appreciate your business and the opportunity to provide service to you. We wanted to make sure you knew we had received your request and we are working on addressing your grievance.

Sincerely,

Irma Bullicer
Customer Service

English: If you need assistance in Spanish to understand this document, you may request it for free by calling customer service at the number on your identification card or in your enrollment booklet.

Spanish: Si usted necesita ayuda en español para entender éste documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en su folleto de inscripción.

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TAGACK

EXHIBIT 12

ANTHEM BLUE CROSS
GRIEVANCES & APPEALS
P.O. BOX 4310
WOODLAND HILLS, CA 91365

Anthem Blue Cross

April 15, 2015

Jane Blumenfeld
969 Hilgard Ave #1109
Los Angeles, CA 90024

Name:	Jane Blumenfeld
Certificate No.:	461A62239
Reference:	Magi Case #58582
Requested Service:	Harvoni 400MG/90MG Tablet
Claim No.:	N/A
Provider:	Dr. Han Steven
Date(s) of Service:	N/A

Dear Ms. Blumenfeld:

Your health plan has received your request for reconsideration (re-review) of the appeal decision regarding the denial of the above provider claim or service. However, no new pertinent medical information was submitted with your request for an appeal re-review. As there is no new medical information to review that would change the original appeal determination, your plan will not re-open your appeal file at this time. You have exhausted the health plan's appeal process.

Your next level of appeal is to the Department of Managed Health Care (DMHC). We recommend that if you are dissatisfied with your plan's decision, to contact the DMHC to initiate an independent review.

This letter constitutes our written notice of the final disposition of your appeal. Thank you for your patience while this matter underwent review.

Sincerely,

Chandra Lalsa

Chandra Lalsa
Grievances and Appeals Analyst
Grievances and Appeals

We are required to inform you of the following:

California Department of Managed Health Care (DMHC)

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 **1-800-365-0609** or at our TDD line **1-866-333-4823** for the speech and hearing impaired 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.

Binding Arbitration

If you or your representative agree with the manner in which this case was handled, no action is necessary. However, if you disagree, recourse to binding arbitration may be available pursuant to your health plan. Written inquiries regarding binding arbitration may be submitted to the following address:

Legal Department, AC01
21555 Oxnard Street
Woodland Hills, CA 91367