

LOS ANGELES POLICE RELIEF ASSOCIATION, INC.

LAPRA/RETIRED MEMBERS

**PRUDENT BUYER PPO PLAN
FOR CALIFORNIA RESIDENTS**

July 1, 2007

Prudent Buyer®

FOR YOUR INFORMATION

ORGAN DONATION

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

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

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

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

www.donatelifecalifornia.org/

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

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 Blue Cross of California web site at www.bluecrossca.com. 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.

**COMBINED EVIDENCE OF COVERAGE
AND DISCLOSURE FORM**

**Blue Cross of California
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. The Los Angeles Police Relief Association, Inc. will provide you with a copy of the health plan contract upon request.

TABLE OF CONTENTS

TYPES OF PROVIDERS	1
SUMMARY OF BENEFITS.....	6
MEDICAL BENEFITS.....	7
PRESCRIPTION DRUG BENEFITS	13
YOUR MEDICAL BENEFITS	15
HOW COVERED EXPENSE IS DETERMINED	15
DEDUCTIBLES-PENALTY, CO-PAYMENTS AND BENEFIT MAXIMUMS.....	17
CONDITIONS OF COVERAGE	19
MEDICAL CARE THAT IS COVERED	20
MEDICAL CARE THAT IS NOT COVERED.....	37
PRE-EXISTING CONDITION EXCLUSION	43
REIMBURSEMENT FOR ACTS OF THIRD PARTIES	44
YOUR PRESCRIPTION DRUG BENEFITS	46
PRESCRIPTION DRUG COVERED EXPENSE.....	46
PRESCRIPTION DRUG CO-PAYMENTS	47
HOW TO USE YOUR PRESCRIPTION DRUG BENEFITS	47
PRESCRIPTION DRUG UTILIZATION REVIEW	49
PRESCRIPTION DRUG CONDITIONS OF SERVICE.....	49
PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED.....	50
PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED.....	51
COORDINATION OF BENEFITS	56
BENEFITS FOR MEDICARE ELIGIBLE MEMBERS	60
UTILIZATION REVIEW PROGRAM.....	62

THE MEDICAL NECESSITY REVIEW PROCESS..... 68

PERSONAL CASE MANAGEMENT 70

DISAGREEMENTS WITH MEDICAL MANAGEMENT DECISIONS..... 73

QUALITY ASSURANCE 73

HOW COVERAGE BEGINS AND ENDS 74

HOW COVERAGE BEGINS 74

HOW COVERAGE ENDS 83

CONTINUATION OF COVERAGE 85

CALCOBRA CONTINUATION OF COVERAGE 92

SENIOR COBRA CONTINUATION FOR QUALIFYING MEMBERS 96

EXTENSION OF BENEFITS..... 99

HIPAA COVERAGE AND CONVERSION 100

GENERAL PROVISIONS 102

BINDING ARBITRATION 112

DEFINITIONS..... 114

GRIEVANCE PROCEDURES 127

INDEPENDENT MEDICAL REVIEW OF DENIALS OF EXPERIMENTAL
OR INVESTIGATIVE TREATMENT 128

INDEPENDENT MEDICAL REVIEW OF GRIEVANCES INVOLVING A
DISPUTED HEALTH CARE SERVICE 130

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. Blue Cross has 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. They have agreed to provide our members with health care at a special low cost. The amount of benefits payable under this *plan* will be different for *non-participating providers* than for *participating providers*. See the definition of "Participating Providers" in the DEFINITIONS section for a complete list of the types of providers which may be *participating providers*.

We publish a directory of Participating Providers. 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 and ask us to send you a directory. You may also search for a *Prudent Buyer Plan provider* using the "Provider Finder" function on our website at www.bluecrossca.com. The listings include the credentials of our *participating providers* such as specialty designations and board certification.

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 *negotiated 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 Blue Cross. While only some *hospitals* are *participating providers*, all eligible California hospitals are invited to be *contracting hospitals* and most--over **90%**--accept. **For those which do not (called Non-Contracting Hospitals), there is a significant benefit penalty in your Plan.**

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.

Member Rights and Responsibilities. Blue Cross of California is committed to maintaining a mutually respectful relationship with our *members*, and at the same time we expect our *members* to assume certain responsibilities. Your Member Rights and Responsibilities are described below and your rights, our legal duties, and our privacy practices related to HIPAA are described in our "Notice of Privacy Practices" found on our website at <http://www.bluecrossca.com> or by calling the customer service telephone number on your ID card.

Member Rights. You have the right to:

- Receive clear and accurate information about Blue Cross of California, your rights and responsibilities, your health plan benefits and services, and how and when you can use them;
- Receive the names and contact information of participating doctors, *hospitals*, pharmacies, and other health care providers available to you;
- Be treated with courtesy, respect and dignity;
- Your privacy and to have your personal health information be kept secure and confidential;
- Be involved with doctors and other health care professionals in decision-making regarding your health care;
- Talk over your health care needs with the health care professionals caring for you, including a clear and open discussion about appropriate or medically necessary care available for your condition, without concern for the cost or whether it is covered by your health plan benefits;
- Make a written or spoken suggestion, expression of dissatisfaction, or complaint about the care or service you received from a participating health professional or provider, or about the service you received from your health plan, and you may appeal any decision made relating to you or your health plan benefits and/or health plan services; and
- Write to Blue Cross of California with ideas or questions about this statement on *member* rights and responsibilities. Your letter can be sent to Quality Improvement Department, Attn: Rights and Responsibilities, Mailstop AC-6G, P.O. Box 70000, Van Nuys, CA 91470-0001.

Member Responsibilities. To assist participating health care professionals and providers in meeting these responsibilities to you, it is your duty to:

- Give patient identification and medical information, to the best of your ability, that your health care professionals and providers need in order to care for you and for your health plan to provide services to you;
- To the best of your ability, work with your doctor to be aware of and understand your health issues so you can participate in developing mutually agreed-upon treatment goals;
- Follow the prescribed medical treatment plan and health care instructions that you have agreed upon with your doctor or other health care professional and tell him or her if you decide to take part in any Blue Cross of California-sponsored health activity or program;
- Treat all providers and their staff with courtesy and respect;
- Keep scheduled appointments for care, and give adequate advance notice of delay or cancellation; and
- Read and understand to the best of your ability all materials concerning your health benefits or ask for clarification as needed.

Participating and Non-Participating Pharmacies. “Participating Pharmacies” agree to charge only the *prescription drug negotiated rate* to fill the *prescription*. You pay only your co-payment amount as indicated in the PRESCRIPTION DRUG BENEFITS section. Please visit our Pharmacy website at www.bluecrossca.com.

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

Centers of Expertise Transplant Facilities. We have established a Centers of Expertise (COE) network of transplant facilities 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). **These procedures are covered only at a COE.** These “COE” agree to accept the *COE negotiated rate* as payment in full for covered services. A *participating provider* in the Prudent Buyer Plan network is not necessarily a *Centers of Expertise* transplant facility.

SUMMARY OF BENEFITS

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

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

For your convenience, this summary provides a brief outline of your benefits. You need to refer to the entire Combined Evidence of Coverage and Disclosure (Evidence of Coverage) Form for more complete information, and you must consult The Los Angeles Police Relief Association, Inc. health plan contract with Blue Cross 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.

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

The benefits of this <i>plan</i> may be subject to the REIMBURSEMENT FOR ACTS OF THIRD PARTY section.

MEDICAL BENEFITS

DEDUCTIBLES AND PENALTY

Calendar Year Deductibles

Retired Employees

- *Member* Deductible..... **\$400**
- Family Deductible **\$800**

Additional Penalty and Deductible

- Emergency Room Deductible **\$75**
- Non-Certification Penalty **20%**
(Applicable to Inpatient Admissions only)

SEE UTILIZATION REVIEW PROGRAM.

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

- The Calendar Year Deductible will not apply to services by a *participating or non-participating provider* for Routine Physical Exam (For Retired Employees and Dependents Age 19 or over).
- The Calendar Year Deductible will not apply to covered expense incurred for hearing aids.
- The Calendar Year Deductible will not apply to transplant travel expenses in connection with an authorized transplant procedure provided at an approved COE.
- The Calendar Year Deductible will not apply to *members* who are enrolled under Medicare Parts A and B.
- The Emergency Room Deductible will not apply if you are admitted as a *hospital* inpatient immediately following emergency room treatment.
- The Non-Certification Penalty will not apply to *emergency* admissions or services, nor to services provided by a *participating provider*. See UTILIZATION REVIEW PROGRAM.

- The Non-Certification Penalty will not apply to inpatient admission for treatment of *mental or nervous disorders* or substance abuse. See UTILIZATION REVIEW PROGRAM.

CO-PAYMENTS

Co-Payments.* After you have met your Calendar Year Deductible, and any other applicable penalty, you will be responsible for the following percentages of *covered expense* you incur:

- *Participating Providers*.....**10%**
- Outpatient Surgery Services.....**10%**
- *Home Health Care*.....**20%**
(For either *Participating* or *Non-Participating Providers*)
- *Other Health Care Providers***20%**
- *Non-Participating Providers*.....**30%**
- *Infertility Treatment*.....**50%**

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

***Exceptions:**

- Your Co-Payment for outpatient psychotherapy and psychological testing for treatment of *mental or nervous disorders* and substance abuse will be **50%** of *covered expense* incurred.
- Your Co-Payment for *non-participating providers* will be the same as for *participating providers* for the following services. You may be responsible for charges which exceed *covered expense*.
 - Emergency services* provided by other than a *hospital*;
 - 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);
 - An *authorized referral* from a *physician* who is a *participating provider* to a *non-participating provider*;

- d. Charges by a type of *physician* not represented in the Prudent Buyer Plan network (for example, an audiologist); or
 - e. Cancer Clinical Trials.
- 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 *Centers of Expertise (COE)* will be the same as for *participating providers*. **Services for specified organ transplants are not covered when performed at other than a designated *Centers of Expertise (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 *Centers of Expertise (COE)* is more than 250 miles from the recipient or donor's residence.

Out-of-Pocket Amount. After each *member* has made **\$1,500** (other than for the treatment of *infertility* or *mental or nervous disorders* or substance abuse) in total out-of-pocket payments for *covered expense* you incur during a *calendar year*, you will no longer be required to pay a Co-Payment.

Exceptions:

- You will be required to continue to pay your Co-Payment for the treatment of *mental or nervous disorders* or substance abuse even after you have reached your Out-Of-Pocket Amount. In addition, any Co-Payments you make for such treatment will not be applied toward reaching that amount.
- Expense which is applied toward any deductible, which is incurred for non-covered services or supplies, or which is in excess of the amount of *covered expense*, will not be applied toward your Out-Of-Pocket Amount; and is always your responsibility.

Non-Contracting Hospital Penalty. *Covered expense is reduced by 25% for services and supplies provided by a non-contracting hospital. This penalty will be deducted from covered expense prior to calculating your Co-Payment amount, and any benefit payment by us will be based on such reduced covered expense. You are responsible for paying this extra expense. This reduction will be waived only for emergency services. To avoid this expense, please be sure to choose a contracting hospital.*

MEDICAL BENEFIT MAXIMUMS

We will pay, for the following services and supplies per member at the percentages stated in the Co-Payments section, up to the maximum amounts, or for the maximum number of days or visits shown below:

Hearing Aids

- For all covered services.....**\$1,500**
for both ears, during
a three year period

Home Health Care

- For covered home health services**365 visits**
per calendar year

Home Infusion Therapy

- For all covered services and supplies
received during any one day **\$600***
**Non-participating providers only*

Ambulatory Surgical Center

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

Infertility Treatment

- For all covered services.....**\$4,000**
per calendar year

Lifetime Maximum*

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

*Exception to the Lifetime Maximum: A maximum of up to **\$1,000** in paid benefits will be automatically added to your lifetime maximum each January 1st.

Mental or Nervous Disorders

- For covered outpatient *physician's* services..... **\$75**
(*Participating providers*)
- For covered outpatient *physician's* services..... **\$25**
(*Non-participating providers*)

Physical Therapy, Physical Medicine, Occupational Therapy and Chiropractic Care

- For covered outpatient services **24**
visits per *calendar year*,
additional visits as authorized
by us if *medically necessary*
- For each covered visit when provided
by a *non-participating provider* **\$25**
per visit

Routine Physical Exam (For Retired Employees and Dependents Age 19 and Over)

- For all covered services provided by a *participating*
and *non-participating provider* **\$250**
per *calendar year*

Substance Abuse

- For covered outpatient *physician's* services..... **\$75***
(*Participating providers*)
- For covered outpatient *physician's* services..... **\$25***
(*Non-participating providers*)

*Per visit, for up to 50 visits per *calendar year* for *participating* and *non-participating providers* combined.

- For inpatient *hospital* services **30****
days per *calendar year*

**The 30 day limit will not apply to inpatient *hospital* services for detoxification during the acute phase of alcoholism or drug dependence.

Transplant Travel Expense

- For the Recipient and One Companion per Transplant Episode (limited to 6 trips per episode)
 - For transportation to the *Centers of Expertise (COE)*..... **\$250**
per trip for each person
for round trip coach airfare
 - For hotel accommodations..... **\$100**
per day, for up to 21 days per trip,
limited to one room,
double occupancy
 - For expenses such as meals **\$25**
per day for each person,
for up to 21 days per trip
- For the Donor per Transplant Episode limited to one trip per episode)
 - For transportation to the *Centers of Expertise (COE)*..... **\$250**
for round trip coach airfare
 - For hotel accommodations..... **\$100**
per day, for up to 7 days
 - For expenses such as meals **\$25**
per day, up to 7 days

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*.....**\$15**
- *Brand Name Drugs*:
 - When no *generic drug* equivalent is available**\$25**
 - When a *generic drug* equivalent is available**\$25**
plus the difference of
prescription drug covered
expense between the *generic*
drug and the *brand name drug*
- Self-administered injectable
drugs, except insulin**20%**
of *prescription drug covered expense*
to a maximum copayment of **\$100**
for each prescription

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 us.

Non-Participating Pharmacies*

- *Generic Drugs*.....**\$15**
- *Brand Name Drugs:*
 - When no *generic drug* equivalent is available**\$25**
 - When a *generic drug* equivalent is available**\$25**
plus **50%** of *prescription drug covered expense*
- Self-administered injectable drugs, except insulin**20%**
of *prescription drug covered expense*
to a maximum copayment of **\$100** for each *prescription*
plus **50%** of the remaining *prescription drug covered expense*

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

- *Generic Drugs*.....**\$15**
- *Brand Name Drugs:*
 - When no *generic drug* equivalent is available**\$25**
 - When a *generic drug* equivalent is available**\$25**
- Self-administered injectable drugs, except insulin**20%**
of *prescription drug covered expense*
to a maximum copayment of **\$100**
for each *prescription*

***Important Note About Prescription Drug Covered Expense and Your Co-Payment:** *Prescription drug covered expense* for *non-participating pharmacies* is significantly lower than what providers customarily charge, so you will almost always have a higher out-of-pocket expense when you use a *non-participating pharmacy*.

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

YOUR MEDICAL BENEFITS

HOW COVERED EXPENSE IS DETERMINED

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

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

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

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

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

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

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

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

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

WARNING! Reduction of Covered Expense for Non-Contracting Hospitals. A small percentage of *hospitals* which are *non-participating providers* are also *non-contracting hospitals*. Except for *emergency care*, *covered expense* **is reduced by 25%** for all services and supplies provided by a *non-contracting hospital*. You will be responsible for paying this amount. You are strongly encouraged to avoid this additional expense by seeking care from a *contracting hospital*. **You can call the customer service number on your identification card to locate a *contracting hospital*.**

DEDUCTIBLES-PENALTY, CO-PAYMENTS AND BENEFIT MAXIMUMS

After we subtract any applicable deductible or penalty and your Co-Payment, we will pay benefits up to the amount of *covered expense*, not to exceed the applicable Medical Benefit Maximum. The Deductible-Penalty amounts, Co-Payments, and Medical Benefit Maximums are set forth in the SUMMARY OF BENEFITS.

DEDUCTIBLES OR PENALTY

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

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.

Any *covered expense* applied to your Calendar Year Deductible during October through December will also be applied toward your Calendar Year Deductible for the next *year*.

Prior Plan Calendar Year Deductibles. If you were covered under LAPRA'S Blue Cross HMO PLUS Plan any amount paid during the same *calendar year* toward your calendar year deductible under LAPRA'S Blue Cross HMO PLUS Plan, will be applied toward your Calendar Year Deductible under this *plan*. Any payments applied to the calendar year deductible under LAPRA'S Blue Cross HMO PLUS Plan will be applied toward this *plan's* Calendar Year Deductible, only if such payments were for charges that would be *covered expense* under this *plan*.

Non-Certification Penalty

Each time you are admitted to a *hospital* without properly obtaining certification, you are responsible for paying the Non-Certification Penalty. This penalty will not apply to (a) inpatient admission for treatment of *mental or nervous disorder* or substance abuse or (b) an *emergency* admission or procedure, nor to services provided at a *participating provider*. Certification is explained in UTILIZATION REVIEW PROGRAM.

Emergency Room Deductible

Each time you visit an emergency room for treatment you will be responsible for paying the Emergency Room Deductible. But this deductible will not apply if you are admitted as a *hospital* inpatient from the emergency room immediately following emergency room treatment.

CO-PAYMENTS

After you have satisfied any applicable deductible or penalty, we will subtract your Co-Payment, if any, from the amount of *covered expense* remaining.

If your Co-Payment is a percentage, we will apply the applicable percentage to the amount of *covered expense* remaining after any deductible or penalty 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 *covered expense* you incur during the remainder of that *calendar year*, other than for *covered expense* incurred for treatment of *mental or nervous disorders* or substance abuse.

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 which are not considered *covered expense*;
- Any expense applied to a deductible; and
- Charges for services for the treatment of *mental or nervous disorders* or substance abuse.

In addition, you will continue to be required to pay your Co-Payment for the treatment of *mental or nervous disorders* or substance abuse, even after the Out-of-Pocket Amount is reached.

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 paid by Blue Cross to you or on your behalf under any other Blue Cross health plan provided by the *group*.

Restoration of the Lifetime Maximum. If we have made any benefit payments for you prior to any January 1, and you are not subject to the EXTENSION OF BENEFITS provision, the amount of benefits remaining for additional expenses you incur will be increased on that January 1 by the lesser of **\$1,000**, or the amount of such prior benefits not previously restored.

CONDITIONS OF COVERAGE

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

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

MEDICAL CARE THAT IS COVERED

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

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.

Ambulance. The following ambulance services:

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

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

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.

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

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

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.

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*.

Chemotherapy.

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

1. A *Christian Science Sanatorium* will be considered a *hospital* for purposes of this booklet. The sanatorium must be accredited by the Department of Care of the First Church of Christ, Scientist; Boston, Massachusetts.
2. The term *physician* includes a *Christian Science Practitioner* approved and accredited by the Mother Church, The First Church of Christ, Scientist.
3. The term registered nurse includes a *Christian Science Nurse* approved and accredited by the Mother Church, The First Church of Christ, Scientist.

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.

1. **Christian Science Sanatorium.** Services provided by a *Christian Science sanatorium* if the *member* is admitted for active care of an illness or injury.
2. **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.
3. **Christian Science Nurse.** Services of a *Christian Science Nurse* providing treatment for a diagnosed illness or injury according to the healing practices of Christian Science.

NO BENEFITS ARE AVAILABLE FOR SPIRITUAL REFRESHMENT.

All other provisions of the **EXCLUSIONS AND LIMITATIONS** in this booklet apply equally to Christian Science benefits as to all other benefits and providers of care.

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*.

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*.

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 mail service program (see YOUR PRESCRIPTION DRUG BENEFITS).

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.

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

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

Rental charges that exceed the reasonable purchase price of equipment are not covered. We will determine whether the item satisfies the conditions above.

Hearing Aids. Hearing aids or services related to the fitting or making of a hearing aid, up to **\$1,500** for both ears in a three year period.

Hemodialysis Treatment.

Hepatitis B and Varicella Zoster Immunizations. Hepatitis B and Varicella Zoster (chickenpox) immunizations for dependent children ages 7 through 18.

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 365 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 the *member* is receiving benefits under the "Hospice Care" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.

Home Infusion Therapy. The following services and supplies when provided by a *home infusion therapy provider* in the *member's* home for the intravenous administration of a *member's* 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.

The maximum Blue Cross 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.

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

Hospital

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

Infertility Treatment. Diagnosis and treatment of *infertility*, as *medically necessary*, provided you are under the direct care and treatment of a *physician*. Artificial insemination, and in vitro fertilization are also covered.

Our payment will not exceed **\$4,000** for any *member* during a *calendar year*, and any laboratory procedures related to in vitro fertilization are not covered.

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.

Mental or Nervous Disorders. Covered services shown below for the treatment of *mental or nervous disorders*, provided such services offer a reasonable expectation of improvement, and are the lowest level of care consistent with safe medical practice.

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

Physician visits for rehabilitative care (such as physical therapy, occupational therapy, or speech therapy) for the treatment of *mental or nervous disorders*. All *physician* visits are limited to our maximum payment of **\$75** for each visit to a *participating provider* and **\$25** for *non-participating providers*.

Covered services for the treatment of *severe mental disorders* will not be subject to any limitations applicable to *mental or nervous disorders* shown in the SUMMARY OF BENEFITS or under these “Mental or Nervous Disorders” provision. Such services will be subject to all other terms, conditions, limitations and exclusions, including applicable Medical Benefit Maximums. Please refer to the DEFINITIONS section for a description of “severe mental disorders.”

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.

Covered expense 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 Center of Expertise (COE) will not be considered covered expense.** See UTILIZATION REVIEW PROGRAM for details.

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

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

Outpatient Surgery Services. Services and supplies in connection with a non-emergency outpatient surgery performed at a *hospital*, an outpatient surgical center, an *ambulatory surgical center* or in a *physician's* office. Outpatient surgery benefits will also be provided for the services of the *physician* or anesthetist performing the outpatient surgery.

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

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*.

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

1. Physical therapy and physical medicine or chiropractic care provided on an outpatient basis for the treatment of illness or injury including the therapeutic use of heat, cold, exercise, electricity, ultra violet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care which are customarily provided by chiropractors, physical therapists and osteopaths.)
2. Occupational therapy provided on an outpatient basis when the ability to perform daily life tasks has been lost or reduced by 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.

For the services of a *non-participating provider* only, our maximum payment is limited to **\$25** for each visit.

Up to 24 visits in a *year* for all covered services are payable. But, if it is determined that an additional period of physical therapy, physical medicine or occupational therapy is *medically necessary*, we will specify a specific number of additional visits.

Such additional visits are not payable if pre-service review is not obtained, and remain limited to **\$25** for each specified additional visit to a *non-participating provider*. (See UTILIZATION REVIEW PROGRAM.)

Pregnancy and Maternity Care

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

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

Professional Services

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

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

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. Other *medically necessary prosthetic devices*, including:
 - a. Surgical implants;
 - b. Artificial limbs or eyes; and
 - 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.

Radiation Therapy.

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.

Routine Physical Exam (For Retired Employees and Dependents Age 19 and over). We will pay up to **\$250** during a *calendar year* for the following services when provided for retired employees and dependents age 19 and over:

1. A *physician's* services for one routine physical examination.
2. Immunizations given as standard medical practice.
3. Radiology and laboratory services and tests ordered by the examining *physician* in connection with a routine physical examination, including pap smears.

Note: We will pay for BodyScan services in lieu of the Routine Physical Exam up to the **\$250** maximum for *participating* and *non-participating providers*.

Routine Physical Exam services are covered only if provided by a participating provider. Hepatitis B and Varicella Zoster Immunizations, Prostate Cancer Screenings, Cervical Cancer Screenings including human papillomavirus (HPV) screening and Breast Cancer screenings are not provided under these preventive care benefits but are provided under other benefits specifically stated under this section.

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*.

Skilled Nursing Facility. Inpatient services and supplies provided by a *skilled nursing facility*. The amount by which your room charge exceeds the prevailing two-bed room rate of the *skilled nursing facility* is not considered *covered expense*. For the purpose of care provided for the treatment of *severe mental disorders* or substance abuse, the term "skilled nursing facility" includes *residential treatment center*.

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

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.

Substance Abuse. Covered services shown below for the treatment of substance abuse, provided such services offer a reasonable expectation of improvement, and are the lowest level of care consistent with safe medical practice.

1. Inpatient *hospital* services as stated in the "Hospital" provision of this section and services from a *residential treatment center*.
2. Visits to a *day treatment center*.

The combined maximum for inpatient *hospital* and *residential treatment center* services and visits to a *day treatment center* will be 30 days during a *calendar year*. This 30 day limit will not apply to inpatient *hospital* services for detoxification during the acute phase of alcoholism or drug dependence.

3. *Physician* visits during a covered inpatient *stay* or for outpatient treatment of substance abuse. *Physician* visits for rehabilitative care (such as physical therapy, occupational therapy, or speech therapy). All *physician* visits are limited to our maximum payment of **\$75** for each visit to a *participating provider* and **\$25** for *non-participating providers* and a combined total of 50 visits per *calendar year*.

If we apply *covered expense* toward the *Calendar Year* Deductible, and do not provide payment, that visit is not included in the visit maximum (50 visits) for that *year*. However, if we pay any portion of your *covered expense* for a visit, we do include the visit in the visit maximum.

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

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

Well Woman Care. Benefits are provided for one visit per *calendar year* for a routine gynecological examination. Benefits for routine gynecological exams include patient history, physical exam, breast exams, breast exam instructions, pelvic exam, annual pap smear, and mammograms if appropriate.

Well Baby and Well Child Care. The following services for a dependent *child* under 19 years of age:

The following services for a dependent *child*:

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

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.)

Acupuncture. Acupuncture treatment except as specifically stated in the “Acupuncture” provision of YOUR MEDICAL BENEFITS: 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 dermatoses or acupuncture points.

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

Bulimia. Inpatient services for bulimia and/or bulimia nervosa (binge-purge syndrome).

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

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.

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

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.

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.

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.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, 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 "Dental Care" or "Jaw Joint Disorders" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED. Cosmetic dental surgery or other dental services for beautification.

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

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

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

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*.

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.

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.

Gambling. Services for pathological gambling or codependency.

Government Treatment. Any services actually given to you by a local, state or federal government agency, 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.

Hearing Aids or Tests. Hearing aids. Routine hearing tests, except as specifically provided under “Routine Physical Exam Benefits” provision under MEDICAL CARE THAT IS COVERED. Hearing aids, except as specifically provided under the “Hearing Aids” provision under MEDICAL CARE THAT IS COVERED.

Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of *infertility*, except as specifically stated in the “Infertility Treatment” provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED. Laboratory procedures related to artificial insemination or in vitro fertilization are not covered.

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.

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.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. *Mental or nervous disorders* or substance abuse, including rehabilitative care in relation to these conditions, except as specifically stated in the “Mental or Nervous Disorders” or “Substance Abuse” provisions of MEDICAL CARE THAT IS COVERED.

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

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

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

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

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, except as specifically provided under “Routine Physical Exam Benefits” 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.

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

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

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a *home health agency* as specifically stated in the “Home Health Care” provision of MEDICAL CARE THAT IS COVERED, or as specifically stated in the “Physical Therapy, Physical Medicine, Occupational Therapy and Chiropractic Care” provision of MEDICAL CARE THAT IS COVERED.

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

Outpatient Speech Therapy. Outpatient speech therapy except as stated in the “Outpatient Speech Therapy” provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.

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

Physical Therapy or Physical Medicine. Services of a *physician* for physical therapy or physical medicine, except when provided during a covered inpatient confinement, or as specifically stated in the “Home Health Care,” “Hospice Care,” “Home Infusion Therapy” or “Physical Therapy, Physical Medicine, Occupational Therapy and Chiropractic Care” provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.

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.

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

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 (For Retired Employees and Dependents Age 19 and over),” “Well Woman Care,” “Cervical Cancer Screening,” “Breast Cancer,” “Screening For Blood Lead Levels” or “Hepatitis B and Varicella Zoster Immunizations” provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.

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 YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.

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

Spiritual Refreshment.

Sterilization Reversal. Reversal of sterilization.

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

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.

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.

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.

PRE-EXISTING CONDITION EXCLUSION

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

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

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

REIMBURSEMENT FOR ACTS OF THIRD PARTIES

Under some circumstances, a *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 mail service program whenever possible. In addition, you may also reduce your costs by asking your *physician*, and your pharmacist, for the more cost-effective *generic* form of *prescription drugs*.

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

Type of Provider	Maximum Prescription Drug Covered Expense is..
Participating Pharmacies and Mail Service Program	Prescription Drug Negotiated Rate
Non-Participating Pharmacies	Drug Limited Fee Schedule Amount

When you choose a *participating pharmacy*, we 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 drug negotiated rate* for the covered services of a *participating pharmacy*.

When we receive a claim for *drugs* supplied by a *non-participating pharmacy*, we first subtract any expense which is not covered under your *prescription drug* benefits, and then any expense exceeding the *drug limited fee schedule*. 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 we determine *prescription drug covered expense*, we 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 we 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 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.

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 us at the address shown below:

Blue Cross of California Prescription Drug Program
P.O. Box 4165
Woodland Hills, CA 91365-4165

Participating pharmacies usually have claims forms, but, if the *participating pharmacy* does not have claim forms, claim forms and customer service are available by calling 1-800-700-2541. 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 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:

Blue Cross of California Prescription Drug Program
P.O. Box 4165
Woodland Hills, CA 91365-4165

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

Claim forms and customer service are available by calling 1-800-700-2541. 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. If you cannot locate a *participating pharmacy*, you must pay for the *drug* and submit a claim to us. (See "When You Go to a Non-Participating Pharmacy" above.)

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

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

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

Order forms can be obtained by contacting:

Blue Cross of California Prescription Drug Program - Mail Service
P.O. Box 961025
Fort Worth, TX 76161-9863
1-866-274-6825

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 CONDITIONS OF SERVICE

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

1. It must be prescribed by a licensed prescriber and be dispensed within one year of being prescribed, subject to federal and state laws.
2. It must be approved for general use by the State of California Department of Health Services or the Food and Drug Administration (FDA).
3. It must be for the direct care and treatment of your illness, injury or condition. Dietary supplements, health aids or drugs 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 mail service program.
5. It must not be used while you are an inpatient in any facility. Also, it must not be dispensed in or administered by an outpatient facility.
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 and that require a triplicate prescription form must not exceed a 60-day supply. If the *physician* prescribes a 60-day supply for *drugs* classified as Schedule II for the treatment of attention deficit disorders, the *member* has to pay double the amount of co-payment for retail *pharmacies*. If the *drugs* are obtained through the mail service program, the co-payment will remain the same as for any other *prescription drug*.

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 mail service 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 co-payment 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 co-payment 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. Tretinoin, all dosage forms (Retin-A), for *members* through the age of 35 years.
9. *Prescription drugs* for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.
10. Inhaler spacers and peak flow meters for the treatment of pediatric asthma. These items are subject to the copayment for *brand name drugs*.

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, sanatorium, convalescent hospital, or similar facility. While not covered under this *prescription drug* benefit, such *drugs* are covered as specified under the “Hospital”, “Skilled Nursing Facility”, and “Hospice Care”, provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits. While you are confined in a rest home, sanitarium, convalescent hospital or similar facility, *drugs* and medications supplied and administered by your *physician* are covered as specified under the “Professional Services” provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to the benefit.

Other *drugs* that may be prescribed by your *physician* while you are confined in a rest home, sanitarium, convalescent hospital or similar facility, may be purchased at a *pharmacy* by the *member*, or a friend, relative or care giver on your behalf, and are covered under this *prescription drug* benefit.

8. Durable medical equipment, devices, appliances and supplies, even if prescribed by a *physician*, except *prescription* contraceptive diaphragms as specified under PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED. While not covered under this *prescription drug* benefit, these items are covered as specified under the “Durable Medical Equipment”, “Hearing Aid Services”, and “Diabetes” provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.
9. Services or supplies for which you are not charged.
10. Oxygen. While not covered under this *prescription drug* benefit, oxygen is covered as specified under the “Hospital”, “Skilled Nursing Facility”, “Home Health Care” and “Hospice Care” provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.
11. Cosmetics and health or beauty aids. However, health aids that are *medically necessary* and meet the requirements for durable medical equipment as specified under the “Durable Medical Equipment” provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), are covered, subject to all terms of this *plan* that apply to that benefit.
12. *Drugs* labeled “Caution, Limited by Federal Law to Investigational Use” or Non-FDA approved investigational *drugs*. Any *drugs* or medications prescribed for *experimental* indications. If you are denied a *drug* because 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: (a) the *drug limited fee schedule* for *drugs* dispensed by *non-participating pharmacies*; or (b) the *prescription drug negotiated rate*, for *drugs* dispensed by *participating pharmacies* or through the mail service program.
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. Anorexiant and drugs used for weight loss except when used to treat morbid obesity (e.g., diet pills and appetite suppressants).
19. *Drugs* obtained outside of the United States unless they are furnished in connection with *urgent care* or an *emergency*.
20. Allergy desensitization products or allergy serum. While not covered under this *prescription drug* benefit, such *drugs* are covered as specified under the "Hospital", "Skilled Nursing Facility", and "Professional Services" provisions of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this *plan* that apply to those benefits.
21. Infusion *drugs*, except *drugs* that are self-administered subcutaneously. While not covered under this *prescription drug* benefit, infusion *drugs* are covered as specified under the "Professional Services" and "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. For the purposes of determining our payment, the total value of Allowable Expense as provided under This Plan and all Other Plans will not exceed the greater of: (1) the amount which we would determine to be eligible expense, if you were covered under This Plan only; or (2) the amount any Other Plan would determine to be eligible expenses in the absence of other coverage.

Other Plan is any of the following:

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

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

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

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

EFFECT ON BENEFITS

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

ORDER OF BENEFITS DETERMINATION

The following rules determine the order in which benefits are payable: Please note that the first of the following rules that applies to your situation will determine the order in which benefits are payable. If the first rule does not determine primary payor, proceed to the next rule, etc.

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

For Retired Employees and Their Spouses and Disabled Retirees or a Disabled Dependent of a Retiree under age 65. If a *member* is a *retired employee* or the *spouse* of a *retired employee* and eligible for Medicare Part A, having made the required number of quarterly contributions to the Social Security System, or if you are a disabled retiree or a disabled dependent of a retiree under age 65, the *member's* benefits under this *plan* will be paid up to either Medicare's Allowable charge, the *negotiated rate*, or the *customary and reasonable charge*, depending on what kind of provider is used and whether or not that provider accepts assignment from Medicare.

1. When any *participating* or *non-participating provider* accepts assignment from Medicare, Blue Cross will pay the difference between Medicare's payment and Medicare's approved amount. The *member* is not responsible for the difference between Medicare's approved amount and the total charge when the provider accepts assignment of benefits.
2. When a *participating provider* does not accept assignment from Medicare, Blue Cross will pay the difference between Medicare's payment and the *negotiated rate*. The *member* is not responsible for the difference between the *negotiated rate* and the total charge when a *participating provider* does not accept assignment of benefits.
3. When a *non-participating provider* does not accept assignment from Medicare, Blue Cross will pay the difference between Medicare's payment and the *customary and reasonable charge* for that service. The *member* will be responsible for any difference between the *customary and reasonable charge* for that service and the total amount billed.
4. For Medicare Part B, the plan deductible will not apply.
5. For inpatient *hospital* claims, Blue Cross will pay the Medicare Part A deductible and coinsurance.

If no payment is made by Medicare because the charge has been applied toward the deductible or because Medicare does not cover that service, full benefits of this *plan* will be paid by Blue Cross for covered services.

Blue Cross will apply this method of payment when a *member* is retired and eligible to enroll in Medicare Part A, whether or not a *member* is actually enrolled in Medicare Parts A or B, and whether or not benefits to which a *member* is entitled are actually paid by Medicare.

Note: You must notify the Los Angeles Police Relief Association, Inc. if you are a retiree or *family member* under age 65 and have elected Medicare due to disability.

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 *covered expense* for the covered services.

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*, *severe mental disorders*, and substance abuse.
- Organ and tissue transplants.
- Visits for physical therapy, physical medicine, occupational therapy and chiropractic care beyond those described under the "Physical Therapy, Physical Medicine, Occupational Therapy and Chiropractic

Care" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.

- 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.

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, severe mental disorders, and substance abuse*.
 - Organ and tissue transplants.
 - Visits for physical therapy, physical medicine, occupational therapy and chiropractic care beyond those described under the "Physical Therapy, Physical Medicine, Occupational Therapy

and Chiropractic Care" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.

- 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.
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** 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, severe mental disorders*, and substance abuse, the benefits to which you would have been otherwise entitled will be subject to the Non-Certification Penalty shown in the SUMMARY OF BENEFITS.
2. When pre-service review is performed and the admission, procedure or service is determined to be *medically necessary* and appropriate, benefits will be provided for the following:
 - Organ and tissue transplants as follows:

- a. For kidney, bone, skin or cornea transplants if the *physicians* on the surgical team and the facility in which the transplant is to take place are approved for the transplant requested.
 - b. For transplantation of liver, heart, heart-lung, lung, kidney-pancreas or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures if the providers of the related preoperative and postoperative services are approved and the transplant will be performed at a *Centers of Expertise (COE)* facility.
- A specified number of additional visits for physical therapy, physical medicine, occupational therapy and chiropractic care if you need more visits than is provided under the “Physical Therapy, Physical Medicine, Occupational Therapy and Chiropractic Care” provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.
- Services of a home infusion therapy provider if the attending *physician* has submitted both a prescription and a plan of treatment before services are rendered.
- Home health care services if:
 - a. The services can be safely provided in your home, as certified by your attending *physician*;
 - b. Your attending *physician* manages and directs your medical care at home; and
 - c. Your attending *physician* has established a definitive treatment plan which must be consistent with your medical needs and lists the services to be provided by the *home health agency*.
- Services provided in a *skilled nursing facility* if you require daily skilled nursing or rehabilitation, as certified by your attending *physician*.
- Select imaging procedures, including, but not limited to: Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and nuclear cardiac imaging.

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

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

HOW TO OBTAIN UTILIZATION REVIEWS

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

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

1. For all scheduled services that are subject to utilization review, you or your *physician* must initiate the pre-service review at least three working days prior to when you are scheduled to receive services.
2. You must tell your *physician* that this *plan* requires pre-service review. *Physicians* who are *participating providers* will initiate the review on your behalf. A *non-participating provider* may initiate the review for you, or you may call 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, severe mental 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 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.
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; and
 - 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.

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 member of the following class and your primary residence is in the State of California:

Class 3: All sworn *retired employees* of the Los Angeles Police Department who are receiving a pension from the City of Los Angeles Department of Fire & Police Pensions and all *retired employees* of the Los Angeles Police Relief Association, Inc., the Los Angeles Police Protective League and the Los Angeles Retired Fire and Police Association who are eligible to participate as an employee in a LAPRA medical plan at the time of retirement and who are eligible to receive an employer pension as of the date of retirement.

Individuals who are not eligible for a subsidy with the Department of Fire and Police Pensions at the time they retire are eligible for coverage under the *agreement* provided they pay full monthly subscription charges. If the retiree subsequently becomes eligible for a subsidy, the retiree will then be responsible for the difference between the full monthly subscription charges and the subsidy amount paid on his or her behalf.

2. **Family Members.** The following persons are eligible to enroll as *family members*: (a) The *subscriber's spouse or domestic partner*, and (b) An unmarried *child*.
3. **Surviving Family Members.** Surviving family members as described under the **Definition of Family Members**:
 1. If the *subscriber* dies while covered under this *plan* coverage continues for enrolled *family members*.
 2. If a former *subscriber* dies while he or she or their *family members* are not covered under a plan offered by the Los Angeles Police Relief Association, Inc., surviving *family members* may become eligible to enroll in this *plan*:
 - a. on the date of death of the former *subscriber*,
 - b. during the open enrollment period;

- c. on the date the surviving *family member* becomes eligible for a subsidy with the Department of Fire and Police Pensions;
or
- d. on either (1) the surviving *family member's* pension approval date or (2) the date notification is received by the Los Angeles Police Relief Association, Inc. from the Department of Fire and Police Pensions of the surviving *family member's* Pension approval.

Coverage will continue for enrolled surviving *family members* until one of the following occurs:

1. Subscription charges are not paid to Blue Cross on the *member's* behalf;
2. The *group* cancels coverage for the class of *subscribers* to which the *member* belongs;
3. The agreement between Blue Cross and the group terminates;
or
4. The *child* no longer meets all of the conditions of coverage as described under this section entitled HOW COVERAGE BEGINS AND ENDS.

Note:

- A surviving *spouse's* coverage may continue if he or she remarries or enters into a domestic partnership, but the new spouse or domestic partner, new stepchildren, the domestic partner's children or any new children may not be added to this *plan as family members*.
- A surviving *domestic partner's* coverage may continue if he or she enters into a new domestic partner relationship or marriage, but the new domestic partner or spouse, new stepchildren, new domestic partner's children or any new children may not be added to this plan as *family members*.

Definition of Family Member

1. **Spouse** is the *subscriber's* spouse under a legally valid marriage between persons of the opposite sex. Spouse does not include any person who is: (a) covered as a *subscriber*; or (b) in active service in the armed forces.

2. **Domestic partner** is the *subscriber's* domestic partner under (1) a legally registered and valid domestic partnership, or (2) an application for domestic partnership that has been approved by the Department of Fire and Police Pensions, and has been submitted by the *subscriber* to the LAPRA office.

Note: If both the *subscriber* and his or her *spouse* or *domestic partner* are eligible employees of the *group*, they are eligible to enroll for coverage as either a *subscriber* or as a dependent, but not as both. If both parents are covered as *subscribers*, their children may be covered as the *family members* of either, but not of both.

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

- a. The child is unmarried and either (i) the child resides with the *subscriber* for more than half the year (temporary absences for special circumstances, such as for school, vacation, and medical care, are permitted) and depends on the *subscriber* for support and maintenance (i.e., the *subscriber* provides over one-half of the child's support each year); or (ii) the *subscriber*, *spouse* or *domestic partner* is legally required to provide group health coverage for the child pursuant to an administrative or court order.
- b. The unmarried child is under 19 years of age, or if over the age of 19, that child is eligible until his or her 25th birthday, provided he or she is enrolled as a full-time student (for 9 or more credits) in a properly accredited two-year community college, four-year college or university, or an accredited post-high school trade or technical school.

An overage dependent (i.e., over 19 years of age) who enters or returns to an eligible status will become eligible for coverage on the date they return to a full time eligible status.

Note:

- If your child is a full-time student at an accredited school and graduates or finishes school, coverage will end at the end of the month that they graduate or finish school. For example, if they graduate in June, coverage will end on June 30th.

- If your child discontinues going to school or ceases to be a full time student (less than 9 credits), coverage will end at the end of the month that they are no longer eligible.
- c. A child who is in the process of being adopted is considered a legally adopted child if the *group* receives legal evidence of both: (i) the intent to adopt; and (ii) that the *subscriber, spouse* or *domestic partner* has 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 *domestic partner's* right to control the health care of the child.
 - d. A child for whom the *subscriber, spouse* or *domestic partner* is a legal guardian is considered eligible on the date of the court decree. We must receive legal evidence of the decree.
 - e. A child for whom the *subscriber, spouse, or domestic partner* is legally required to provide group health coverage pursuant to an administrative or court order is considered eligible on the date of the order directing that a dependent be added for coverage. We must receive a copy of the administrative or court order.
 - 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.

ELIGIBILITY DATE

1. For *subscribers*, you become eligible for coverage as follows:

Class 3: For Class 3 eligible retired employees, coverage begins as follows:

- a. For retirees who at the time of retirement were enrolled as an active employee in a plan sponsored by the Los Angeles Police Relief Association, Inc. or for retirees who were not enrolled at the time of retirement: on the first day of the month following the retiree's pension effective date.

- b. For retirees who (i) go off payroll while an active employee and do not lose coverage under the active plan, (ii) subsequently retire and (iii) become eligible for a pension from the Department of Fire and Police Pensions with a pension effective date that is retroactive to either before or after the off payroll date: on the first day of the month following either (1) the retiree's pension effective date or (2) the date the Los Angeles Police Relief Association, Inc. receives notification from the Department of Fire and Police Pensions of the retiree's pension effective date. Coverage will be retroactive only to the extent permitted by Blue Cross.
 - c. For retirees who retire prior to becoming eligible for a subsidy from the Department of Fire and Police Pensions and who are not enrolled at the time they become eligible for a subsidy: on the first day of the month in which the retiree become eligible for a subsidy.
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 31 days from your eligibility date.

If you enroll an eligible *family member*, you must submit proof of dependent status, such as a copy of a certified marriage certificate, a copy of a certified birth certificate, a copy of a commemorative hospital birth certificate with the names of both parents, or Court approval of legal guardianship. If you do not have the required certificate or Court approval documents at the time of enrollment, you must submit temporary proof of dependent status and you have 60 days from your *family member's* effective date of coverage to submit the required documents. If you fail to submit required proof within the 60-day period, your *family member's* coverage will automatically be cancelled on the first day of the month following the end of the 60-day period. You must then wait until the next Open Enrollment Period to re-enroll your family member and submit proof of dependent status.

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 31 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 31 days after your eligibility date, you must wait until the *group's* next Open Enrollment Period to enroll unless you experience a Qualified Family Status Change as described below. Qualified Family Status Changes include:
 - Birth, adoption or placement for adoption.
 - Marriage or legal and valid registration of a domestic partnership, or approval of a domestic partnership application by the Department of Fire and Police Pensions, whichever is applicable.
 - Divorce, legal separation, or annulment of a marriage, or the termination, legal separation or annulment of a domestic partnership, which results in your losing coverage under another plan.
 - Death of a *family member* which results in losing coverage under another plan.
 - Receipt of a court order requiring the *subscriber* to provide medical coverage for *subscriber's* child.

Certain other event permitted by your *group* in accordance with law.
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* is already covered: (1) any *child* born to the *subscriber*, *spouse* or *domestic partner* will be covered from the moment of birth; and (2) any *child* being adopted by the *subscriber* will be covered from the date on which either: (a) the adoptive *child's* birth parent, or other appropriate legal authority, signs a written document granting the *subscriber* the right to control the health care of the *child* (in the absence of a written document, other evidence of the *subscriber's* right to control the health care of the *child* may be used); or (b) the *subscriber* 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.

For both newborn and newly adopted children, coverage will be in effect for 31 days only. For coverage to continue beyond this 31-day period, the *subscriber* must enroll the *child* within the 31-day period by submitting a membership change form to the *group* (see below for more details).

Special Enrollment Periods

You (and your *family members* in certain instances) 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 under another health plan as an individual or dependent, including coverage under a COBRA or CalCOBRA continuation, the Healthy Families Program, or no share-of-cost Medi-Cal coverage.
 - 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 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 because:
- you lost eligibility under the other plan or employer contributions toward coverage under the other plan terminated,
 - your coverage under a COBRA or CalCOBRA continuation was exhausted,
 - you lost coverage under the Healthy Families Program as a result of exceeding the program's income or age limits, or you lost no share-of-cost Medi-Cal coverage.
- d. You properly file an application with the *group* within 31 days from the date on which you lose coverage.

If you meet the requirements above, coverage will become effective on the first day of the month following the month in which your other coverage was lost.

2. A court has ordered coverage be provided for a *spouse* or *domestic partner* or dependent *child* under your retiree health plan, and such individual is otherwise eligible for coverage under the plan. Coverage will become effective on the first day of the month following the date we receive a copy of the order and a completed enrollment form.
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 31 days after your eligibility date, or if you disenroll, and later file an enrollment application, your coverage may not begin until the designated date following the open enrollment period.
4. You have a change in family status through either marriage, domestic partnership or the birth, adoption, or placement for adoption of a *child*.
 - a. If you get married, you may enroll your new *spouse* (you must also enroll yourself if you are not enrolled at that time). You must enroll your new *spouse* (and yourself, if applicable) within 31 days of the date of marriage. Your new *spouse's* children may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances

listed above. Coverage will be effective on the first day of the month following the date of marriage.

- b. If you acquire a new dependent *child* by reason of birth, adoption, or placement for adoption, you may enroll your new dependent *child* (you must also enroll yourself if you are not enrolled at that time). At that time, you may also enroll your *spouse* if he or she is eligible but not enrolled. Other children may not enroll at that time unless they qualify under another of these circumstances listed above. Application must be made within 31 days of the birth or date of adoption or placement for adoption; coverage will be effective as of the date of birth or adoption.
 - c. If you are enrolling a new *domestic partner*, your enrollment application must be received within 31 days of the legal and valid registration of a domestic partnership, or approval of a domestic partnership application by the Department of Fire and Police Pensions, whichever is applicable. Coverage will be effective on the first day of the month following the date of the legal and valid registration of a domestic partnership, or approval of a domestic partnership application by the Department of Fire and Police Pensions.
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. Coverage will be effective on the first day of the month following 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 plan.

OPEN ENROLLMENT PERIOD

The *group* has a reenrollment period once each *year*. This period is determined between Blue Cross and the *group*. 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 designated date following the Open Enrollment Period.

HOW COVERAGE ENDS

Your coverage ends without notice from Blue Cross as provided below:

1. If the *agreement* between the *group* and Blue Cross terminates, your coverage ends at the same time. This *agreement* may be cancelled or changed without notice to *members*.
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 the *subscriber's* coverage ends.
4. Coverage ends at the end of the period for which subscription charges have been paid to Blue Cross on your behalf when the required subscription charges for the next period are not paid.
5. If you voluntarily cancel coverage at any time, as permitted by the plan, coverage ends on the last day of the month following the date you file a coverage cancellation form.
6. If you no longer meet the requirements set forth in the "Eligible Status" provision of HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE BEGINS, your coverage ends on the subscription charge due date coinciding with or following the date you cease to meet such requirements.

Exception to item 6:

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: (i) is covered under this *plan*; (ii) qualifies as a dependent of the *subscriber* for federal income tax purposes; (iii) still resides with the *subscriber* for more than half the year and still depends on the *subscriber* for support and maintenance (i.e., the *subscriber* provides over one-half of the child's support each year); and (iv) is incapable of self-sustaining employment due to a physical handicap or mental retardation. A *physician* must certify this disability in writing. Blue Cross must receive the certification, at no expense to Blue Cross, within 31 days of the date the *child* otherwise becomes ineligible. When a period of two years has passed, Blue Cross may request proof of continuing

dependency and disability, but not more often than once each year. This exception will last until the *child* no longer meets all of the requirements listed above.

7. If the *subscriber's* domestic partnership was established through the approval of a domestic partnership application by the Department of Fire and Police Pensions and the *subscriber's* domestic partnership terminates, the *subscriber* must give or send to the Department of Fire and Police Pensions written notice of the termination by providing a signed copy of the Affidavit of Termination of Domestic Partnership, and the *subscriber* must contact the Los Angeles Police Relief Association, Inc. to complete the necessary forms to terminate the domestic partner's coverage. If a *subscriber's* marriage or legally registered domestic partnership terminates, the *subscriber* must contact the Los Angeles Police Relief Association, Inc., provide a copy of the signed divorce or domestic partner termination decree, and complete the necessary forms to remove the *spouse* or *domestic partner* from coverage. Coverage for a former *spouse* or *domestic partner*, and *children*, if any, ends according to the "Eligible Status" provisions. If Blue Cross suffers a loss because the *subscriber* fails to notify the *group* of the termination of the *subscriber's* marriage or domestic partnership, Blue Cross 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 loss of eligibility for coverage or 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, COVERAGE FOR SURVIVING FAMILY MEMBERS, EXTENSION OF BENEFITS and HIPAA COVERAGE AND CONVERSION.

Unfair Termination of Coverage. Your coverage may not be terminated because of your health status or requirements for health care services. If you believe that your coverage has been terminated for either of these reasons, you may request a review of the matter by the Director of the Department of Managed Health Care.

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 continuation of coverage. Check with the *group* for details.

DEFINITIONS

The meanings of key terms used in this CONTINUATION OF COVERAGE 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: (a) 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; or (b) a *domestic partner*, or a *child* of a *domestic partner*.

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

1. **For Retired Employees and 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.

2. **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 *child's* status as a dependent *child*, as defined by the *agreement*, or (d) the *subscriber's* entitlement to Medicare.

ELIGIBILITY FOR COBRA CONTINUATION

A *subscriber* or *family member*, **other than a *domestic partner*, and a *child of a domestic partner***, may choose to continue coverage under the *agreement* if his or her coverage would otherwise end for a Qualifying Event.

TERMS OF COBRA CONTINUATION

Notice. The *group* or its 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 Event 1 the *group* or its administrator will notify the *subscriber* of the right to continue coverage.
2. For Qualifying Events 2(a) or 2(d) above, a *family member* will be notified of the COBRA continuation right.
3. You must inform the *group* within 60 days following the later of: (1) Qualifying Events 2(b) or 2(c) above; or (2) the date the qualified beneficiary would lose coverage on account of the qualifying event, if you wish to continue coverage. The *group* in turn will promptly give you official notice of the COBRA continuation right.

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

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

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

Additional Family Members. A *spouse* 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. The *group* may require that you pay the entire cost of your COBRA continuation coverage plus 2%. This cost, called the “subscription charge,” must be remitted to the *group* each month during the COBRA continuation period. We must receive payment of the subscription charge each month from the *group* in order to maintain the coverage in force.

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

1. A *spouse* whose COBRA continuation began due to divorce, separation or death of the *subscriber*;
2. 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
3. A *child* whose COBRA continuation began due to the person no longer meeting the dependent *child* definition.

Subsequent Qualifying Events. Once covered under the COBRA continuation, it’s possible for a second Qualifying Event to occur. If that happens, 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, 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;
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 1.

*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 1 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.

Coverage after COBRA. 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 a conversion notice within 180 days prior to your scheduled COBRA termination date so that you may contact Blue Cross regarding your HIPAA and Conversion coverage options.

If continuation coverage ends due to items 2 or 7 above, a surviving spouse and *family members* are eligible for the coverage as specified in this *plan* under COVERAGE FOR SURVIVING FAMILY MEMBERS.

EXTENSION OF CONTINUATION DURING TOTAL DISABILITY

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

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

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

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

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

Cost of Coverage. For the 19th through 29th months that the total disability continues, the *group* must remit the cost for the extended continuation coverage to us. This cost (called the “subscription charge”) shall be subject to the following conditions:

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

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

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

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

You must inform the *group* 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.

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 15 days prior to cancelling your coverage. If you make payment in full within 15 days after we issue this notice of cancellation, your coverage will not be cancelled. If you do not make the required payment in full within this 15 day period, your coverage will be cancelled as of 12:00 midnight on the fifteenth day after the date on which the notice of cancellation is sent and will not be reinstated. Any payment we receive more than 15 days after we issue the notice of cancellation will be refunded to you within 20 business days.

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 30 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.

SENIOR COBRA CONTINUATION FOR QUALIFYING MEMBERS

This section does not apply to any individual who is not eligible for this continuation prior to January 1, 2005. Subject to payment of subscription charges as stated in the *agreement*, coverage under this *plan* may be continued for the *subscriber*, the *subscriber's spouse*, and the *subscriber's former spouse* (if any) under Section 1373.621 of the Health and Safety Code and Section 2800.2 of the Labor Code, in accordance with the following provisions. This continuation may be elected following the CONTINUATION OF COVERAGE (the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), or Title X of P.L. 99-272) and the CALCOBRA CONTINUATION OF COVERAGE shown above.

For the purposes of this section, "former *spouse*" means: (a) an individual who is divorced from the *subscriber*; or (b) an individual who was married to the *subscriber* at the time of the *subscriber's* death.

Requirements. The *subscriber* and *spouse* may continue coverage under this *plan* if:

1. The *subscriber*, or the *subscriber* on behalf of himself or herself and the *spouse*, was entitled to, and had elected to continue coverage under, COBRA or CalCOBRA, as described in the preceding sections;
2. The *subscriber* or *spouse* has not elected to continue coverage under any other available continuation;
3. The *subscriber* has worked for the employer for at least the prior five years; and
4. The *subscriber* is at least 60 years old on the date employment with the employer ended.

The former *spouse* may continue coverage under this *plan* in accordance with this section if he or she was covered as a qualified beneficiary under COBRA or CalCOBRA, as described in the preceding section.

Notice and Election. The employer will notify the *subscriber* or *spouse* and the former *spouse* of the right to continue coverage within 180 days prior to the date continuation of coverage under COBRA or CalCOBRA is scheduled to end.

For the *subscriber* and *spouse*, this continuation may be chosen for both, for the *subscriber* only, or for the *spouse* only. The former *spouse* may elect this continuation for himself or herself only.

To elect this continuation, you must notify us in writing within 30 days prior to the date continuation coverage under COBRA or CalCOBRA is scheduled to end. If you fail to elect this continuation when first eligible, you may not elect this continuation at a later date. You must remit the initial subscription charge to us within 45 days after you elect this continuation.

Cost of Coverage. You are required to pay the entire cost of this continuation coverage. You must remit this cost to us each month during the continuation period. We must receive payment of the subscription charge each month in order to continue the coverage in force. The rate for continuation coverage under this section shall be 213% of the applicable *group* rate. For the purpose of determining subscription charges payable, the *spouse* or former spouse continuing coverage alone will be considered to be a *subscriber*.

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. We will provide you with written notice at least 30 days prior to the date any subscription charge increase goes into effect.

Accuracy of Information. You are responsible for supplying accurate, 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. We can hold you responsible for any loss or expense we incur because of your failure to do so.

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

1. The end of the period for which subscription charges are last paid;
2. The date the *agreement* terminates;
3. The date, following the election of Senior COBRA, the *subscriber*, *spouse*, or former *spouse* first becomes covered under any group health plan not maintained by the employer;
4. The date, following the election of Senior COBRA, the *subscriber*, *spouse*, or former *spouse* first becomes entitled to Medicare;
5. The date the *subscriber*, *spouse*, or former *spouse* reaches age 65;
or
6. For the *spouse* or former *spouse*, five years from the date the *spouse's* or former *spouse's* COBRA or CalCOBRA continuation coverage ended.

If your continuation under this *plan* ends in accordance with item 6, you are eligible for medical conversion coverage. If your continuation under this *plan* ends in accordance with items 2 or 6, you may be eligible for HIPAA coverage. Please see HIPAA COVERAGE AND CONVERSION in this booklet for more information.

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 the *group'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 including Post-COBRA, such coverage must have been elected and exhausted; and
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 *group'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 the *group'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

Area of Service. The benefits of this Evidence of Coverage are provided for covered services anywhere in the world, including but not limited to emergency services or accidental injuries.

Availability of Care. If there is an epidemic or public disaster and you cannot obtain care for covered services, Blue Cross refunds 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 Blue Cross within 31 days. This payment fulfills the obligation of Blue Cross under this *plan*.

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

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.

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.

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 Blue Cross 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 Blue Cross.
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 Blue Cross.
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 Blue Cross.

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, Blue Cross 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 Blue Cross prior to termination. The provider must also agree in writing to accept the terms and reimbursement rates under his or her agreement with Blue Cross 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.

Blue Cross 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 Blue Cross 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.

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

Financial Arrangements with Providers. Blue Cross 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 Blue Cross or an affiliate is a party, including all persons covered under the *agreement*.

Under the above-referenced contracts between Providers and Blue Cross 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 Blue Cross or an affiliate for the same medical services. In negotiating the terms of the *agreement*, the *group* was aware that Blue Cross 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 Blue Cross or its affiliates' agreements for insured group accounts.

Also, under arrangements with some Providers certain discounts, payments, rebates, settlements, incentives, adjustments and/or allowances, including, but not limited to, pharmacy rebates, may be based on aggregate payments made by Blue Cross or an affiliate in respect to all health care services rendered to all persons who have coverage through a program provided or administered by Blue Cross 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 Blue Cross or an affiliate in determining its fees or subscription charges or premiums.

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*.

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.

Liability of Subscriber to Pay Providers. In accordance with California law, *members* 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, deductibles or penalties), even in the unlikely event that we fail to pay that provider. *Members* may be liable, however, to pay *non-participating providers* any amounts not paid to them by us.

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.

Medical Policy and Technology Assessment. Blue Cross 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 Blue Cross' medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 physicians from various medical specialties including Blue Cross' 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.

Non-Regulation of Providers. The benefits provided under 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*.

Notice of Claim. You or the provider of service must send properly and fully completed claim forms to Blue Cross 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. Blue Cross is not liable for the benefits of the *agreement* if you do not file claims within the required time period. Claim forms must be used; cancelled checks or receipts are not acceptable.

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

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

- Billed charges for your covered services, or
- Negotiated price that the on-site Blue Cross and/or Blue Shield Licensee (“host Blue”) passes on to us.

Often the “negotiated price,” referred to above, will consist of a simple discount, which reflects the actual price paid by the Host Blue. But, sometimes it is an estimated price that factors in expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect **average** expected savings with your health care provider or with a specified group of providers. If the negotiated price reflects average expected savings, it may result in greater variation (more or less) from the actual price paid than will the estimated price. The estimated or average price may be adjusted in the future to correct for over or underestimation of past prices. Regardless of how the negotiated price is determined, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating *member* liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate *member* liability calculation methods that differ from the usual BlueCard Program method noted above in the second paragraph of this section, or require a surcharge, we would then calculate your co-payment for any covered health care services using the methods outlined by the applicable state statute in effect at the time you received your care.

Providers available to you through the BlueCard Program have not entered into contracts with Blue Cross of California. 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.

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

Plan Administrator - COBRA. In no event will we be plan administrator for the purposes of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA). 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. 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.

Prepayment Fees. The *group* is responsible for paying subscription charges to us for all coverage provided to you and your *family members*. The *group* may require that you contribute all or part of the costs of these subscription charges. You should consult the *group* for details.

Protection of Coverage. Blue Cross does not have the right to cancel your coverage under this *plan* while:

1. This *plan* is in effect;
2. You are eligible; and
3. Your subscription charges are paid according to the terms of the *agreement*.

Providing of Care. Blue Cross is not responsible for providing any type of *hospital*, medical or similar care. Also, Blue Cross is not responsible for the quality of any type of *hospital*, medical or similar care received.

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.

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.

Renewal Provisions. The *group'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.

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

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.

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

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 Blue Cross 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 Blue Cross 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 Blue Cross and Blue Cross 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 Blue Cross. 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 Blue Cross, or by order of the court, if the *member* and Blue Cross 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, Blue Cross will assume all or a portion of the costs of the arbitration.

Please send all Binding Arbitration demands in writing to Blue Cross of California, 21555 Oxnard Street, Woodland Hills, CA 91367 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 DEFINITIONS 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 Blue Cross 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.

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

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

Average wholesale price is a term accepted in the pharmaceutical industry as a benchmark for pricing by pharmaceutical manufacturers.

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

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 agree to accept the *COE negotiated rate* as payment in full for covered services. A participating provider in the Prudent Buyer Plan network is not necessarily a COE. A provider's participation in the Prudent Buyer Plan network or other agreement with us is not a substitute for a Centers of Expertise Agreement.

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

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

Christian Science Nurse. A Christian Science Nurse is an individual who is authorized by the Mother Church, The First Church of Christ, Scientist, Boston, Massachusetts.

Christian Science Practitioner. A Christian Science Practitioner is an individual who is authorized by the Mother Church, The First Church of Christ, Scientist, Boston, Massachusetts, and who is listed in the Christian Science Journal at the time services are provided.

Christian Science Sanatorium. A Christian Science Sanatorium is a facility which is approved and accredited by the department of care of the Mother Church, The First Church of Christ, Scientist, Boston, Massachusetts.

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

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

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

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

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

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

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

Day treatment center is an outpatient psychiatric facility which is licensed according to state and local laws to provide outpatient programs and treatment of *mental or nervous disorders, severe mental 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 prescribed drug approved by the State of California Department of Health or the Food and Drug Administration for general use by the public. For the purposes of this *plan*, insulin will be considered a prescription drug.

Drug limited fee schedule represents the maximum amounts we will allow as *prescription drug covered expense* for *prescriptions* filled at *non-participating pharmacies*. These amounts are the lesser of billed charges or the *average wholesale price*.

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

Emergency is a sudden, serious, and unexpected acute illness, injury, or condition (including without limitation sudden and unexpected severe pain) which the *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, severe mental disorders,* or substance abuse.

Family member meets the *plan's* eligibility requirements for family members as outlined under HOW COVERAGE BEGINS AND ENDS.

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 Blue Cross has issued this *agreement*. The name of the group is LOS ANGELES POLICE RELIEF ASSOCIATION, INC.

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 for the acute phase of a *mental or nervous disorder, severe mental disorder, or substance abuse*, "Hospital" also includes *psychiatric health facilities*.

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

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

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;
 - 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.

Any condition meeting this definition is a mental or nervous disorder no matter what the cause of the condition may be; but medical conditions that are caused by your behavior that may be associated with these mental conditions (*e.g.*, self-inflicted injuries) and treatment for *severe mental disorders* are not subject to *plan* limitations that apply to mental or nervous disorders.

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

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

Non-participating pharmacy is a *pharmacy* which does not have a Participating Pharmacy Agreement in effect with us 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; or
9. A *home infusion therapy provider*.

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

Other health care provider is one of the following providers:

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

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

Participating pharmacy is a *pharmacy* which has a Participating Pharmacy Agreement in effect with us 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. Many participating pharmacies display a “Rx” decal with our logo in their window so that you can easily identify them.

Participating provider is one of the following providers which has 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; or
9. A *home infusion therapy provider*.

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

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, is providing a service for which benefits are specified in this booklet, and when benefits would be payable if the services were provided by a physician as defined above:
 - a. A dentist (D.D.S. or D.M.D.)
 - b. An optometrist (O.D.)
 - c. A dispensing optician
 - d. A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
 - e. A licensed clinical psychologist
 - f. A chiropractor (D.C.)
 - g. An acupuncturist (A.C.)
 - h. A clinical social worker (L.C.S.W.)
 - i. A marriage and family therapist (M.F.T.)
 - j. A physical therapist (P.T. or R.P.T.)*
 - k. A speech pathologist*
 - l. An audiologist*
 - m. An occupational therapist (O.T.R.)*
 - n. A respiratory care practitioner (R.C.P.)*
 - o. A *psychiatric mental health nurse* (R.N.)*
 - p. A nurse midwife**
 - q. 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* issued to the *group* by Blue Cross. (If any changes are made to the plan, an amendment or a revised booklet will be issued to the *group* for distribution to each *subscriber* affected by the change.)

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

Prescription drug covered expense is the expense you incur for a covered *prescription drug*, but not more than the maximum amounts described in items 1 and 2 below. Expense is incurred on the date you receive the service or supply.

Prescription drug covered expense does not include any expense in excess of: (1) the *drug limited fee schedule* for *drugs* dispensed by *non-participating pharmacies*; or (2) the *prescription drug negotiated rate*, for *drugs* dispensed by *participating pharmacies*, or by the mail service program.

Prescription drug negotiated rate is the rate that we have negotiated with *participating pharmacies* under a Participating Pharmacy Agreement for *prescription drug covered expense*. *Participating pharmacies* have agreed to charge *members* no more than the prescription drug negotiated rate. It is also the rate which Blue Cross of California Prescription Drug Program - Mail Service accepts as payment in full for mail service *prescription drugs*.

Prior Plan is a plan sponsored by the *group* which was replaced by this *plan* within 60 days. A *member* is considered covered under the prior plan if that *member*: (1) was 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 health facility is an acute 24-hour facility as defined in California Health and Safety Code 1250.2. It must be:

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

Benefits provided for treatment in a psychiatric health facility which does not have a contract in effect with Blue Cross will be subject to the Blue Cross *non-contracting hospital* penalty in effect at the time of service.

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

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

Residential treatment center is an inpatient treatment facility where the *member* 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, severe mental disorder, or substance abuse*. The facility must be licensed to provide psychiatric treatment of *mental or nervous disorders, severe mental disorders, or rehabilitative treatment of substance abuse* according to state and local laws.

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

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

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

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

Benefits for severe mental disorders will be provided according to the *plan's* benefits for medical conditions, and will not be subject to *plan* provisions for *mental or nervous disorders*.

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. For the purpose of care provided for the treatment of *mental or nervous disorders, severe mental disorders, or substance abuse*, the term "skilled nursing facility" includes *residential treatment center*.

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

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

Stay is an inpatient confinement of a *member* which begins when the *member* is admitted to a facility and ends when the *member* is 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 members are *family members* who are unable to perform all activities usual for persons of that age.

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

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 Blue Cross of California (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, 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 Blue Cross of California, 21555 Oxnard Street, Woodland Hills, CA 91367 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 Blue Cross of California website at www.bluecrossca.com. 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 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.

If you are dissatisfied with the resolution of your grievance, or if your grievance has not been resolved after at least 30 days, 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 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 for review.

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, please call us at the telephone number listed on your identification card or write to us at Blue Cross of California, 21555 Oxnard Street, Woodland Hills, CA 91367. To qualify for this review, all of the following conditions must be met:

- You have a life-threatening or seriously debilitating condition, described as follows:
 - ◆ A life-threatening condition is a condition or disease where the likelihood of death is high unless the course of the disease is interrupted or a condition or disease with a potentially fatal outcome where the end point of clinical intervention is the patient's survival.
 - ◆ A seriously debilitating condition is a disease or condition that causes major, irreversible morbidity.

- Your *physician* must certify that either (a) standard treatment has not been effective in improving your condition, (b) standard treatment is not medically appropriate, or (c) there is no more beneficial standard treatment covered by this *plan* than the proposed treatment.
- The proposed treatment must either be:
 - ◆ Recommended by a *participating provider* who certifies in writing that the treatment is likely to be more beneficial than standard treatments, or
 - ◆ Requested by you or by a licensed board certified or board eligible *physician* qualified to treat your condition. The treatment requested must be likely to be more beneficial for you than standard treatments based on two documents of scientific and medical evidence from the following sources:
 - a) Peer-reviewed scientific studies published in medical journals with nationally recognized standards;
 - b) Medical literature meeting the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medica, Medline, and MEDLARS database Health Services Technology Assessment Research;
 - c) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;
 - d) The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;
 - e) Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes; and
 - f) 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 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 time frame 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.