

**LOS ANGELES COMMUNITY  
COLLEGE DISTRICT**

*October 1, 2003*

***Fee-for-Service  
Medical***

## CERTIFICATE OF INSURANCE

BC Life & Health Insurance Company  
21555 Oxnard Street  
Woodland Hills, California 91367

**This Certificate of Insurance, including any amendments and endorsements to it, is a summary of the important terms of your health plan. It replaces any older certificates issued to you for the coverages described in the Summary of Benefits. The Group Policy, of which this certificate is a part, 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 Certificate of Insurance that apply to those needs. Your employer will provide you with a copy of the Group Policy upon request.**

Your health care coverage is insured by BC Life & Health Insurance Company (BC Life). The following pages describe your health care benefits and includes the limitations and all other *policy* provisions which apply to you. The *insured person* is referred to as “you” or “your,” and BC Life as “we,” “us” or “our.” All italicized words have specific *policy* definitions. These definitions can be found in the DEFINITIONS section of this certificate.

## **COMPLAINT NOTICE**

**Should you have any complaints or questions regarding your coverage, and this certificate was delivered by a broker, you should first contact the broker. You may also contact us at:**

**BC Life & Health Insurance Company  
Customer Service  
21555 Oxnard Street  
Woodland Hills, CA 91367  
818-234-2700**

**If the problem is not resolved, you may also contact the California Department of Insurance at:**

**California Department of Insurance  
Claims Service Bureau, 11th Floor  
300 South Spring Street  
Los Angeles, California 90013**

**1-800-927-HELP (4357) – In California**

**1-213-897-8921 – Out of California**

**1-800-482-4833 – Telecommunication Device for the Deaf**

**E-mail Inquiry:     927HELPSurance.ca.gov**

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## SUMMARY OF BENEFITS

**THE BENEFITS OF THIS CERTIFICATE ARE PROVIDED ONLY FOR THOSE SERVICES WHICH WE DETERMINE TO BE MEDICALLY NECESSARY. THE FACT THAT A PHYSICIAN PRESCRIBES OR ORDERS A SERVICE DOES NOT, IN ITSELF, MAKE IT MEDICALLY NECESSARY OR A COVERED EXPENSE.**

This summary provides a brief outline of your benefits. You need to refer to the entire certificate for complete information about the benefits, conditions, limitations and exclusions of your *plan*.

**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*.

**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.

**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 PARTIES section.
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## MEDICAL BENEFITS

### DEDUCTIBLES

#### Calendar Year Deductibles

- *Insured Person* Deductible ..... **\$200**
- Family Deductible ..... **\$600**

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

- The Calendar Year Deductible will not apply to charges for office visits to a *physician*, if those visits are for treatment for other than *mental or nervous disorders* or substance abuse.

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

- The Calendar Year Deductible will not apply to diabetes education program services.
- The Calendar Year Deductible will not apply to the following Well Baby and Well Child Care services: (a) *physician's* services for routine examinations; or (b) immunizations.
- The Calendar Year Deductible will not apply to services provided under the Preventive Care benefit.
- For *insured persons* who have Medicare Part A and Part B coverage, the Calendar Year Deductibles will not apply to services and supplies for which Medicare provides benefits.

### PAYMENT RATES

**Level of Payments\*.** After your *Calendar Year* Deductible has been satisfied, we will pay benefits for *covered expense* you incur as follows:

- *Facility-based care* for the treatment of *mental or nervous disorders* or substance abuse ..... **80%**
- *Physician services* for the treatment of *mental or nervous disorders* or substance abuse ..... **50%**
- All other services and supplies ..... **100%**

**\*Exceptions:**

- Payment will be **100%** of *covered expense* after you have made a **\$25** co-payment for services provided under the Preventive Care benefit.
- Payment will be **100%** of *covered expense* after you have made a **\$10** co-payment for the following:
  - a. Office visits to a *physician*, if those visits are for treatment for other than *mental or nervous disorders* or substance abuse.
  - b. Diabetes education program services provided by a *physician*.
- Payment for services covered under the Hearing Aid Services benefit will be **80%** of *covered expense*.

**MEDICAL BENEFIT MAXIMUMS**

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

**Acupuncture**

- For all covered services.....**\$25**  
per visit for up to 12  
visits per *calendar year*

**Hearing Aids**

- For covered charges.....**\$500**  
per 36-month period

**Home Health Care**

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

**Mental or Nervous Disorders**

- For covered *physician's* services .....**\$50**  
per visit

**Physical Therapy, Physical Medicine, Chiropractic Services and Occupational Therapy**

- For all covered outpatient services combined .....**24 visits**  
per *calendar year*

**Preventive Care (Insured Persons Age 7 and Over)**

- For all covered services and supplies ..... **\$250**  
per calendar year

**Prosthetic Devices**

- For covered services and supplies (except breast prostheses following a mastectomy or prosthetic devices following a laryngectomy) ..... **\$2,000**  
per calendar year

**Skilled Nursing Facility**

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

**Substance Abuse**

- For covered physician’s services ..... **\$50**  
per visit, for up to 50  
visits per calendar year
- For covered facility-based care ..... **\$175**  
per day, for up to 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.

**LIFETIME MAXIMUM**

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

**PRESCRIPTION DRUG BENEFITS**

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

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

**Participating Pharmacies**

- *Generic Drugs* ..... **\$5**
- *Brand Name Drugs:*
  - *Formulary drugs and non-formulary drugs* when the prescriber has specified “dispense as written” ..... **\$15**
  - *Non-formulary brand name drugs* ..... **\$35**

**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.

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

**Non-Participating Pharmacies\***

- *Generic Drugs* ..... **\$5**  
plus **50%** of *prescription drug covered expense*
- *Brand Name Drugs:*
  - *Formulary drugs and non-formulary drugs* when the prescriber has specified “dispense as written” ..... **\$15**  
plus **50%** of *prescription drug covered expense*



# 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.

**Type of Provider.** The maximum *covered expense* for services provided by a *physician* will be the lesser of the billed charge or the *customary and reasonable charge*. The maximum *covered expense* for services provided by a *hospital* or *other health care provider* will be the lesser of the billed charge or the *reasonable charge*.

**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* or *other health care provider*, in excess of the lesser of the maximum *covered expense* stated above, or:
  - a. For *providers* who accept Medicare assignment, the approved amount as determined by Medicare; or
  - b. For *providers* who do not accept Medicare assignment, the limiting charge as determined by Medicare.

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

## DEDUCTIBLES AND MEDICAL BENEFIT MAXIMUMS

After we subtract any applicable deductible from the total amount of *covered expense*, we will pay benefits at the Payment Rate which applies to such expense, up to the applicable Medical Benefit Maximums. The Deductible amounts, Payment Rates and Medical Benefit Maximums are set forth in the SUMMARY OF BENEFITS.

### DEDUCTIBLES

Only charges that are considered *covered expense* will apply toward satisfaction of any deductible.

**Calendar Year Deductible.** Each year, you will be responsible for satisfying the *insured person's* Calendar Year Deductible before we

begin to pay benefits. If enrolled *members* of a 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.

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

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

## **MEDICAL BENEFIT MAXIMUMS**

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

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

## **CONDITIONS OF COVERAGE**

The following conditions of coverage must be met for expense incurred for services or supplies to be 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 under 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 under 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 CONDITIONS OF COVERAGE and the exclusions or limitations listed under MEDICAL CARE THAT IS NOT COVERED, we will provide benefits for the following services and supplies:

**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, electro-acupuncture, cupping and moxibustion. We will pay for up to 12 visits during a *calendar year*, and for up to a maximum of **\$25** for all covered services rendered during each visit.

**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.

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

**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 of 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 *insured person*.
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 any of the items listed below. You will be responsible for the costs associated with any of the following, in addition to the costs of non-covered services.

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 *insured persons* enrolled in the trial.

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

## **Chemotherapy**

**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 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”).

**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.). 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 *insured person* is less than seven years old, (b) the *insured person* is developmentally disabled, or (c) the *insured person’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.) 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 the *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. Podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes-related complications.
  - e. Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin.

These covered equipment and supplies are covered under your *plan's* benefits for durable medical equipment (see "Durable Medical Equipment").

2. Diabetes education program which:
  - a. Is designed to teach an *insured person* 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 *insured person* 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 radiology and laboratory services.

**Durable Medical Equipment.** Rental or purchase of dialysis equipment; dialysis supplies. Therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications. 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.

We will determine whether the item satisfies the conditions above.

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

1. Audiological evaluations to measure the extent of hearing loss and determine the most appropriate make and model of hearing aid. These evaluations will be covered under *plan* benefits for office visits to *physicians*.
2. Hearing aids (monaural or binaural) including ear mold(s), the hearing aid instrument, batteries, cords and other ancillary equipment.
3. Visits for fitting, counseling, adjustments and repairs for a one year period after receiving the covered hearing aid.

We will pay up to **\$500** in a 36-month period for the services listed above.

No benefits will be provided for the following:

1. Charges for a hearing aid which exceeds specifications prescribed for the correction of hearing loss.
2. Surgically implanted hearing devices (i.e., cochlear implants, audient bone conduction devices). *Medically necessary* surgically implanted

hearing devices may be covered under your *plan's* benefits for prosthetic devices (see "Prosthetic Devices").

## **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 100 visits during a *calendar year*. A visit of four hours or less by a home health aide shall be considered as one home health visit.

Home health care services are subject to prior authorization to determine medical necessity. Please refer to MEDICAL MANAGEMENT PROGRAMS for information on how to obtain the proper reviews.

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

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

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

2. Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications;
3. Hospital and home clinical visits related to the administration of infusion therapy, including skilled nursing services including those provided for: (a) patient or alternative caregiver training; and (b) visits to monitor the therapy;
4. Rental and purchase charges for durable medical equipment (as shown below); maintenance and repair charges for such equipment;
5. Laboratory services to monitor the patient's response to therapy regimen.

*Home infusion therapy provider* services are subject to prior authorization to determine medical necessity. See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION 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 *employee's* or the *insured 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 us and the *hospital*.
2. Services in *special care units*.
3. Outpatient services and supplies provided by a *hospital*, including outpatient surgery.

**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 **\$50** for each visit.

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 *insured person* 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 prior authorization from us, or which are provided at a facility other than a transplant center approved by us. See MEDICAL MANAGEMENT PROGRAMS 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.

**Physical Therapy, Physical Medicine, Chiropractic Services and Occupational Therapy.** The following services provided by a *physician* under a treatment plan which offers a reasonable expectation of significant improvement:

1. Physical therapy and physical medicine provided on an outpatient basis for the treatment of illness or injury include 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.

We will provide payment for up to a combined maximum of 24 visits in a year for all covered services. 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.

If we determine that an additional period of physical therapy, physical medicine, chiropractic services or occupational therapy is both *medically necessary* and likely to result in a significant improvement to your condition by measurably reducing your physical impairment during that period of additional care, we will authorize a specific number of additional visits. Benefits are not payable if prior authorization is not obtained. (See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION 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 an *insured employee* or enrolled *spouse* or *domestic partner*.

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

**Preventive Care (Insured Persons Age 7 and Over).** In addition to any services specified elsewhere in the certificate, we will pay up to **\$250** during a *calendar year* for the services listed below when provided for an *insured person* age 7 or over. You must pay a **\$25** co-payment for each visit.

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

Hepatitis B and Varicella Zoster Immunizations, Prostate Cancer Screenings, Cervical Cancer Screenings and Breast Cancer screenings are not provided under these preventive care benefits but are provided under other benefits specifically stated under this section.

### **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. We will pay for other *medically necessary prosthetic devices*, limited to a maximum payment of **\$2,000** during a *calendar year*, 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.

### **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.

**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*, for up to 100 days per *calendar year*. The amount by which your room charge exceeds the prevailing two-bed room rate of the *skilled nursing facility* is not considered *covered expense*. For the purpose of care provided for the treatment of *mental disorders*, *severe mental disorders* or substance abuse, the term “skilled nursing facility” includes *residential treatment center*.

*Skilled nursing facility* services and supplies are subject to prior authorization to determine medical necessity. Please refer to MEDICAL MANAGEMENT PROGRAMS for information on how to obtain the proper reviews.

Note: *Facility-based care* for the treatment of substance abuse is limited to 30 days per *calendar year*. Any days you spend as an inpatient in a *residential treatment center* will be counted against both this 30 day limit and the 100 day limit applicable to benefits for services provided by a *skilled nursing facility*.

**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*, limited to our maximum payment of **\$175** per day.
2. Visits to a *day treatment center*, limited to our maximum payment of **\$175** per day.
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 **\$50** for each visit, 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.

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.

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

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

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

## **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.)

**Acupressure or Massage.** Acupressure, or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

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

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

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

**Education or Counseling.** Educational services, or nutritional counseling, except as specifically stated under the "Diabetes" or "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED. Food or dietary supplements, except as specifically stated under the "Special Food Products" provision of 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*.

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

**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.

**Government Treatment.** Any services provided by a local, state, or federal government agency, except when payment under this *plan* is expressly required by federal law.

**Hearing Aids or Tests.** Hearing aids and routine hearing tests, except as specifically stated in the "Hearing Aid Services" provision of MEDICAL CARE THAT IS COVERED. Routine hearing tests, except as provided as part of routine physical examinations under "Well Baby and Well Child Care" and "Preventive Care" benefits or as specifically stated in the "Hearing Aid Services" provision of MEDICAL CARE THAT IS COVERED.

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

**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. Smoking cessation *drugs*.

**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.

**Obesity.** Services primarily for weight reduction or treatment of obesity. This exclusion will not apply to surgical treatment of morbid obesity as determined by us if:

1. Surgical treatment of the obesity is necessary to treat another life-threatening condition also involving the obesity; and
2. It has been documented that non-surgical treatments of the obesity have failed.

**Optometric Services or Supplies.** Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, except routine eye screenings provided as part of routine physical examinations under "Well Baby and Well Child Care" or "Preventive Care" benefits 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 and other orthodontic appliances or 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 "Durable Medical Equipment" provision of MEDICAL CARE THAT IS COVERED.

**Outpatient Occupational Therapy.** Outpatient occupational therapy, except by a *home health agency, hospice or home infusion therapy provider* as specifically stated in the "Home Health Care", "Hospice Care", "Home Infusion Therapy", or "Physical Therapy, Physical Medicine, Chiropractic Services And Occupational Therapy" provisions of MEDICAL CARE THAT IS COVERED.

**Outpatient 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 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, Chiropractic Services and Occupational Therapy" provision of MEDICAL CARE THAT IS COVERED.

**Private Contracts.** Services or supplies provided pursuant to a private contract between the *insured person* 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," "Preventive Care", "Cervical Cancer Screening", "Breast Cancer", "Prostate Cancer Screening", or "Screening For Blood Lead Levels" provisions of MEDICAL CARE THAT IS COVERED.

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

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

**Sex Transformation.** Any procedures or treatments to change characteristics of the body to those of the opposite sex.

**Sterilization Reversal.** Reversal of sterilization.

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

**Uninsured.** Services received before your *effective date* or after your coverage ends, except as specifically stated under EXTENSION OF BENEFITS.

**Voluntary Payment.** Services for which you are not legally obligated to pay. Services for which you are not charged. Services for which no charge is made in the absence of insurance 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.

**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.

## REIMBURSEMENT FOR ACTS OF THIRD PARTIES

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

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

# YOUR PRESCRIPTION DRUG BENEFITS

## PRESCRIPTION DRUG 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 an *insured person* 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 an *insured person*, a *participating pharmacy* will only charge your Co-Payment. 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:

**Prescription Drug Program  
P.O. Box 4165  
Woodland Hills, CA 91365-4165**

*Participating pharmacies* usually have *prescription drug* 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 *prescription drug* claim form, 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 *prescription drug* claim form to us, at the address below:

**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 *prescription drug* claim form with you to a *non-participating pharmacy*. The pharmacist must complete the *pharmacy's* portion of the form and sign it.

*Prescription drug* claim forms and customer service are available by calling 1-800-700-2541. Mail your *prescription drug* claim form 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 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 (e.g., Viagra, Enbrel, Celebrex, Vioxx, Growth Hormone and Lotronex). If there are patterns of over-utilization or misuse of *drugs*, our medical consultant will notify your personal *physician* and your pharmacist. We reserve the right to limit benefits to prevent over-utilization of *drugs*.

## **PRESCRIPTION DRUG FORMULARY**

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

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

If we deny a request for prior authorization of a *drug* that is not part of our *formulary drug* list, you or your prescribing *physician* may appeal our decision by calling us at 1-800-700-2541. If you are not satisfied with the resolution based on your inquiry, you may file a grievance with us by following the procedures described in the section entitled INDEPENDENT MEDICAL REVIEW OF GRIEVANCES INVOLVING A DISPUTED HEALTH CARE SERVICE.

## **PRESCRIPTION DRUG CONDITIONS OF SERVICE**

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

1. It must be prescribed by a licensed prescriber and be dispensed within one year of being prescribed, subject to federal and state laws.
2. It must be approved for general use by the Food and Drug Administration (FDA).
3. It must be for the direct care and treatment of your illness, injury or condition. Dietary supplements, health aids or drugs 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 *insured person* has to pay double the amount of copayment for retail *pharmacies*. If the *drugs* are obtained through the mail service program, the copayment 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 copayment for *brand name drugs*.
2. Insulin.
3. Syringes when dispensed for use with insulin and other self-injectable *drugs* or medications.

4. *Prescription* oral contraceptives; contraceptive diaphragms. Contraceptive diaphragms are limited to one per year and are subject to the copayment for *brand name drugs*.
5. Injectable *drugs* which are self-administered by the subcutaneous route (under the skin) by the patient or family member. *Drugs* with Food and Drug Administration (FDA) labeling for self-administration.
6. All compound *prescription drugs* which contain at least one covered *prescription* ingredient.
7. Diabetic supplies (i.e. test strips and lancets).
8. *Prescription drugs* for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.

### **PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED**

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

1. Immunizing agents, biological sera, blood, blood products or blood plasma.
2. Hypodermic syringes and/or needles except when dispensed for use with insulin and other self-injectable *drugs* or medications.
3. *Drugs* and medications used to induce spontaneous and non-spontaneous abortions.
4. *Drugs* and medications dispensed or administered in an outpatient setting; including, but not limited to, outpatient *hospital* facilities and *physicians'* offices.
5. Professional charges in connection with administering, injecting or dispensing of *drugs*.
6. *Drugs* and medications which may be obtained without a *physician's* written prescription, except insulin or niacin for cholesterol lowering.
7. *Drugs* and medications dispensed by or while you are confined in a *hospital, skilled nursing facility, rest home, sanitorium, convalescent hospital, or similar facility*.
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.

9. Services or supplies for which you are not charged.
10. Oxygen.
11. Cosmetics and health or beauty aids.
12. *Drugs* labeled "Caution, Limited by Federal Law to Investigational Use" or experimental drugs. *Drugs* or medications prescribed for experimental indications.
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 Food and Drug Administration.
15. Smoking cessation *drugs*.
16. *Drugs* used primarily for cosmetic purposes (e.g., Retin-A for wrinkles).
17. *Drugs* used primarily for the purpose of treating *infertility* (including but not limited to Clomid, Pergonal, and Metrodin).
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.
20. Allergy desensitization products or allergy serum.
21. Infusion *drugs*, except *drugs* that are self-administered subcutaneously.
22. Herbal, nutritional and dietary supplements except formulas prescribed by a *physician* for the treatment of phenylketonuria.
23. *Prescription drugs* with a non-prescription (over-the-counter) chemical and dose equivalent except insulin.

## COORDINATION OF BENEFITS

If you are covered by more than one group medical plan, your benefits under This Plan will be coordinated with the benefits of those Other Plans, as shown below. These coordination provisions apply separately to each *insured person*, 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 trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.
4. Medicare. This does not include Medicare when, by law, its benefits are secondary to those of any private insurance program or other non-governmental program.

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

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

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

## **EFFECT ON BENEFITS**

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

## **ORDER OF BENEFITS DETERMINATION**

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

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

**For example:** You are covered as a retired employee under this plan and 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 employee would pay last.

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

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

- a. If the parent with custody of that *child* for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that *child* as a dependent pays first.
  - b. If the parent with custody of that *child* for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:
    - i. The plan which covers that *child* as a dependent of the parent with custody.
    - ii. The plan which covers that *child* as a dependent of the stepparent (married to the parent with custody).
    - iii. The plan which covers that *child* as a dependent of the parent without custody.
    - iv. The plan which covers that *child* as a dependent of the stepparent (married to the parent without custody).
  - c. Regardless of a and b above, if there is a court decree which establishes a parent's financial responsibility for that *child's* health care coverage, a plan which covers that *child* as a dependent of that parent pays first.
4. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But if either plan does not have a provision regarding laid-off or retired employees, provision 6 applies.
  5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering the 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 INSURED PERSONS**

**For Members Continuing Coverage under COBRA or CalCOBRA.** If you are an *insured employee* or a *family member* of an *insured employee* continuing coverage under COBRA or CalCOBRA and entitled to Medicare, you will receive the full benefits of this *plan*, except as listed below:

1. You are receiving treatment for end-stage renal disease following the first 30 months you are entitled to end-stage renal disease benefits under Medicare; or
2. You are entitled to Medicare benefits as a disabled person, unless you have a current employment status as determined by Medicare rules through a *group* of 100 or more employees (according to federal OBRA legislation).

In cases where exceptions 1 or 2 apply, our payment will be determined according to the provisions in the section entitled COORDINATION OF BENEFITS and the provision "Coordinating Benefits With Medicare", below.

**For Retired Employees and Their Spouses.** If you are a *retired employee* or the *spouse* of a *retired employee* and you are eligible for Medicare Part A and/or Part B, your benefits under this *plan* will be determined according to the section entitled COORDINATION OF BENEFITS and the provision "Coordinating Benefits With Medicare", below.

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

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

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

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

## **MEDICAL MANAGEMENT PROGRAMS**

**No benefits are payable 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*.**

**It is always your responsibility to see that your *physician* starts the utilization review process before scheduling you for any service subject to the utilization review or authorization 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" provisions of the appropriate section below.**

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

## UTILIZATION REVIEW PROGRAM

The utilization review program evaluates the medical necessity and appropriateness of care and the setting in which care is provided.

### UTILIZATION REVIEW REQUIREMENTS

Utilization reviews are conducted for the following services:

- All inpatient *hospital stays* and *residential treatment center* admissions;
- Outpatient surgery at an *ambulatory surgical center*; and
- *Facility-based care* for the treatment of *mental or nervous disorders*, *severe mental disorders*, and substance abuse.

**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.

There are three stages of utilization review:

1. **Pre-service review** determines the medical necessity and appropriateness of scheduled, non-emergency inpatient *hospital* and *residential treatment center* admissions, *ambulatory surgical center* services, and *facility-based care* for the treatment of *mental or nervous disorders*, *severe mental disorders*, and substance abuse.
2. **Concurrent review** determines whether services are *medically necessary* and appropriate when pre-service review is not required or 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-authorization, 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, an outpatient surgical procedure at an *ambulatory surgical center*, or for *facility-based care* for the treatment of *mental or nervous disorders*, *severe mental disorders*, and substance abuse, in the absence of extraordinary circumstances\*, no benefits will be provided.
2. The services must be *medically necessary* and appropriate. Inpatient *hospital* benefits will be provided only when an inpatient *stay* is *medically necessary* and appropriate. *Facility-based care* for the treatment of *mental or nervous disorders*, *severe mental disorders*, and substance abuse will be provided only when the type and level of care requested is *medically necessary* and appropriate for your condition. 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

**Pre-service Reviews.** Penalties will result for failure to obtain 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 business days prior to when you are scheduled to receive services. The toll-free telephone number for pre-service review is printed on your identification card.
2. If you do not receive the certified service within 60 days of the certification, or if the nature of the service changes, a new pre-service review must be obtained.

3. We will certify services that are *medically necessary* and appropriate. For inpatient *hospital* and *residential treatment center* stays, we will, if appropriate, certify a specific length of *stay* for approved services. For *facility-based care* for the treatment of *mental or nervous disorders, severe mental disorders,* and substance abuse, we will, if appropriate, certify 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 or the provider of the service must contact us for concurrent review. For an *emergency* admission or procedure, we must be notified within one business day of the admission or procedure. The toll-free number is printed on your identification card.
2. When we determine that the service is *medically necessary* and appropriate, we will, depending upon the type of treatment or procedure, certify the service for a period of time that is medically appropriate. We will also determine the medically appropriate setting.
3. 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.

### **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.

## AUTHORIZATION PROGRAM

The authorization program provides prior authorization for certain "special services".

### SERVICES REQUIRING AUTHORIZATION

1. Organ and tissue transplants.
2. Visits for physical therapy, physical medicine, chiropractic services and occupational therapy beyond those described under the "Physical Therapy, Physical Medicine, Chiropractic Services and Occupational Therapy" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.
3. Home infusion therapy.
4. Home health care.
5. Admissions to a *skilled nursing facility*.

### EFFECT ON BENEFITS

Benefits for special services subject to prior authorization will be provided as stated in this *plan* for the specific service only when authorization has been obtained as required. No benefits are payable for unauthorized special services.

### WHEN AUTHORIZATION WILL BE PROVIDED

#### Special Services

1. **Organ and Tissue Transplants.** Authorizations for organ and tissue transplants will be provided only if both of the following criteria are met:
  - a. The services are *medically necessary*; and
  - b. The *physicians* on the surgical team and the facility in which the transplant is to take place are approved for the transplant requested.
2. **Physical Therapy, Physical Medicine, Chiropractic Services and Occupational Therapy.** The number of visits for physical therapy, physical medicine, chiropractic services and occupational therapy which are payable without prior authorization is stated in the "Physical Therapy, Physical Medicine, Chiropractic Services or Occupational Therapy" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED. A specific number of additional visits will be authorized when:

- a. Additional visits are *medically necessary* and appropriate and likely to result in a significant improvement in your condition.
  - b. You or your *physician* requests approval for the additional benefits prior to those services being rendered.
3. **Home Infusion Therapy.** Authorizations for services by a *home infusion therapy provider* will be provided only if the following criteria are met:
- a. The services are *medically necessary* and appropriate; and
  - b. The attending *physician* has submitted both a prescription and a plan of treatment prior to services being rendered.
4. **Home Health Care.** Authorizations for home health care services will be provided only if the following criteria are met:
- a. The services are *medically necessary* and appropriate and can be safely provided in the *insured person's* home, as certified by the attending *physician*.
  - b. The attending *physician* manages and directs the *insured person's* medical care at home.
  - c. The attending *physician* must establish a definitive treatment plan which must be consistent with the *insured person's* medical needs and must list the services to be provided by the *home health agency*.
5. **Skilled Nursing Facility.** We will authorize inpatient services provided in a *skilled nursing facility* if:
- a. You require daily skilled nursing or rehabilitation, as certified by the attending *physician*;
  - b. You were an inpatient in a *hospital* for at least three consecutive days, and are to be admitted to the *skilled nursing facility* within 30 days of your discharge from the *hospital*; and
  - c. You will be treated for the same condition for which you were treated in the *hospital*.

Note: Admissions to a *residential treatment center* will not be subject to the authorization program. They are instead subject to the utilization review program (see UTILIZATION REVIEW PROGRAM).

## HOW TO OBTAIN AN AUTHORIZATION

You or your *physician* must call the toll-free telephone number printed on your identification card before the services are rendered.

### 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 2 business days from receipt of the information necessary to make the decision.
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 necessary to make the decision.
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.
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-authorization, 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 changes. 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 certified as *medically necessary* will be sent to you and your provider no later than 2 business days from the decision.
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 telephonically 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 telephonically 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 one business day of the decision. This written notice will include:
  - an explanation of the reason for the decision,
  - reference of the criteria used in the decision to modify or not certify the request,
  - the name and phone number of the Peer Clinical Reviewer making the decision to modify or not certify the request,
  - how to request reconsideration if you or your provider disagree with the decision.
9. Reviewers may be plan employees or an independent third party we chose 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. We have the right, through a case manager, 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

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 belongs 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 *insured person*, which alternatives may be offered and the terms of the offer.
3. Any 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 *insured person*.
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 *insured person*.

**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. 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 is binding arbitration. (See BINDING ARBITRATION.)

## QUALITY ASSURANCE

Medical management 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

Resource Management 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. **Insured Employees.** You are in an eligible status if your usual residence is not in the State of California, and you are either:
  - a. Entitled to continuation of coverage through COBRA (See CONTINUATION OF COVERAGE) or CalCOBRA (See CALCOBRA CONTINUATION OF COVERAGE); or
  - b. A *retired employee* who: (i) is retired from active full-time employment with the Los Angeles Community College District (herein referred to as the “District”.); (ii) was continuously employed by the District immediately prior to retirement for the period of time indicated in the appropriate collective bargaining contract or in accordance with existing policies at the date of hire; (iii) retired from the District service in accordance with the Rules and Regulations then in effect with the retirement system of which you are a member; and (iv) is actively enrolled under Part A and Part B of Medicare, if you are eligible.
2. **Family Members.** The following are eligible to enroll as *family members*: (a) Either the *employee’s spouse* or *domestic partner*; and (b) An unmarried *child*.

Note: The *family member* of a *retired employee* must be actively enrolled under both Part A and Part B of Medicare if such *family member* is eligible.

#### Definition of Family Member

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

2. **Domestic partner** is the *employee's* domestic partner, subject to the following:
  - a. The *employee* and *domestic partner* (i) have provided the *group* a signed, notarized affidavit that neither partner has had a different domestic partner less than twelve months before they signed the affidavit; and (ii) if living in a city or county providing for such registration, have registered as domestic partners with such city or county or the state of residence and have provided the *group* with a copy of the Certificate of Domestic Partnership.
  - b. The *employee* and domestic partner are not related to each other, have assumed mutual obligations for the welfare and support of each other, and have been living together as a couple in the same household for at least twelve months; and they so certify in writing.
  - c. Domestic partner does not include any person who is: (i) covered as an *employee* or *spouse*; or (ii) in active service in the armed forces.
3. **Child** is the *employee's, spouse's* or *domestic partner's* unmarried natural child, stepchild, foster child, legally adopted child, or a child for whom the *employee, spouse* or *domestic partner* has been appointed legal guardian by a court of law, subject to the following:
  - a. The unmarried child is under 19 years of age and depends on the *employee, spouse* or *domestic partner* for financial support or the *employee, spouse* or *domestic partner* is legally required to provide group health coverage for the child pursuant to an administrative or court order. A child is considered financially dependent if he or she qualifies as a dependent for federal income tax purposes.
  - b. An unmarried child age 19 or over is eligible until his or her 26th birthday, provided he or she qualifies as a dependent of the *employee, spouse* or *domestic partner* for federal income tax purposes and is enrolled as a full-time student at a college or university. We must receive this information in writing. An overage child who enters or returns to an eligible status will become eligible for coverage on the first day of the month following the date an enrollment application is filed on their behalf.
  - c. A child who is in the process of being adopted is considered a legally adopted child if we receive legal evidence of both: (i) the intent to adopt; and (ii) that the *employee, spouse* or *domestic partner* have either: (a) the right to control the health care of the child; or (b) assumed a legal obligation for full or partial financial

responsibility for the child in anticipation of the child's adoption. Legal evidence to control the health care of the child means a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or relinquishment form, signed by the child's birth parent, or other appropriate authority, or in the absence of a written document, other evidence of the *employee's*, the *spouse's* or the *domestic partner's* right to control the health care of the child.

- d. A child for whom the *employee*, *spouse* or *domestic partner* is a legal guardian is considered eligible on the date of the court decree (the "eligibility date"). We must receive legal evidence of the decree.
- e. With respect to a foster child, we will require a copy of the Agency-Foster Parents Agreement under which the foster parent *employee* is primarily financially responsible for medical care of the foster child. In addition, we will require that the foster child be recertified with us on an annual basis.
- f. With respect to a dependent child of a *domestic partner*, we must receive proof that such child is not otherwise eligible for health benefits. "Health benefits" means health insurance coverage under an employer-sponsored plan or other health insurance coverage partially or fully paid by a party other than the *employee* or *domestic partner*.
- g. An unmarried child of an *insured employee* who is a *retired employee* is eligible regardless of age if he or she is: (i) financially dependent on the *employee*, *spouse* or *domestic partner* as determined by the District policies in force at the time of the *subscriber's* retirement; and (ii) physically or mentally incapacitated. We must receive, at no expense to us, a *physician's* written certification of this disability. When a period of two years has passed, we may request proof of continuing financial dependency and disability, but not more often than once each year.

Note: If such child has a lapse in coverage beginning prior to October 1, 2002, he or she may be eligible to reenroll for coverage during the *group's* next Open Enrollment Period if the *subscriber's* date of retirement was prior to October 1, 2002.

- h. The term "*child*" does not include any person who is: (i) covered as an *employee*; or (ii) in active service in the armed forces.
- i. If both parents are covered as *employees*, their children may be covered as the *family members* of either, but not of both.

## ELIGIBILITY DATE

1. **For Insured Employees:** You become eligible for coverage as follows:
  - a. If you are eligible through COBRA or CalCOBRA continuation: On the date of the Qualifying Event. (See CONTINUATION OF COVERAGE or CALCOBRA CONTINUATION OF COVERAGE.)
  - b. *Retired employees:* On your date of retirement.
2. **For Family Members:** You become eligible for coverage on the later of: (a) the date the *employee* becomes eligible for coverage; or (b) the date you meet the *family member* definition.

**The Enrollment, Effective Date and Open Enrollment Period provisions which follow are applicable to Retired Employees and Family Members only. For the terms applicable to continuation of coverage under COBRA, see the section entitled CONTINUATION OF COVERAGE. For the terms applicable to continuation of coverage under CalCOBRA, see the section entitled CALCOBRA CONTINUATION OF COVERAGE.**

## ENROLLMENT

To enroll as a *retired employee*, or to enroll *family members*, the *employee* 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. We must receive this application from the *group* within 90 days. If any of these steps are not followed, your coverage may be denied.

## EFFECTIVE DATE

Your effective date of coverage is subject to the timely payment of premium 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 *employees*, on your eligibility date; and (b) for *family members*, on the later of (i) the date the *employee's* coverage begins, or (ii) the first day of the month after the *family member* becomes eligible. If you become eligible before the *policy* takes effect, coverage begins on the effective date of the *policy*, 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.
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 *insured employee* (or *spouse* or *domestic partner*, if the *spouse* or *domestic partner* is enrolled) is already covered: (1) any *child* born to the *employee, spouse* or *domestic partner* will be covered from the moment of birth; and (2) any *child* being adopted by the *employee, spouse* or *domestic partner* will be covered from the date on which either: (a) the adoptive *child's* birth parent, or other appropriate legal authority, signs a written document granting the *employee, spouse* or *domestic partner* the right to control the health care of the *child* (in the absence of a written document, other evidence of the *employee's, spouse's* or *domestic partner's* right to control the health care of the *child* may be used); or (b) the *employee, spouse* or *domestic partner* assumed a legal obligation for full or partial financial responsibility for the *child* in anticipation of the *child's* adoption. The "written document" referred to above includes, but is not limited to, a health facility minor release report, a medical authorization form, or relinquishment form.

In both cases, coverage will be in effect for 31 days. For coverage to continue beyond this 31-day period, the *employee* must enroll the *child* within the 31-day period by submitting a membership change form to the *group*. We must then receive the form from the *group* within 90 days.

### **Special Enrollment Periods**

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

1. You have met all of the following requirements:
  - a. You were covered under another health plan as an individual or dependent, including coverage under a COBRA continuation.

- 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. You have lost coverage under the other health plan wherein you were covered as an individual or dependent, or your coverage under a COBRA continuation was exhausted.
  - d. You properly file an application with the *group* within 31 days from the date on which you lose coverage.
- 2. A court has ordered coverage be provided for a *spouse* or dependent *child* under your employee health plan and an application is filed within 31 days from the date the court order is issued.
  - 3. We do not have a written statement from the *group* stating that prior to declining coverage or disenrolling, you received and signed acknowledgment of a written notice specifying that if you do not enroll for coverage within 31 days after your eligibility date, or if you disenroll, and later file an enrollment application, your coverage may not begin until the first day of October following the end of the *group's* next open enrollment period.
  - 4. You have a change in family status through either marriage or the birth or adoption of a *child*. You may also enroll a new *spouse* or *child* at that time. You must enroll within 31 days of the marriage, birth, or adoption. Coverage will become effective as follows:
    - a. If you are enrolling following marriage, the first day of the month following the date you filed the enrollment application.
    - b. If you are enrolling following the birth or adoption of a *child*, as of the date of birth or adoption.

Your *spouse* (if you are already married), who is eligible but not enrolled, may also enroll at the time of the birth or adoption of a *child*. Application must be made within 31 days of the birth or date of adoption; coverage will be effective as of the date of the birth or adoption.

## **OPEN ENROLLMENT PERIOD**

The *group* has an open enrollment period once each *year*, during a period agreed upon by the *group* and us. During that time, an individual who meets the eligibility requirements as an *employee* under this *plan* may enroll. An *employee* may also enroll any eligible *family members* at

that time. Persons eligible to enroll as *family members* may enroll only under the *employee's plan*.

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

## HOW COVERAGE ENDS

Your coverage ends, without notice from us, as provided below:

1. If the *policy* terminates, your coverage ends at the same time. The *policy* may be cancelled or changed without notice to you.
2. If the *group* no longer provides coverage for the class of *insured persons* to which you belong, your coverage ends on the effective date of that change. If this *policy* 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 *employee's* coverage ends.
4. Coverage ends at the end of the period for which premium has been paid to us on your behalf when the required premium for the next period is not paid.
5. If you voluntarily cancel coverage at any time, coverage ends as follows:
  - a. For an *insured employee*, coverage ends on the date of voluntary cancellation, as provided by written notice to us;
  - b. For a *family member* whose coverage is cancelled while the *insured employee's* coverage remains in effect, coverage ends on the premium due date coinciding with or following the date of voluntary cancellation, as provided by written notice to us.
6. If you no longer meet the requirements set forth in the "Eligible Status" provision of HOW COVERAGE BEGINS, coverage ends as follows:
  - a. For an *insured employee*, coverage ends as of the date the *insured employee* ceases to meet such requirements;
  - b. For a *family member* whose coverage is cancelled while the *insured employee's* coverage remains in effect, coverage ends on the premium due date coinciding with or following the date the *family member* ceases 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 is:

- i. covered under this *plan* (if the *child* has a lapse in coverage, he or she may not be reenrolled nor have his or her coverage reinstated.\*); and
- ii. still financially dependent on the *employee*, *spouse* or *domestic partner* (A *child* of an active *employee* is considered financially dependent if he or she qualifies as a dependent for federal income tax purposes. The financial dependency requirement for a *child* of a *retired employee* is determined by the District policies in force at the time of the *subscriber's* retirement.); and
- iii. incapable of self-sustaining employment due to a physical handicap or mental retardation. A *physician* must certify this disability in writing. We must receive the certification, at no expense to us, within 31 days of the date the *child* otherwise becomes ineligible.

When a period of two years has passed, we may request proof of continuing financial dependency and disability, but not more often than once each *year*. This exception will last until the *child* is no longer handicapped or dependent on the *employee*, *spouse* or *domestic partner* for financial support.

\*This does not apply to a disabled *child* of a *retired employee* whose date of retirement was before October 1, 2002, if the *child's* lapse in coverage began prior to October 1, 2002. See "Definition of Family Member" under HOW COVERAGE BEGINS.

**Note:** If a domestic partnership terminates, the *employee* must notify the *group*, by providing a signed, notarized copy of the Affidavit of Termination of Domestic Partnership within 30 days of the termination. A new *domestic partner* may not be enrolled under this *plan*, until at least twelve months after the Affidavit of Termination has been filed.

You may be entitled to continued benefits under terms which are specified elsewhere under CONTINUATION OF COVERAGE, CONTINUATION FOR DOMESTIC PARTNERS AND CHILDREN OF DOMESTIC PARTNERS, COVERAGE FOR SURVIVING FAMILY MEMBERS, EXTENSION OF BENEFITS and HIPAA COVERAGE AND CONVERSION.

## 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). You may be entitled to a period of continuation of coverage even after you no longer work for the Los Angeles Community College District. Check with the Benefit Service Center for details.

### DEFINITIONS

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

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

**Qualified Beneficiary** means: (a) a person enrolled for this COBRA continuation coverage who, on the day before the Qualifying Event, was covered under this *policy* as either an *insured employee* or *insured family member*; and (b) a *child* who is born to or placed for adoption with the *insured employee* 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; and (b) a *domestic partner* and the *child* of a *domestic partner* if they are eligible under HOW COVERAGE BEGINS AND ENDS. (See the section entitled CONTINUATION FOR DOMESTIC PARTNERS AND CHILDREN OF DOMESTIC PARTNERS.)

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

#### 1. For Insured Employees and Insured Family Members:

- a. The *employee's* termination of employment, for any reason other than gross misconduct; or
- b. A reduction in the *employee's* work hours, including due to labor dispute.

#### 2. For Retired Employees and their Insured Family Members.

Cancellation or a substantial reduction of retiree benefits under the *plan* due to the *group's* filing for Chapter 11 bankruptcy, provided:

- a. The *policy* expressly includes coverage for retirees; and

- b. Such cancellation or reduction of benefits occurs within one year before or after the *group's* filing for bankruptcy.

3. **For Insured Family Members:**

- a. The death of the *insured employee*;
- b. The *spouse's* divorce or legal separation from the *employee*;
- c. The end of a *child's* status as a dependent *child*, as defined by the *policy*; or
- d. The *employee's* entitlement to Medicare.

## **ELIGIBILITY FOR COBRA CONTINUATION**

An *insured employee* or *insured family member* may choose to continue coverage under the *policy* if his or her coverage would otherwise end due to a Qualifying Event.

## **TERMS OF COBRA CONTINUATION**

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

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

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

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 premium, must be delivered to us by the *group* within 45 days after you elect COBRA continuation coverage.

**Additional Insured 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 *policy* apply to enrollees during the COBRA continuation period.

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

Besides applying to the *insured employee*, the *employee's* premium rate will also apply to:

1. A *spouse* whose COBRA continuation began due to divorce, separation or death of the *employee*;
2. A *child*, if neither the *employee* nor the *spouse* has enrolled for this COBRA continuation coverage (if more than one *child* is so enrolled, the premium 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, an *insured person*, 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 *insured employee's* employment, and was 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 premium 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 *policy*.

**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 *insured employee*, divorce or legal separation, or the end of dependent *child* status;\*
3. The end of 36 months from the date the *insured employee* became entitled to Medicare, if the Qualifying Event was the *employee's* entitlement to Medicare. If entitlement to Medicare does not result in coverage terminating and Qualifying Event 1 occurs within 18 months after Medicare entitlement, coverage for Qualified Beneficiaries other than the *insured employee* will end 36 months from the date the *insured employee* became entitled to Medicare;
4. The date the *policy* terminates;
5. The end of the period for which premiums are last paid;
6. The date, following the election of COBRA, the *insured person* 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 *insured person*, 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 *insured person* first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

\*For an *insured person* 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 *policy* remaining in effect, a retired *employee* whose COBRA continuation coverage began due to Qualifying Event 2 may be covered for the remainder of his or her life; that person's covered *family members* may continue coverage for 36 months after the *employee's*

death. However, coverage could terminate prior to such time for either *employee* or *family member* in accordance with items 4, 5 or 6 above.

If your COBRA continuation under this *plan* ends in accordance with items 1, 2 or 3, you may be eligible for medical conversion coverage. If your COBRA continuation under this *plan* ends in accordance with items 1, 2, 3, or 4 you may be eligible for HIPAA coverage. The *group* will provide notice of these options within 180 days prior to your COBRA termination date. Please see HIPAA COVERAGE AND CONVERSION in this booklet for more information.

If continuation coverage ends due to items 2 or 7 above, the surviving spouse and *family members* are eligible for the coverage 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 *insured persons* 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 *insured person* 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 *insured person* 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 date of the Social Security Administration's determination of such disability.

**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 "premium") shall be subject to the following conditions:

1. If the disabled *insured person* continues coverage during this extension, this rate shall be **150%** of the applicable rate for the length of time the disabled *insured person* remains covered, depending upon the number of covered dependents. If the disabled

*insured person* 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 premium 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 premium rate shall then be **150%** of the applicable rate for the 19th through 36th months if the disabled *insured person* remains covered. The charge will be **102%** of the applicable rate for any periods of time the disabled *insured person* 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 *policy* terminates;
4. The end of the period for which premiums are last paid;
5. The date, following the election of COBRA, the *insured person* first becomes covered under the other group health plan, unless the other group health plan contains an exclusion or limitation to a pre-existing condition of the *insured person*, 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 *insured person* first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

You must inform the *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.

**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 *policy* 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 “premium”). 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 premium 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 certified mail or other reliable means of delivery, in an amount sufficient to pay any required premium and premium due. Failure to submit the correct amount within this 45-day period will disqualify you from receiving continuation coverage under CalCOBRA. Succeeding premium is due on the first day of each following month.

**Grace Period.** For every premium due date, except the first, there is a 31-day grace period in which to pay premium. If premium is not received by the end of the grace period, your coverage will be canceled at the end of the period for which premium is last paid.

**Change of Premium.** The amounts of the premium may be changed by us as of any premium due date. We will provide you with written notice at least 30 days prior to the date any premium 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 premium 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 premium, 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 *policy*.

**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 *policy* terminates;
3. The end of the period for which premium is last paid;
4. 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;
5. The date you become entitled to Medicare; or
6. The date you become covered under a federal COBRA continuation.

CalCOBRA continuation will also end if you move out of 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 item 1, you may be eligible for medical conversion coverage. If your CalCOBRA continuation under this *plan* ends in accordance with items 1 or 2, you may be eligible for HIPAA 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 INSURED PERSONS**

Subject to payment of premium as stated in the *policy*, coverage under this *plan* may be continued for the *insured employee*, the *insured employee's spouse*, and the *insured employee's former spouse* (if any) under Section 10116.5 of the Insurance 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 shown above (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 *insured employee*; or (b) an individual who was married to the *insured employee* at the time of the *insured employee’s* death.

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

1. The *employee*, or the *employee* 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 section;
2. The *employee* or *spouse* has not elected to continue coverage under any other available continuation;
3. The *employee* worked for Los Angeles Community College District for at least the prior five years; and
4. The *employee* is at least 60 years old on the date employment with Los Angeles Community College District 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, as described in the preceding section.

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

For the *employee* and *spouse*, this continuation may be chosen for both, for the *employee* 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 premium 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 premium 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 premiums payable, the *spouse* or former *spouse* continuing coverage alone will be considered to be an *employee*.

**Payment Dates.** The first payment is due along with your enrollment form within 45 days after you elect this continuation. We will bill you for any retroactive charges which may be due. Succeeding premium are due on the first day of each following month (the Premium Due Date).

**Grace Period.** For every Premium Due Date, except the first, there is a 31-day grace period in which to pay premium. If premium are not received by the end of the grace period, your coverage will be canceled at the end of the period for which premium are last paid.

**Change of Premium.** The amounts of the premiums may be changed by us as of any Premium Due Date. We will provide you with written notice at least 30 days prior to the date any premium 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 premiums are last paid;
2. The date the *policy* terminates;
3. The date, following the election of Senior COBRA, the *insured employee, spouse, or former spouse* first becomes covered under any group health plan not maintained by the *group*;
4. The date, following the election of Senior COBRA, the *employee, spouse, or former spouse* first becomes entitled to Medicare;
5. The date the *employee, 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.

## CONTINUATION COVERAGE FOR DOMESTIC PARTNERS AND CHILDREN OF DOMESTIC PARTNERS

A *domestic partner* and the *domestic partner's children*, if any, may continue benefits under the *plan* if the *insured employee* terminates employment and elects to continue benefits as specified under CONTINUATION OF COVERAGE (COBRA) or the *insured employee* dies while covered under this *plan*.

Continuation is subject to payment of the monthly premium as stated in the *policy*. A *domestic partner* and *children* of a *domestic partner* may not make an independent election of continuation under this provision except when coverage would otherwise terminate because of the *subscriber's* death. Therefore, an *employee* must elect COBRA at the two-party or family rate in order to cover a *domestic partner* and the *domestic partner's children*, if any.

This continuation coverage will end on the earliest of the following:

1. The end of 18 months from the *employee's* termination of employment, or the date the *employee's* COBRA coverage terminates, if earlier.
2. The end of 36 months from the death of the *employee*. If the *employee* dies while covered under COBRA, this 36 month continuation for an enrolled *domestic partner* and *domestic partner's children* begins on the date of the *employee's* Qualifying Event for COBRA (i.e., termination of employment).
3. The end of 36 months from the *employee's* first Qualifying Event for COBRA if coverage would otherwise terminate due to the *employee's* entitlement to Medicare.
4. The date the domestic partnership terminates, except in the event of the *employee's* or *domestic partner's* death.
5. The date the *group* cancels coverage for *domestic partners* under the "Eligible Status" provision of HOW COVERAGE BEGINS AND ENDS – HOW COVERAGE BEGINS.
6. The date the *insured person* first becomes entitled to Medicare, unless eligibility for Medicare is solely as a result of end-stage renal disease.
7. The date the *insured person* 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 *insured person*, in which case this continuation

will end at the end of the period for which the pre-existing condition exclusion or limitation applied.

8. The date the maximum benefits of this *plan* are paid.
9. The end of the period for which premium is last paid to us on the *insured person's* behalf.
10. The date the *policy* between the *group* and us terminates.

A *domestic partner* or the *domestic partner's children* may not change to a different plan at the annual Open Enrollment Period. That is, if an *employee* selects one plan, then the *domestic partner* must choose coverage under the same plan.

It is your responsibility to notify the *group* or designated representative upon the occurrence of any event which would result in a termination of coverage.

The *group* will inform you of any change in its policy regarding your right to continue coverage.

## **COVERAGE FOR SURVIVING FAMILY MEMBERS**

If the *insured employee* dies while covered under this *plan* as a *retired employee*, coverage may be continued for his or her enrolled *family members* until one of the following occurs:

1. The surviving *spouse* remarries;\*
2. Premium is not paid to us on the *insured person's* behalf;
3. The *group* cancels coverage for the class of *insured employees* to which the *insured person* belongs;
4. The *policy* between the *group* and us terminates; or
5. The *child* no longer meets all of the conditions of coverage in HOW COVERAGE BEGINS AND ENDS; or
6. The surviving *spouse* enters a domestic partnership; or
7. The surviving *spouse* becomes eligible for group coverage under his or her own employment; or
8. The surviving *domestic partner* marries, enters a domestic partnership, or becomes eligible for group coverage under his or her own employment.

**\*Exception.** Coverage continues for the surviving *spouse* of a retired certificated employee as stipulated under California Assembly Bill 528. Coverage does not continue for *children*.

**Note:** The cost of continuing coverage under this provision may be more than the cost of coverage the *group* provides to its employees or their *family members*. The *insured person* may be responsible for all or part of the premium.

## EXTENSION OF BENEFITS

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

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

## HIPAA COVERAGE AND CONVERSION

If your coverage for medical benefits under this *plan* ends, you may be eligible to enroll for coverage with any carrier or health plan that offers individual medical coverage. HIPAA coverage and conversion coverage are available upon request if you meet the requirements stated below. Both HIPAA coverage and conversion are available for medical benefits only. Please note that the benefits and cost of these plans will differ from your employer's *plan*.

### HIPAA Coverage

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides an option for individual coverage when coverage under the employer's group *plan* ends. To be eligible for HIPAA coverage, you must meet all of the following requirements:

1. You must have a minimum of 18 months of continuous health coverage, most recently under an employer-sponsored health plan, and have had coverage within the last 63 days.
2. Your most recent coverage was not terminated due to nonpayment of premiums or fraud.
3. If continuation of coverage under the employer *plan* was available under COBRA, CalCOBRA, or a similar state program including Senior COBRA, such coverage must have been elected and exhausted.
4. You must not be eligible for Medicare, Medicaid, 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 premium payment within 63 days of the date your coverage under the employer's *plan* ends. Under certain circumstances you are not eligible for a conversion plan. They are:

1. You are not eligible if your coverage under this *plan* ends because the *policy* terminates and is replaced by another group plan within 15 days.

2. You are not eligible if your coverage under this *plan* ends because premium is not paid when due because you (or the *insured employee* who enrolled you as a dependent) did not contribute your part, if any.
3. You are not eligible for a conversion plan if you are eligible for health coverage under another group plan when your coverage ends.
4. You are not eligible for a conversion plan if you are eligible for Medicare coverage when your coverage under this *plan* ends, whether or not you have actually enrolled in Medicare.
5. You are not eligible for a conversion plan if you are covered under an individual health plan.
6. You are not eligible for a conversion plan if you were not covered for medical benefits under the *plan* for three consecutive months immediately prior to the termination of your coverage.

If you decide to enroll in a conversion plan, you will no longer qualify for HIPAA coverage.

**Important:** The intention of conversion coverage is not to replace the coverage you have under this *plan*, but to make available to you a specified amount of coverage for medical benefits until you can find a replacement. The conversion plan provides lesser benefits than this *plan* and the provisions and rates differ.

When coverage under your employer's group *plan* ends, you will receive more information about how to apply for HIPAA coverage or conversion, including a postcard for requesting an application and a telephone number to call if you have any questions.

## **GENERAL PROVISIONS**

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

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

**Non-Regulation of Providers.** The benefits provided under this *plan* do not regulate the amounts charged by providers of medical care.

## Terms of Coverage

1. In order for you to be entitled to benefits under the *policy*, both the *policy* and your coverage under the *policy* 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 *policy* is subject to amendment, modification or termination according to the provisions of the *policy* without your consent or concurrence.

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

**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.

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

**Benefits Not Transferable.** Only *insured persons* are entitled to receive benefits under this *plan*. The right to benefits cannot be transferred.

**Notice of Claim.** You, or someone on your behalf, must give us written notice of a claim within 20 days after you incur *covered expense* under this plan, or as soon as reasonably possible thereafter.

**Claim Forms.** After we receive a written notice of claim, we will give you any forms you need to file proof of loss. If we do not give you these forms within 15 days after you have filed your notice of claim, you will not have to use these forms, and you may file proof of loss by sending us written proof of the occurrence giving rise to the claim. Such written proof must include the extent and character of the loss.

**Proof of Loss.** You or the provider of service must send us properly and fully completed claim forms within 90 days of the date you receive the service or supply for which a claim is made. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed. Except in the absence of legal capacity, we are not liable for the benefits of the *plan* if you do not file claims within the required time period. We will not be liable for benefits if we do not receive written proof of loss on time.

Services received and charges for the services must be itemized, and clearly and accurately described. Claim forms must be used; canceled checks or receipts are not acceptable.

**Timely Payment of Claims.** Any benefits due under this *plan* shall be due once we have received proper, written proof of loss, together with such reasonably necessary additional information we may require to determine our obligation.

**Payment to Providers.** We will pay the benefits of this *plan* directly to medical transportation providers. Also, we will pay other providers of service directly when you assign benefits in writing. If another party pays for your medical care and you assign benefits in writing, we will pay the benefits of this *plan* to that party. These payments will fulfill our obligation to you for those covered services.

**Exception:** Under certain circumstances we will pay the benefits of this *plan* directly to a provider or third party even without your assignment of benefits in writing. To receive direct payment, the provider or third party must provide us the following:

1. Proof of payment of medical services and the provider's itemized bill for such services;
2. If the *insured employee* does not reside with the patient, either a copy of the judicial order requiring the *employee* to provide coverage for the patient or a state approved form verifying the existence of such judicial order which would be filed with us on an annual basis;
3. If the *employee* does not reside with the patient, and if the provider is seeking direct reimbursement, an itemized bill with the signature of the custodian or guardian certifying that the services have been provided and supplying on an annual basis, either a copy of the judicial order requiring the *employee* to provide coverage for the patient or a state approved form verifying the existence of such judicial order;

4. The name and address of the person to be reimbursed, the name and policy number of the *employee*, the name of the patient, and other necessary information related to the coverage.

**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.

**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 Los Angeles Community College District Health Insurance Section or to a person or entity, other than us, engaged by the *group* to perform or assist in performing administrative tasks in connection with the *group's* health plan. The Health Insurance Section is responsible for satisfaction of notice, disclosure and other obligations of administrators. In providing notices and otherwise performing under the CONTINUATION OF COVERAGE section of this booklet, the *group* is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as your agent.

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

**Entire Contract.** This certificate, including any amendments and endorsements to it, is a summary of your benefits. It replaces any older certificates issued to you for the coverages described in the Summary of Benefits. All benefits are subject in every way to the entire *policy* which includes this certificate. The terms of the *policy* may be changed only by a written endorsement signed by one of our authorized officers. No agent or employee has any authority to change any of the terms, or waive the provisions of, the *policy*.

**Liability For Statements.** No statements made by you, unless they appear on a written form signed by you or are fraudulent, will be used to deny a claim under the *policy*. Statements made by you will not be deemed warranties. With regard to each statement, no statement will be used by us in defense to a claim unless it appears in a written form signed by you and then only if a copy has been furnished to you. After two years following the filing of such claim, if the coverage under which such claim is filed has been in force during that time, no such statement will be used to deny such a claim, unless the statement is fraudulent.

**Physical Examination.** At our expense, we have the right and opportunity to examine any *insured person* claiming benefits when and as often as reasonably necessary while a claim is pending.

**Legal Actions.** No attempt to recover on the plan through legal or equity action may be made until at least 60 days after the written proof of loss has been furnished as required by this plan. No such action may be started later than three years from the time written proof of loss is required to be furnished.

**Financial Arrangements with Providers.** Under arrangements with some health care providers and suppliers (hereafter referred to together as “Providers”) certain discounts, payments, rebates, settlements, incentives, adjustments and/or allowances, including, but not limited to, pharmacy rebates, may be based on aggregate payments made by BC Life or an affiliate in respect to all health care services rendered to all persons who have coverage through a program provided or administered by BC Life 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 BC Life or an affiliate in determining its fees or subscription charges or premiums.

## **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. To request this review, please call us at the telephone number listed on your identification card or write to us at BC Life & Health Insurance Company, 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.
- The proposed treatment must be recommended by a board certified or board eligible *physician* qualified to treat you who certifies in writing that the proposed treatment is more likely to be beneficial than standard treatment. This certification must include a statement of the evidence relied upon.

- If this review is requested either by you or by a qualified *physician* (as described above), the requestor must supply two items of acceptable medical and scientific evidence. This evidence consists of 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 Medicus, 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.

Within five days of receiving 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*. Information we receive subsequently will be sent to the review panel within five business days. 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 in the case of an expedited review). This timeframe may be extended by up to three days for any delay in receiving necessary records.

## 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 California Department of Insurance (“DOI”) 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 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 DOI will review your application for IMR to confirm that:

1. (a) Your provider has recommended a health care service as *medically necessary*, or
  - (b) You have received urgent care or *emergency services* that a provider determined was *medically necessary*, or
  - (c) You have been seen by a 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 may bring it immediately to the DOI's attention. The DOI may waive the requirement that you follow our grievance process in extraordinary and compelling cases.

If your case is eligible for IMR, the dispute will be submitted to a medical specialist 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 DOI 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 business 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.

## **BINDING ARBITRATION**

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this *plan* or the *policy* 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 or claim within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act will 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 will apply.

The *insured person* and BC Life agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The *insured person* and BC Life agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class arbitration, the *insured person* waives any right to pursue, on a class basis, any such controversy or claim against BC Life and BC Life waives any right to pursue on a class basis any such controversy or claim against the *insured person*.

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

The arbitration is begun by the *insured person* making written demand on BC Life. The arbitration will be conducted by Judicial Arbitration and Mediation Services (“JAMS”) according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration

entity, by mutual agreement of the *insured person* and BC Life, or by order of the court, if the *insured person* and BC Life cannot agree. The arbitration will be held at a time and location mutually agreeable to the *insured person* and BC Life.

## DEFINITIONS

The meanings of key terms used in this certificate 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 your certificate, you should refer to this section.

**Accidental injury** is physical harm or disability which is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental injury does not include illness or infection, except infection of a cut or wound.

**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.

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

**BC Life & Health Insurance Company (BC Life)** is the company which insures the benefits of the *plan*.

**Brand name prescription drug (brand name drug)** is a *prescription drug* that has been patented and is only produced by one manufacturer.

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

**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.

**Custodial care** is care provided primarily to meet your personal needs. This includes help in walking, bathing or dressing. It also includes preparing food or special diets, feeding, 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 us, 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 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 which the *insured person* reasonably perceives could permanently endanger health if medical treatment is not received immediately. We will have sole and final determination as to whether services were rendered in connection with an emergency.

**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*.

**Formulary drug** is a *drug* listed on the *prescription drug formulary*.

**Generic prescription drug (generic drug)** is a pharmaceutical equivalent of one or more *brand name drugs* and must be approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength, and effectiveness as the *brand name drug*.

**Group** refers to the business entity to which we have issued this *policy*. The name of the group is LOS ANGELES COMMUNITY COLLEGE DISTRICT.

**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.

**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.

**Insured employee (employee)** is the primary insured; that is, the person who is allowed to enroll under this *plan* for himself or herself and his or her eligible *family members*.

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

**Insured person** is the *insured employee or insured family member*.

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

**Medically necessary** procedures, supplies equipment or services are those we determine to be:

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Provided for the diagnosis or direct care and treatment of the medical condition;
3. Within standards of good medical practice within the organized medical community;
4. Not primarily for your convenience, or for the convenience of your *physician* or another provider; and
5. The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:
  - a. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and
  - b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
  - c. For *hospital stays*, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received by you as an outpatient or in a less intensified medical setting.

**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 (for example, 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.

**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.

**Other health care provider** is one of the following providers:

1. A certified registered nurse anesthetist;
2. A facility which provides diagnostic radiology services;
3. A blood bank;
4. A durable medical equipment outlet;
5. A clinical laboratory;
6. A *skilled nursing facility*;
7. A *home health agency*;
8. A licensed ambulance company;
9. A *hospice*; or
10. An *ambulatory surgical 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.

**Pharmacy** means a licensed retail pharmacy.

**Physician** means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or
2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, 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.)
  - b. An optometrist (O.D.)
  - c. A dispensing optician
  - d. A podiatrist or chiropract (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 licensed midwife
- i. A clinical social worker (L.C.S.W.)
- j. A marriage and family therapist (M.F.T.)
- k. A physical therapist (P.T. or R.P.T.)\*
- l. A speech pathologist\*
- m. An audiologist\*
- n. An occupational therapist (O.T.R.)\*
- o. A respiratory care practitioner (R.C.P.)\*
- p. A *psychiatric mental health nurse* (R.N.)\*
- 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.

**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 *policy* we have issued to the *group*. If changes are made to the plan, an amendment or revised booklet will be issued to the *group* for distribution to each *employee* affected by the change. (The word "plan" here does not mean the same as "plan" as used in ERISA.)

**Policy** is the Group Policy we have issued to the *group*.

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

**Prescription drug covered expense** is the expense you incur for a covered *prescription drug*, but not more than the 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 formulary (formulary)** is a list which we have developed of outpatient *prescription drugs* which may be cost-effective, therapeutic choices. Any *participating pharmacy* can assist you in purchasing *drugs* listed on the formulary.

**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 *insured persons* no more than the prescription drug negotiated rate. It is also the rate which 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. You are considered covered under the prior plan if you: (1) were covered under the prior plan on the date that plan terminated; (2) properly enrolled for coverage within 31 days of this *plan's* effective date; and (3) had coverage terminate solely due to the prior plan's termination.

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

**Psychiatric 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 California Insurance Code;
3. Accredited by the Joint Commission on Accreditation of Health Care Organizations; and
4. Staffed by an organized medical or professional staff which includes a *physician* as medical director.

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

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

**Residential treatment center** is an inpatient treatment facility where the *insured person* 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 disorder*, 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 Insurance Code section 10144.5: 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 which begins when you are admitted to a facility and ends when you are discharged from that facility.

**Totally disabled employee** is: (i) an active *employee* who, because of illness or injury, is unable to work for income in any job for which he or she is qualified or for which he or she become qualified by training or experience, and who is in fact unemployed; or (ii) a *retired employee* who is unable to perform all activities usual for persons of that age.

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

**We (us, our)** refers to BC Life & Health Insurance Company.

**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 *insured employee* and *insured family members* who are enrolled for benefits under this *plan*.