Anthem.

13550 Triton Park Blvd.
Louisville, KY 40223

[redacted]

06/20/2019

Confidential Health Plan Information for

[redacted]
Date of Birth: [redacted]

Reference Number: [redacted]
Provider: Cedars Sinai Medical Center / Dr. [redacted]

More details found at the end of this letter

Dear Mr[redacted]:

We're enclosing a summary of transplant benefit information that you or your doctor requested. For a full description, please refer to your health plan benefits.

This information doesn't mean the service has been approved. That requires a separate review.

To start the review, we need to get some medical information from your doctor. We encourage you to talk to your doctor about having an evaluation, which is covered by your benefits. We have sent a Clinical Data Submission Tool to your provider. Your provider simply has to complete the demographic information section of the form, answer all the medical necessity questions that apply to the requested service, sign / date the form and then return to us. *(No action is needed by you)*

We'll need to look at your benefits again, if your plan changes or renews. If that happens, just call the number at the bottom of this letter.

It's important that we are able to communicate with you regarding your health plan benefits. We may not be able to call you under federal law if your phone number on file (1) is a mobile number and we do not have your consent to call this number, (2) has changed recently, or (3) is on our internal Do Not Call list. Please call us at the number listed below.

In addition, make sure you or your doctor gives us a call before you schedule your hospital stay. That's because the hospital stay needs to be pre-approved first.

For questions about benefits, eligibility, or coverage limits for this service, call the number listed below. If you have questions about claims or other benefits, please call the member service number listed on your ID card.

Last, just a friendly reminder to show your ID card when you get care. It will simplify the process and help ensure you get all the benefits of your health plan. Thank you again for being an Anthem member.

Sincerely,

Anthem Transplant Department
Phone number: [redacted]
Fax number: [redacted]

Note: We're also sending a copy of this letter to Cedars Sinai Medical Center and Dr. M[redacted]

Providers: You are required to return, destroy or further protect any PHI received on this document pertaining to members that you are not currently treating. Providers are required to immediately destroy any such PHI or safeguard the PHI for as long as it is retained. In no event are you permitted to use or re-disclose such PHI.

TRANSPLANT BENEFIT SUMMARY

This is a summary of the current transplant benefit for the member listed below. If the member's benefits change or renew, a new summary must be requested. This does not constitute coverage determination for the transplant. A medical necessity review has not been performed at this time. In order to perform this review, a formal request must be submitted by your provider.

Providers: You are required to return, destroy or further protect any PHI received on this document pertaining to members that you are not currently treating. Providers are required to immediately destroy any such PHI or safeguard the PHI for as long as it is retained. In no event are you permitted to use or re-disclose such PHI.

Date 06/20/2019 *These benefits are effective through* 12/31/2019 *as long as the policy remains active*

Requester [redacted]	Fax Number [redacted]
Transplant Facility: Cedars Sinai Medical Center	
Transplant Physician/ Director: D [redacted]	
Diagnosis: Cardiomyopathy	ICD: I42.9
Procedure: Heart Transplant	CPT: 33945
Solid Organ: ☐ Deceased Donor ☐ Living Donor ☐ Unknown	

MEMBER DEMOGRAPHICS

Identification Number: J [redacted]	Date of Birth: [redacted]	
First Name [redacted]	Last Name: [redacted]	
Address: [redacted]		
City: [redacted]	State: CA	Zip: [redacted]

TRANSPLANT BENEFITS

Coverage☐ Primary	Center of Excellence for Transplant Required for Highest Benefit? Yes	Transplant Network Status of Facility Tier 2 In Network

SECTION 1: Transplant Facility

Network Coverage	Lifetime Maximum	Deductible	Coinsurance	Annual Out of Pocket
Tier 1 In Network/BDCT/CME	Unlimited	$1350	40%	$7900
Tier 2 In Network	Unlimited	$1350	$500 copay per admit then 40%	$7900
Out of Network	No Coverage			

SECTION 2: Transplant Travel

☒ Transplant Travel Benefits	A. Member has Travel Benefits for Transplant if: ☒ Mileage from residency to transplant facility is over 50 miles B. What is included: Travel/ Lodging C. Maximum: $10,000 D. Other: Travel and Lodging based on limits in the IRS guidelines

SECTION 3: Additional Transplant Coverage

HLA Typing: N/A	Transplant Clinical Trial Coverage: N/A
Donor Search: N/A	Maximum:

TRANSPLANT BENEFIT SUMMARY

This is a summary of the current transplant benefit for the member listed below. If the member's benefits change or renew, a new summary must be requested. This does not constitute coverage determination for the transplant. A medical necessity review has not been performed at this time. In order to perform this review, a formal request must be submitted by your provider.

SECTION 4: Other
Radiology, Labs, Pharmacy: Refer to member's insurance card for customer service to verify precertification needs and medical benefits.
Dental Coverage: Refer to member's dental customer service for benefits, if applicable
Other: Please keep in mind payment is dependent upon eligibility at the time of the service and the member having the benefit for the requested service.
If we can be of additional service, please call the Enterprise Transplant Department at 888-574-7215

Anthem.

6/20/2019

Dear Member:

Attached to this letter is an Individual Authorization Form that needs to be signed and returned to us.

Frequently, family members wish to ask questions or discuss a member's care with our staff. By law, we are not permitted to speak with anyone regarding your health status unless you first give us permission. By completing and signing this form, you are authorizing us to speak to another designated person on issues surrounding managing your health care needs.

Please sign the attached document at your earliest convenience and return it to us. If you have any questions, please call us at the number listed below.

Sincerely,

Enterprise Transplant Department
Toll free phone number: [redacted]5

Enclosure

Anthem.

INDIVIDUAL AUTHORIZATION

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

Instructions: The individual member who is requesting the release of his or her information to another person or Organization/Entity must complete this form in its entirety and include as much information as possible. If necessary, call the number listed on the back of your member ID card for assistance.

Member last name	Member first name	Middle Initial	Member date of birth	
Member street address	City		State	Zip code
Daytime telephone number (with area code)	Identification number (see identification card)		Group number (see identification card)	

Part A: I authorize the following person or Organization/Entity to disclose my information:

Your health plan and its affiliates and agents

Part B: I authorize the following person or Organization/Entity to receive my information (the person receiving the information must be 18 years of age or older):

Relationship to the individual_____

Part C: I authorize the following information to be used or disclosed on my behalf (check one block):

☐ **All my information** including health (e.g. diagnosis, claims, provider) and financial information (e.g. premium information, checking account) may be disclosed	**OR**	☐ **Only limited information** may be disclosed (check all applicable blocks below)

Limited Information

- ☐ Appeal
- ☐ Benefits & coverage
- ☐ Billing
- ☐ Claims & payment
- ☐ Diagnosis & procedure
- ☐ Eligibility & enrollment
- ☐ Financial
- ☐ Medical records (excludes psychotherapy notes*)
- ☐ Physician & hospital
- ☐ Pre-certification & pre-authorization
- ☐ Referral
- ☐ Treatment
- ☐ Dental
- ☐ Vision
- ☐ Pharmacy
- ☐ Mental Health
- ☐ Other: _____

I authorize the release of the following types of sensitive information (check all blocks that apply):

- ☐ Abortion
- ☐ Abuse (sexual/physical/mental)
- ☐ Alcohol/substance abuse
- ☐ Genetic testing
- ☐ HIV or AIDS
- ☐ Maternity
- ☐ Mental health
- ☐ Sexually transmitted or other communicable diseases
- ☐ Other: _____

Part D: The purpose of my authorization is (check one block):

- ☐ To disclose the information at my request
- ☐ For the following purposes: _____

Part E: Expiration Date. If not previously revoked, this authorization will terminate on the earliest of the following dates:

- the date my coverage ends (only if disclosure requested by insurance company); or
- one year from the signature date below; or
- upon the following date, event or condition (within the one year time frame):

_____

Part F: I have read the contents of this authorization and understand and agree to the use and disclosure of my information as specified above. I also understand this authorization is voluntary and that the person listed in Part A will not condition my treatment, payment, or enrollment or eligibility for benefits on signing this authorization.

I have the right to revoke this authorization at any time by giving written notice of my revocation to the person listed in Part A. I understand that my revocation will not affect any action taken before my written revocation notice is received. I also understand that information disclosed may be subject to re-disclosure by the recipient in which case it

may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this authorization.

Date	Individual Signature

Designated Legal Representative / Guardian

If this form is signed by a legal representative / guardian on behalf of the individual, please complete the following. A copy of a Health Care Power of Attorney, a court order or other documentation establishing custody or other legal documentation demonstrating the authority of the legal representative to act on the individual's behalf must be attached.

Legal representative (print full name):_____

Legal relationship to individual:_____

Signature: _____Date: _____

**Note:* *This form cannot be used for psychotherapy notes. If you seek to authorize the use or disclosure of psychotherapy notes, then you will need to do so using a separate form.*

Please keep a copy of this form for your records and return the completed form to:

Anthem Transplant Department
13550 Triton Park Blvd.
Mailstop KY0304-A670
Louisville, KY 40223

Get help in your language

Language Assistance Services

Anthem. BlueCross

Curious to know what all this says? We would be too. Here's the English version:
IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD: 711)

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

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

Arabic
مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم1-888-254-2721 (TTY/TDD:711).

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

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

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

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

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

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

MCASH4644CML 06/16 DMHC3 DMHCW

Khmer

សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចឲ្យអ្នកណាម្នាក់អានវាជូនអ្នក។ អ្នកក៏អាចទូលលិខិតនេះដោយសរសៃរជាភាសារបស់អ្នកផងដែរ។ ដើម្បីទទួលជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទមកលេខ 1-888-254-2721។ (TTY/TDD: 711)

Korean

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

Punjabi

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

Russian

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

Tagalog

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

Thai

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

Vietnamese

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

Navajo

DÍÍ ÍLÍIGO BAAH TSÍDÍKÉÉS: Díí naaltsoos nich'į' ályaaígíí daats'í bik'i'diitįįh? Doo bik'i'diitįįhgóó háida ła' ná nídadidiidlóo sgo díí naaltsoos nich'į' yidóoltah. Díí naaltsoos aldó' t'áá ni nizaad k'ehjí bee bik'e'eshchíigo ná ádoolníił. T'áá jíík'e shíká a'doowoł nínízingo t'áá hahí ko jį' hodíílnih 1-888-254-2721. **(TTY/TDD: 711)**

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.