The automatic enrollment of a Newborn or Adopted Children under the Eligibility section may cause the applicable deductible to automatically change from the Individual Deductible to a Family Deductible.

During each Year, each Insured is responsible for all expenses incurred up to the Surgical/Hospital and/or Outpatient Professional Services Deductible amounts. These Deductibles are not prorated for a partial Year. Only Covered Expense will apply toward the Deductibles. A Surgical/Hospital claim must be submitted in order for us to record your eligible covered Surgical/Hospital Deductible expense. A Professional claim must be submitted in order for us to record your eligible covered Outpatient Professional Services Deductible expense. We will record your Deductibles in our files in the order in which your claims are processed, not necessarily in the order in which you receive the service or supply.

If you submit a claim for services which have a maximum payment limit and neither of your Deductibles are satisfied, we will apply only the allowed per visit or per day amount, whichever applies, toward your Surgical/Hospital or Outpatient Professional Services Deductible.

After your Outpatient Professional Services Deductible has been satisfied, for the remainder of that Year: 1) You will not have any Copayment/Coinsurance responsibility for Covered Services rendered by Participating Providers, except as set forth in the Copayment/Coinsurance list; 2) You will continue to be required to pay Copayments/Coinsurance for Covered Services rendered by Non-Participating Providers as set forth in the Copayment/Coinsurance list

Services Not Subject to Deductible
The first two (2) office visits from Participating Providers in a Year
HealthyCheck Center Visits
Services Subject to Individual $5,000/Family $10,000 Surgical and Hospital Inpatient Deductible
All Inpatient Services and Outpatient Surgical Services
Ambulatory Surgical Center Services
Emergency Room Visits
Ambulance Services
Home Health Services
Skilled Nursing Facility Services
Hospice Services
Services Subject to Individual $8,500/Family $17,000 Outpatient Professional Services Deductible
Professional Services (excluding Office Visits)
All Outpatient Services (including Preventive Care Services)
Physical Therapy Services
Occupational Therapy Services
Speech Therapy Services

THIS CHART IS INTENDED TO BE USED TO HELP YOU UNDERSTAND WHICH BENEFITS APPLY TO EACH DEDUCTIBLE AND IS A SUMMARY ONLY. PLEASE REFER TO THE COPAYMENT/COINSURANCE LISTS TO DETERMINE HOW BENEFITS ARE APPLIED.

Your Yearly Copayment/Coinsurance Maximum is the amount of Copayment/Coinsurance that each Insured Person is required to pay for Covered Services in a calendar Year after satisfying Deductible requirements. For this Policy, you will be required to pay Copayment/Coinsurance after satisfying the Surgical/Hospital Deductible. Copayment/Coinsurance amounts are described in SURGICAL AND HOSPITAL INPATIENT BENEFIT COPAYMENT/COINSURANCE LIST.

Hospital admission charges, Emergency Room Copayments and Prior Authorization Copayments will not count toward satisfying your Yearly Copayment/Coinsurance Maximum and will continue to be required even after your Yearly Copayment/Coinsurance Maximum has been reached.

Charges for services that are not covered or charges exceeding our payment, such as Physician charges above the Negotiated Fee Rate or Customary and Reasonable charges, are your responsibility. These charges do not count toward the Yearly Copayment/Coinsurance Maximum and may cause your payment responsibility to exceed the Yearly Out of Pocket Maximum, which is defined immediately below.

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YEARLY OUT OF POCKET MAXIMUM FOR COVERED SERVICES AND COVERED CHARGES ("Out of Pocket Maximum")

The Yearly Out of Pocket Maximum is the sum of any combination of the Yearly Surgical and Hospital Inpatient Deductible, Yearly Outpatient Professional Services Deductible and Copayments/Coinsurance for Covered Services.

- **Individual Yearly Out of Pocket Maximum: $8,500** per Year for each Insured. Once You have satisfied your Participating/Preferred Participating and/or Non-Participating Provider Yearly Out of Pocket Maximum, no further Coinsurance will be required for the remainder of that Year.

- **Family Yearly Out of Pocket Maximum: $17,000** per Year for a Family Contract. Once the total of allowable charges applying to the Individual Yearly Out of Pocket Maximum for two (2) or more Insureds in a Family contract equal the Family Yearly Out of Pocket Maximum, no family member will be required to pay Surgical/Hospital Deductible amounts, Yearly Outpatient Professional Service Deductible amounts or Copayment/Coinsurance amounts, except as otherwise required by this Policy for the remainder of that Year. However, no one person can contribute more than their individual Yearly Out of Pocket Maximum amount to the Family Out of Pocket Maximum.

The automatic enrollment of a Newborn or Adopted Children under the Eligibility section may cause the applicable Out of Pocket Maximum to automatically change from the Individual Out of Pocket Maximum to a Family Out of Pocket Maximum.

Please refer to the chart below for examples of how the Yearly Out of Pocket Maximum is satisfied:

This	Plus this	Satisfies the
$5,000 Surgical/Hospital Deductible	$3,500 in copayment/coinsurance Amounts	$8,500 Out of Pocket Maximum
OR		
$8,500 Outpatient Professional Services Deductible	$0 in copayment/coinsurance amounts	$8,500 Out of Pocket Maximum
OR		
$4,500 applied to the Hospital/Surgical Deductible	$4,000 applied to the Outpatient Professional Services Deductible	$8,500 Out of Pocket Maximum

THIS CHART IS INTENDED TO HELP YOU UNDERSTAND HOW YOUR OUT OF POCKET MAXIMUM IS REACHED AND IS A SUMMARY ONLY. PLEASE REFER TO THE YEARLY OUT OF POCKET MAXUMUM DESCRIPTION ABOVE.

Exception: Amounts you pay for Home Health Care, Inpatient Hospital Services, Ambulatory Surgical Centers, or Outpatient Surgical Services rendered by **Non-Participating Providers** will **not** apply to your Yearly Out of Pocket Maximum and you will continue to be required to pay Copayments/Coinsurance for these services even after your Yearly Out of Pocket Maximum has been reached. You will continue to be responsible for amounts over our allowed payment for the above listed services rendered by Non-Participating Providers.

In addition, Emergency Room Copayments, Hospital admission charges, Prescription Drug Copayments and Copayments for not obtaining Preservice Review will not accumulate toward satisfying your Yearly Out of Pocket Maximum and will continue to be required even after your Yearly Out of Pocket Maximum has been reached.

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DETERMINATION OF COVERED EXPENSE

- Covered Expense is the expense incurred, up to the maximum described in the next bullet, for a Covered Service or supply. Expense is incurred on the date the Insured receives the service or supply for which the charge is made. Please review the parts entitled SURGICAL AND INPATIENT HOSPITAL BENEFIT COPAYMENT/COINSURANCE LIST and OUTPATIENT PROFESSIONAL SERVICES BENEFIT COPAYMENT/COINSURANCE LIST for any per day, Year or visit and the Part entitled MAXIMUM COMPREHENSIVE BENEFITS for your Lifetime Maximum, which may be applied, to a particular benefit.
- In no event will Covered Expenses exceed:
    - Any charge for services of a Participating or Preferred Participating Hospital, participating Physician, Participating Skilled Nursing Facility, Participating Hospice, Participating Ambulatory Surgical Center, Participating Home Health Care provider or Participating Infusion Therapy provider in excess of the Negotiated Fee Rate.
    - Any charge for services of a Non-Participating Physician in excess of the Negotiated Fee Rate except if Special Circumstances apply in which case Covered Expense will not exceed Customary and Reasonable charge.*
    - Any charge for services of a Non-Participating Hospital in excess of a Reasonable Charge.*
    - Any charge for services of a Non-Participating Ambulatory Surgical Center, Hospice, Skilled Nursing Facility or Home Health Care provider in excess of a Customary and Reasonable charge.*
    - Any charge in excess of $50 per day for administrative and professional services of a Non-Participating Infusion Therapy provider; or any charge in excess of the Average Wholesale Price for Drugs provided by a Non-Participating Infusion Therapy provider. The combined maximum Covered Expense for a Non-Participating Infusion Therapy provider will not exceed $500 per day for all Drugs, professional and administrative services.
    - Any charge in excess of a Reasonable Charge for all other covered providers, services and supplies for which Anthem does not enter into Prudent Buyer Participating Agreements.

Your personal financial costs when using Non-Participating Providers will be considerably higher than when you use Participating Providers. You will be responsible for any balance of a provider's bill which is above the allowed amount payable under this Policy for Non-Participating Providers.*

No benefits are provided for the few Non-Contracting Hospitals within California for inpatient Hospital services or outpatient surgical procedures except as specifically stated in the Part entitled, **SPECIAL CIRCUMSTANCES BENEFIT COPAYMENT/COINSURANCE LIST**.

* **See the Part SPECIAL CIRCUMSTANCES BENEFIT COPAYMENT/COINSURANCE LIST for situations that may reduce your payment responsibility when utilizing Non-Participating Providers.**

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 would be provided according to the benefits, limitations and exclusions of this Policy. If you wish to receive a second medical opinion remember that greater benefits are provided when you choose a Participating Provider. You may also ask your Physician to refer you to a Participating Provider to receive a second opinion.

COPAYMENTS/COINSURANCE

You will be required to pay a Copayment/Coinsurance for services received while you are covered under this Policy. Your Copayment/Coinsurance may be a fixed dollar amount per day, per visit or it may be a percentage of eligible charges. It could also be a combination of a fixed dollar amount and a percentage of eligible charges. Hospital admission charges and some Copayments/Coinsurance (e.g., Copayment for not obtaining Preservice Review, or amounts in excess of the Negotiated Fee Rate or Customary and Reasonable) **will not** be applied toward your Yearly Out of Pocket Maximum and **will continue to be required** even after your Yearly Out of Pocket Maximum has been reached. **Refer to the following sections to determine your Copayment/Coinsurance responsibility for Covered Services for Participating and Non-Participating Providers.**

Questions? Visit www.MediCoverage.com or call (800) 930-7956

SURGICAL AND HOSPITAL INPATIENT BENEFIT COPAYMENT/COINSURANCE LIST

The benefits described below are provided for Covered Services incurred for treatment of a covered illness, injury or condition. These benefits are subject to all provisions of this Policy, which may limit benefits or result in benefits not being payable. Any limits on the number of visits or days covered are stated under the specific benefit.

The following Copayment/Coinsurance list describes your payment responsibility after you have satisfied your **$5,000** Surgical/Hospital Deductible per Insured (either individually or by family maximum) for Covered Services incurred in a Year.

BENEFIT	YOUR PAYMENT RESPONSIBILITY
INPATIENT HOSPITAL	
Preferred Participating Hospital	40% of the Negotiated Fee Rate.
Participating Hospital	40% of the Negotiated Fee Rate.*
Non-Participating Hospital	All charges in excess of $650 per day for Covered Services unless **Special Circumstances** apply. This includes treatment for Severe Mental Illnesses and Serious Emotional Disturbances of a Child.

*The Insured is responsible for a $500 admission charge per admission for inpatient services or when an outpatient visit is related to surgery or Infusion Therapy at a Participating Hospital. This admission charge is separate from any Deductible required by this Policy. It does not apply toward satisfying the Insured's Yearly Deductible(s) or Yearly Out of Pocket Maximum. The admission charge will not be required for Medical Emergency admissions or Ambulatory Surgical Centers.

A Center of Medical Excellence (CME) Network has been established for transplant and bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss. These procedures are covered only at a CME, except for Medical Emergencies. For more information, please see the section entitled Centers of Medical Excellence (CME) for Transplants and Bariatric Surgery under COMPREHENSIVE BENEFITS: WHAT IS COVERED.

EMERGENCY ROOM	
Preferred Participating Provider	40% of the Negotiated Fee Rate.
Participating Provider	40% of the Negotiated Fee Rate.
Non-Participating Provider	40% of Customary and Reasonable

Emergency Room services received in the state of California are subject to an additional $100 Copayment per visit, which is waived if the visit results in an inpatient admission into a Hospital immediately following the emergency room services.

AMBULANCE	
Participating Provider	40% of the Negotiated Fee Rate.
Non-Participating Provider	**Ground Ambulance**: 50% of the Negotiated Fee Rate **plus** all charges in excess of the Negotiated Fee rate up to a maximum Anthem payment of $750 for medically necessary ground ambulance transportation. **Air Ambulance:** 50% of the Negotiated Fee Rate **plus** all charges in excess of the Negotiated Fee rate for medically necessary air ambulance transportation.

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BENEFIT	YOUR PAYMENT RESPONSIBILITY

AMBULATORY SURGICAL CENTERS AND OUTPATIENT SURGICAL SERVICES

Preferred Participating Provider	40% of the Negotiated Fee Rate.
Participating Provider	40% of the Negotiated Fee Rate.
Non-Participating Provider	All charges in excess of $380 per day for Covered Services unless **Special Circumstances** apply. This includes treatment for Severe Mental Illnesses and Serious Emotional Disturbances of a Child.

SKILLED NURSING FACILITY
Limited to 30 days per Year for Participating and Non-Participating Providers combined.

Participating Provider	40% of the Negotiated Fee Rate.
Non-Participating Provider and out of state provider	50% of the Negotiated Fee Rate **plus** all charges in excess of the Negotiated Fee Rate.

SEVERE MENTAL ILLNESSES AND SERIOUS EMOTIONAL DISTURBANCES OF A CHILD – Inpatient Services Preservice review required for all facility based treatment.

Benefits provided as any other medical condition.

Participating Provider	40% of the Negotiated Fee Rate.
Non-Participating Provider	50% of the Negotiated Fee Rate **plus** all charges in excess of the Negotiated Fee Rate.

OTHER ELIGIBLE PROVIDERS (Inpatient services)
The following class of providers do not enter into Participating agreements with us and your payment responsibility for these providers is as indicated below: a blood bank, a Dentist (D.D.S.), a dispensing optician, a speech pathologist, a respiratory therapist.

All providers listed above	40% of Customary and Reasonable charges or billed charges, whichever is less, **plus** all charges in excess of Customary and Reasonable.

The providers listed above must be licensed according to state and local laws to provide covered medical services.

HOME HEALTH CARE
Limited to sixty (60) visits per Year for Participating and Non-Participating Providers combined up to four (4) hours or less each visit.

Participating Provider	40% of the Negotiated Fee Rate.
Non-Participating Provider	All charges in excess of $75 per visit **plus** 50% of the Negotiated Fee Rate and all charges in excess of the Negotiated Fee Rate.

HOSPICE
Limited to a lifetime maximum of $10,000 for Participating and Non-Participating Providers combined.

Participating Provider	40% of the Negotiated Fee Rate.
Non-Participating Provider	50% of the Negotiated Fee Rate **plus** all charges in excess of the Negotiated Fee Rate.

INPATIENT INFUSION THERAPY/RADIATION THERAPY/CHEMOTHERAPY

Participating Provider	40% of the Negotiated Fee Rate.
Non-Participating Provider	50% of the Negotiated Fee Rate **plus** all charges in excess of the Negotiated Fee Rate.

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Questions? Visit www.MediCoverage.com or call (800) 930-7956

OUTPATIENT PROFESSIONAL SERVICES BENEFIT COPAYMENT/COINSURANCE LIST

The benefits described below are provided for Covered Services incurred for treatment of a covered illness, injury or condition. These benefits are subject to all provisions of this Policy, which may limit benefits or result in benefits not being payable. Any limits on the number of visits or days covered are stated under the specific benefit.

Prior to the Outpatient Professional Services Deductible of **$8,500** being satisfied, all covered services indicated below are subject to the **$8,500** Outpatient Professional Services Deductible (unless indicated below) per insured, per year.

The following Copayment/Coinsurance list describes your payment responsibility **after** you have satisfied your **$8,500** Outpatient Professional Services Deductible and/or yearly Out of Pocket maximum per Insured (either individually or by family maximum) for Covered Services incurred in a Year.

BENEFIT	**YOUR PAYMENT RESPONSIBILITY**

Preventive Care coverage is subject to the Outpatient Professional Services Deductible for the first six (6) months each Insured is enrolled. After each individual family member has been enrolled for six (6) months, Preventive Care services are not subject to the Outpatient Professional Services Deductible and are covered as indicated below.

PREVENTIVE CARE
FDA-approved cancer screenings including an annual pap examination, breast exams, mammography testing, appropriate screening for breast cancer, ovarian, and cervical cancer screening tests, including the human papilloma virus (HPV) test for cervical cancer, prostate specific antigen (PSA) testing, and the Office Visit related to these services. These services are provided at your Physician's office and not at the HealthyCheck centers.

Participating Provider	40% of the Negotiated Fee Rate..
Non-Participating Provider	50% of the Negotiated Fee Rate **plus** all charges in excess of the Negotiated Fee Rate unless **Special Circumstances** apply.

WELL BABY AND WELL CHILD CARE/ PREVENTIVE CARE – Children through age 6
Only childhood immunizations are covered for Insureds up to and including 6 years of age. The Office Visit related to these services is not covered.

Participating Provider	40% of the Negotiated Fee Rate.
Non-Participating Provider	50% of the Negotiated Fee Rate **plus** all charges in excess of the Negotiated Fee Rate unless **Special Circumstances** apply.

PREVENTIVE CARE – HealthyCheck Centers
For Insureds age 7 to adult. No Outpatient Professional Services Deductible applies. Copayments paid at HealthyCheck Centers do not accumulate toward satisfying your yearly Outpatient Professional Services Deductible.

Performed at HealthyCheck Centers only	$25 Basic Screening or $75 Premium Screening

This benefit does **not** apply to Non-Participating Providers.

BENEFIT	**YOUR PAYMENT RESPONSIBILITY**

OFFICE VISITS
The first two (2) office visits from Participating Providers are covered at a $40 copay per insured, per year regardless of the type of provider seen. The total number of visits covered at the $40 copay is combined for all Participating providers. No Outpatient Professional Services Deductible is required. After the first two (2) office visits, once the Outpatient Professional Services Deductible is satisfied, your benefits from all Participating Providers will be as stated under PROFESSIONAL SERVICES below.

PROFESSIONAL SERVICES
Rendered by a Physician including surgery, anesthesia, radiation therapy, in Hospital doctor visits, diagnostic x-ray, lab work and Office Visits. Refer to the section PROFESSIONAL SERVICES under COMPREHENSIVE BENEFITS: WHAT IS COVERED for a detailed description.

Participating Provider	No coinsurance required for Covered Services for the remainder of the Year.
Non-Participating Provider	50% of the Negotiated Fee Rate **plus** all charges in excess of the Negotiated Fee Rate unless **Special Circumstances** apply.

OUTPATIENT HOSPITAL
Outpatient hospital services and supplies, outpatient lab, x-ray, radiation and anesthesia.

Preferred Participating Provider	No coinsurance required for Covered Services for the remainder of the Year.
Participating Provider	No coinsurance required for Covered Services for the remainder of the Year.*
Non-Participating Provider	50% of the Negotiated Fee Rate plus all charges in excess of the Negotiated Fee Rate unless **Special Circumstances** apply..

Emergency Room services received in the state of California are subject to an additional $100 Copayment per visit, which is waived if the visit results in an inpatient admission into a Hospital immediately following the emergency room services.

*The Insured is responsible for a $500 admission charge per admission for inpatient services or when an outpatient visit is related to surgery or Infusion Therapy at a Participating Hospital. This admission charge is separate from any Deductible required by this Policy. It does not apply toward satisfying the Insured's Yearly Deductible or Yearly Out of Pocket Maximum. The admission charge will not be required for Medical Emergency admissions or Ambulatory Surgical Centers.

PHYSICAL THERAPY and OCCUPATIONAL THERAPY
Limited to 24 visits per Year combined for Participating and Non-Participating Providers.

Participating Provider	No coinsurance required for Covered Services for the remainder of the Year.
Non-Participating Provider	50% of the Negotiated Fee Rate **plus** all charges in excess of the Negotiated Fee Rate

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BENEFIT	YOUR PAYMENT RESPONSIBILITY

SPEECH THERAPY
Outpatient speech therapy when following surgery, injury or non-congenital organic disease.

Participating Provider	No coinsurance required for Covered Services for the remainder of the Year.
Non-Participating Provider	50% of Customary and Reasonable **plus** all charges in excess of Customary and Reasonable.

Note: Limited to 50 visits per Year. We will not pay more than 50 visits maximum per Year unless authorized by Anthem in advance of the services being rendered. If Anthem determines that an additional period of speech therapy is both Medically Necessary and likely to result in a significant improvement to the Insured's condition during that period of additional care, Anthem will authorize a specific number of additional visits.

SEVERE MENTAL ILLNESSES AND SERIOUS EMOTIONAL DISTURBANCES OF A CHILD – Outpatient Services Preservice review required for all facility based treatment, as well as outpatient professional services after the twelfth (12th) visit.

Benefits provided as any other medical condition.

Participating Provider	No coinsurance required for Covered Services for the remainder of the Year.
Non-Participating Provider	All charges in excess of 50% of the Negotiated Fee Rate.

HOSPICE
Limited to a lifetime maximum of $10,000 for Participating and Non-Participating Providers combined.

Participating Provider	No coinsurance required for Covered Services for the remainder of the Year.
Non-Participating Provider	50% of the Negotiated Fee Rate **plus** all charges in excess of the Negotiated Fee Rate.

OUTPATIENT INFUSION THERAPY/RADIATION THERAPY/CHEMOTHERAPY

Participating Provider	No coinsurance required for Covered Services for the remainder of the Year.
Non-Participating Provider	50% of the Negotiated Fee Rate **plus** all charges in excess of the Negotiated Fee Rate.

Questions? Visit www.MediCoverage.com or call (800) 930-7956

BENEFIT	YOUR PAYMENT RESPONSIBILITY

FOREIGN COUNTRY PROVIDERS
For initial treatment of a Medical Emergency only.

All providers	0% of Customary and Reasonable charges **plus** all charges in excess of Customary and Reasonable.

Note: You are responsible, at your expense, for obtaining an English language translation of foreign country provider claims and medical records.

OTHER ELIGIBLE PROVIDERS (outpatient services)
The following class of providers do not enter into Participating agreements with us and your payment responsibility for these providers is as indicated below: a blood bank, a Dentist (D.D.S.), a dispensing optician, a speech pathologist, a respiratory therapist.

All providers listed above	0% of Customary and Reasonable charges or billed charges, whichever is less, **plus** all charges in excess of Customary and Reasonable.

The providers listed above must be licensed according to state and local laws to provide covered medical services.

DENTAL INJURY

Participating Provider	No coinsurance required for Covered Services for the remainder of the Year.
Non-Participating Provider	50% of the Negotiated Fee Rate **plus** all charges in excess of the Negotiated Fee Rate unless **Special Circumstances** apply.

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SPECIAL CIRCUMSTANCES BENEFIT COPAYMENT/COINSURANCE LIST

BENEFIT	YOUR PAYMENT RESPONSIBILITY

Authorized Referral to a Non-Participating Provider

Surgical/Hospital services benefits are subject to the Surgical and Inpatient Hospital Deductible. Once the Surgical/Hospital Deductible is met, those services are covered as indicated below.
Outpatient Professional Services benefits are subject to the Outpatient Professional Services Deductible. Once the Outpatient Professional Services Deductible is met, those services are covered as indicated below:

BENEFIT	YOUR PAYMENT RESPONSIBILITY
Non-Participating Hospital, Ambulatory Surgical Center (inpatient)	40% of Customary and Reasonable charges **plus** all charges in excess of Customary and Reasonable charges.
Non-Participating Hospital, Physician (outpatient)	0% of Customary and Reasonable charges **plus** all charges in excess of Customary and Reasonable charges after the Outpatient Professional Services Deductible is satisfied.

For Medical Emergencies Within California

Emergency Room services received in the state of California are subject to an additional $100 Copayment per visit which is waived if the visit results in an inpatient admission into a Hospital immediately following the emergency room services. Surgical/Hospital services benefits are subject to the Surgical and Inpatient Hospital Deductible. Once the Surgical/Hospital Deductible is met, those services are covered as indicated below.
Outpatient Professional Services benefits are subject to the Outpatient Professional Services Deductible. Once the Outpatient Professional Services Deductible is met, those services are covered as indicated below:

BENEFIT	YOUR PAYMENT RESPONSIBILITY
Non-Participating Provider	**Professional Services:** 0% of Customary and Reasonable charges or billed charges, whichever is less **plus** all charges in excess of Customary and Reasonable.
Non-Participating Providers	**Hospitals and Non-Contracting Hospitals:** 40% of Customary and Reasonable charges or billed charges, whichever is less, **plus** all charges in excess of Customary and Reasonable. **Ambulatory Surgical Centers:** 40% of Customary and Reasonable charges **plus** all charges in excess of Customary and Reasonable. **Ground Ambulance**: 40% of Customary and Reasonable **plus** all charges in excess of Customary and Reasonable up to a maximum Anthem payment of $750 for medically necessary ground ambulance transportation. **Air Ambulance:** 40% of Customary and Reasonable **plus** all charges in excess of Customary and Reasonable for medically necessary air ambulance transportation.

Questions? Visit www.MediCoverage.com or call (800) 930-7956

BLUECARD PROGRAM

For Medical Services Outside California

The Blue Cross and Blue Shield Association, of which we are a member/Independent Licensee, administers a program called the **BlueCard Program**, in which we participate, which allows our Insureds to have the reciprocal use of Participating Providers that contract with other Blue Cross and/or Blue Shield Plans. Providers available to you through the BlueCard Program have not entered into contracts with Anthem Blue Cross Life and Health Insurance Company. If you have any questions or complaints about the BlueCard Program, please call us at 1-800-333-0912.

If you are traveling outside of California and require medical care or treatment, you may use a local Blue Cross and/or Blue Shield Participating Provider. If you use one of these providers, your out-of-pocket expenses may be lower than those incurred when using a provider that does not participate with a local Blue Cross and/or Blue Shield Plan.

In order for you to receive access to whatever reductions in out-of-pocket expenses may be available, we must abide by the BlueCard Program rules, as set by the Blue Cross and Blue Shield Association.

When you obtain health care services through the BlueCard Program outside of California, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your Covered Services or
- The Negotiated Price that the on-site Blue Cross and/or Blue Shield ("Host Blue") passes on to us.

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

Statutes in a small number of states may require the Host Blue to use a basis for calculating Policyholder liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state mandate Policyholder liability calculation methods that differ from the usual BlueCard method noted above in the preceding paragraph of this item or require a surcharge, we would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

BlueCard Provider Types

PPO Providers

These are primarily Hospitals and Physicians who participate in a BlueCard PPO network and have agreed to provide PPO Insureds with health care services at a discounted rate that is generally lower than the rate charged by Traditional providers.

Traditional Providers

These are providers who might not participate in a BlueCard PPO network but have agreed to provide PPO Insureds with health care services at a discounted rate.

Non-Participating Providers

These are providers that do **not** have a contract with their local Blue Cross and/or Blue Shield plan and have **not** accepted the BlueCard or Traditional provider negotiated rates.

To locate a BlueCard PPO or Traditional provider when outside of California call 1-800-810 BLUE (2583) or visit the BlueCard website address: www.bluecares.com/bluecard. When traveling outside the United States, in cases of emergencies only, call 1-800-810-BLUE (2583) to inquire about providers that may participate in the BlueCard Worldwide Program.

Questions? Visit www.MediCoverage.com or call (800) 930-7956

BENEFIT	YOUR PAYMENT RESPONSIBILITY

Medical Non-Emergencies Outside California

Your payment responsibility for Covered Services received from Non-Participating Providers, including ambulance, will be at the Participating Provider percentage for emergency services as described below. Surgical/Hospital services benefits are subject to the Surgical and Inpatient Hospital Deductible. Once the Surgical/Hospital Deductible is met, those services are covered as indicated below. Outpatient Professional Services benefits are subject to the Outpatient Professional Services Deductible. Once the Outpatient Professional Services Deductible is met, those services are covered as indicated below:

Physician

PPO Provider	0% of the BlueCard provider's Negotiated Price.
Traditional Provider*	50% of the BlueCard provider's Negotiated Price.
Non-Participating Provider	50% of the BlueCard provider's Negotiated Price **plus** all charges in excess of the BlueCard provider's Negotiated Price.

Hospital or Ambulatory Surgical Center

PPO Provider	40% of the BlueCard provider's Negotiated Price.
Traditional Provider*	50% of the BlueCard provider's Negotiated Price.
Non-Participating Provider	**Inpatient Hospital:** You pay all charges in excess of $650 per day unless **Special Circumstances** apply. **Ambulatory Surgical Centers and Outpatient Surgical Services:** You pay all charges in excess of $380 per day unless **Special Circumstances** apply. **Outpatient Hospital (non surgical):** 50% of the BlueCard provider's Negotiated price **plus** all charges in excess of the BlueCard provider's Negotiated Price.

*If there are no BlueCard PPO providers in the area, your payment responsibility will be 0% of the BlueCard provider's Negotiated Price.

Questions? Visit www.MediCoverage.com or call (800) 930-7956

BENEFIT	YOUR PAYMENT RESPONSIBILITY

Medical Emergencies Outside California
Your payment responsibility, for Covered Services received from Non-participating Providers, including ambulance, will be at the Participating PPO provider percentage for emergency services as described below. Surgical/Hospital services benefits are subject to the Surgical and Inpatient Hospital Deductible. Once the Surgical/Hospital Deductible is met, those services are covered as indicated below. Outpatient Professional Services benefits are subject to the Outpatient Professional Services Deductible. Once the Outpatient Professional Services Deductible is met, those services are covered as indicated below:

Physician	
PPO Provider	0% of the BlueCard provider's Negotiated Price.
Traditional Provider	0% of the BlueCard provider's Negotiated Price.
Non-Participating Provider	0% of the Customary and Reasonable charges **plus** all charges in excess of Customary and Reasonable.
Hospital or Ambulatory Surgical Center	
PPO Provider	40% of the BlueCard provider's Negotiated Price.
Traditional Provider	40% of the BlueCard provider's Negotiated Price.
Non-Participating Provider	**Inpatient Hospital:** 40% of the Customary and Reasonable charges **plus** all charges in excess of Customary and Reasonable. **Ambulatory Surgical Centers and Outpatient Surgical Services:** 40% of Customary and Reasonable charges **plus** all charges in excess of Customary and Reasonable. **Outpatient Hospital (non surgical):** 40% of Customary and Reasonable charges **plus** all charges in excess of Customary and Reasonable.

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COVERED SERVICES

Before we pay for any benefits, you must satisfy your Deductibles. The medical Deductibles are described in the section DEDUCTIBLES under the Part entitled BENEFIT COPAYMENT/COINSURANCE LIST.

All Covered Services are subject to either the Yearly Surgical/Hospital Deductible or the Yearly Outpatient Professional Services Deductible including limited benefits such as, Home Health services and Mental or Nervous Disorders and Substance Abuse.

If you have questions on whether a condition is covered, please call Anthem toll free at 1-800-274-7767.

Described below are the types of services covered under this Policy for the treatment of a covered illness, injury or condition. Before you review this list of Covered Services take a moment to review the Definitions of Negotiated Fee Rate and Customary and Reasonable charge. Knowing the meaning of these terms will greatly assist you in determining the benefits of this Policy and your Copayment/Coinsurance responsibility.

Another term you should become familiar with is Preservice Review. Preservice Review begins when your Physician provides medical information to us prior to a specific service or procedure taking place so that we can determine if it is Medically Necessary and a Covered Service. The Part entitled UTILIZATION MANAGEMENT AND PRESERVICE REVIEW describes in detail what services require Preservice Review and how to obtain Preservice Review.

HOSPITAL (requires Preservice Review, except for mastectomy surgery, including the length of Hospital stay associated with mastectomy)

Covered Inpatient Services

- A Hospital room with two or more beds. If a private room is used, we will only allow up to the prevailing two-bed room rate.
- Services in Special Care Units.
- Operating and special treatment rooms.
- Supplies and ancillary services including laboratory, cardiology, pathology, radiology rendered while in the facility.
- Physical Therapy, radiation therapy, chemotherapy and hemodialysis treatment.
- Drugs and medicines approved by the Food and Drug Administration, including oxygen given to you during your stay, which are supplied by the Hospital for the illness, injury or condition for which the Insured is hospitalized, including take-home drugs billed on the Insured's inpatient Hospital bill and dispensed by the Hospital's pharmacy at the time of the Insured's discharge from the Hospital.
- Blood transfusions, but **not** the cost of blood, blood products or blood processing.

Covered Outpatient Services

- Emergency room use, supplies, ancillary services, drugs and medicines as listed above.
- Care received when outpatient surgery is performed. Covered Services are operating room use, supplies, ancillary services, drugs and medicines as listed above. These services are also payable when outpatient surgery is performed at an Ambulatory Surgical Center.
- Radiation therapy, chemotherapy and dialysis treatment.
- Outpatient Day Treatment Program services when rendered at a psychiatric facility.

Conditions of Service

- Services must be those which are regularly provided and billed by a Hospital.
- Services must be received in a Contracting Hospital, except for surgical services received at an Ambulatory Surgical Center.
- Emergency room care must be for the first treatment of a Medical Emergency as defined in the Part entitled DEFINITIONS.
- Emergency room care for an injury must be received within 72 hours of the injury date.

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SKILLED NURSING FACILITY
Limited to 30 days per Year for Participating and Non-Participating Providers combined. You must be under the active supervision of a Physician treating your illness or injury.

Benefits for Covered Services are provided according to the following:
- A room with two or more beds. If a private room is used, we will only allow up to the prevailing two-bed room rate.
- Special treatment rooms.
- Laboratory tests.
- Physical, occupational and speech therapy. Oxygen and other respiratory therapy.
- Drugs and medicines approved for general use by the Food and Drug Administration which are used in the facility.
- Blood transfusions, but **not** the cost of blood, blood products or blood processing.

Conditions of Services
- The Insured must be referred to the Skilled Nursing Facility by a Physician.
- Services must be those which are regularly provided and billed by a Skilled Nursing Facility.
- The services must be consistent with the illness, injury, degree of disability and medical needs of the Insured. Benefits are provided only for the number of days required to treat the Insured's illness or injury.
- Benefits are provided if a Skilled Nursing Facility stay is needed outside California.

AMBULANCE
Benefits for Covered Services are provided according to the following:
- Base charge and mileage to transport you to or from a Hospital or Skilled Nursing Facility when Medically Necessary.
- Non-reusable supplies.
- Monitoring, electrocardiograms (EKG's or ECG's), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with the ambulance service. An appropriately licensed person must render the services.

Conditions of Services
- Services must be for ground or air ambulance transportation of the Insured to an acute care Hospital. Upon reaching the Hospital, the Insured must be admitted as an inpatient or receive emergency outpatient care as stated above.
- Services must be provided by a licensed ambulance company.

Maximums
- Ground ambulance transportation benefits are limited to a maximum payment of $750 per trip. This maximum does not apply to air ambulance transportation.
- Payment of benefits for ambulance services will be made directly to the provider of the service unless proof of payment is received by us prior to the benefits being paid.
- If requested through a 911 call, ambulance charges are covered if it is reasonably believed that a Medical Emergency existed even if you are not transported to a Hospital.

  IN SOME AREAS A 911 EMERGENCY RESPONSE SYSTEM HAS BEEN ESTABLISHED. THIS SYSTEM IS ONLY TO BE USED WHEN THERE IS AN EMERGENCY MEDICAL CONDITION THAT REQUIRES AN EMERGENCY RESPONSE.

  IF YOU REASONABLY BELIEVE THAT YOU ARE EXPERIENCING A MEDICAL EMERGENCY, YOU SHOULD CALL 911 OR GO DIRECTLY TO THE NEAREST HOSPITAL EMERGENCY ROOM.

LIMITED PROFESSIONAL SERVICES

- Services of a **Physician**, including surgeons and specialists for a covered surgical procedure.
- Services of an **Assistant Surgeon** for a covered surgical procedure.
- Services of an **anesthesiologist or an anesthetist** for a covered surgical procedure.
- Outpatient diagnostic **radiology**.
  Note: The following procedures require Preservice Review.
  - Computerized Tomography (CT) scan
  - Positron Emission Tomography (PET) scan
  - Magnetic Resonance Imaging (MRI) scan
  - Magnetic Resonance Spectroscopy (MRS) scan
  - Nuclear Cardiology (NC) scan
- **Cancer screening** tests approved by the federal Food and Drug Administration (FDA) and the office visit associated with performing those tests when ordered by your Physician, registered nurse practitioner or certified nurse midwife. This includes screening for breast, cervical, ovarian and prostate cancer.
- Human papilloma virus (HPV) test for cervical cancer.
- **Mammogram examinations** and the office visit associated with performing those tests when ordered by your Physician, registered nurse practitioner or certified nurse midwife.
- **Human Immunodeficiency Virus (HIV) testing**, regardless of whether the testing is related to a primary diagnosis.
- **Radiation therapy and hemodialysis treatment.**
- **Radium and radioactive isotope therapy** whether performed on an inpatient or outpatient basis.
- **Surgical implants.**
- **Artificial limbs or eyes.**
- **Prosthetic devices** to achieve symmetry after mastectomy.
- The first pair of **contact lenses or eyeglasses**, when required as a result of covered eye surgery.
- **Blood transfusions**, including blood processing and the cost of un-replaced blood and blood products. Autologous blood donations will be covered only when the blood is transfused back into the patient.
- **Injectable contraceptives**, except Norplant, when administered in a Physician's office.
- **FDA approved medications** that may only be dispensed by a Physician.
- **Hepatitis B and Varicella Zoster** (chicken pox) vaccine for Dependents age 7 through 18 and the office visit associated with administering that vaccination when ordered by your Physician. Not subject to the Outpatient Professional Services Deductible.
- **Reconstructive Surgery** is defined as Medically Necessary and appropriate surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or create a normal appearance to the extent possible. Reconstructive surgery includes Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for "cleft palate" procedures. "Cleft Palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.
- Services of a Physician for **diabetes education services**.
- Services of a Physician or Dentist treating an **Accidental Injury to your natural** teeth, while you are covered under this Policy when you receive treatment within one (1) Year following the injury. Damage to your teeth due to chewing or biting is not an Accidental Injury.

No benefits for Professional Services are provided for Mental or Nervous Disorders and Substance Abuse, **except for the treatment of Severe Mental Illnesses and Serious Emotional Disturbances of a Child**, whether the care is provided in an inpatient Hospital setting or as an outpatient.

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LIMITED PROFESSIONAL SERVICES

- **Outpatient speech therapy** when following surgery, injury or non-congenital organic disease.
  Note: Limited to 50 visits per Year. We will not pay more than 50 visits maximum per Year unless authorized by Anthem in advance of the services being rendered. If Anthem determines that an additional period of speech therapy is both Medically Necessary and likely to result in a significant improvement to the Insured's condition during that period of additional care, Anthem will authorize a specific number of additional visits.
- **Physical Therapy and Occupational Therapy** visits, when rendered by a Physician are limited to a maximum of 24 visits per Year combined for Participating and Non Participating Providers.
  Note: If Anthem determines that an additional period of Physical Therapy and/or Occupational Therapy is both Medically Necessary and likely to result in a significant improvement to the Insured's condition, during that period of additional care, Anthem will authorize a specific number of additional visits.

WELL BABY AND WELL CHILD CARE

Only childhood immunizations are covered for Insureds up to and including 6 years of age. The Office Visit related to these services is not covered.

- Childhood immunizations.

PREVENTIVE CARE HEALTHYCHECK CENTERS

Insureds age 7 to adult

No Deductibles apply. Copayments paid at HealthyCheck Centers do not accumulate toward satisfying your Yearly Deductible.

Anthem Blue Cross Life and Health will provide, on an annual basis, clinically effective preventive care services at designated HealthyCheck Centers. These HealthyCheck Centers are located in state licensed medical facilities. Call 1-800-274-WELL (9355) or visit www.anthem.com/ca for a list of cities that have HealthyCheck center locations. Call 1-800-274-WELL (9355) to make an appointment.

You will be required to pay a $25 Copayment for Basic Screening or $75 Copayment for Premium Screening per Insured per visit for services performed at a designated HealthyCheck Center. No Deductibles are required. This Copayment does not apply toward your Deductibles.

Note: We cannot schedule an appointment for preventive care services until you have selected a Physician. **You must be free of any illness or condition to receive services at the HealthyCheck Centers.**

The following services available only at HealthyCheck Centers:

$25 Basic Screening (for children ages 7-17 and adults ages 18 and over) includes:

- Blood Pressure
- Height and weight
- Pulse and resting heart rate
- Heart, lung, thyroid and abdomen evaluation
- Body Mass Index (BMI)
- Skin cancer evaluation and education
- Tetanus-Diphtheria booster
- Tetanus-Diphtheria and Pertussis booster
- Flu Shot (per CDC guidelines and availability)

For adults only:

- Cholesterol: Total and HDL ("good")
- Glucose

For children only:

- Hemoglobin
- Urinalysis
- Vision and hearing screenings
- Measles-Mumps-Rubella booster
- Polio booster

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$75 Premium Screening (for adults ages 18 and over) includes everything in the Basic Screening plus:

- Cholesterol: LDL ("bad")
- Triglycerides
- Colorectal cancer screening (per CDC guidelines)
- Urinalysis
- Vision screening
- Flexibility testing
- Body composition - body composition is the true definition of an individual's weight status. HealthyCheck centers use a handheld machine that uses bioelectrical impedance to measure one's body fat.
- Posture analysis - a clinician will use a posture score sheet to grade each part of the member's posture, including head, shoulders, spine, hips, ankles, neck, upper back, trunk, abdomen and lower back.

Adult Preventive Services

The following services are provided at your Physician's office and not at the HealthyCheck Centers. The service, including the Office Visit related to that service, is not subject to the Deductibles.

- Annual pap exam
- Breast exams
- Mammogram testing and appropriate screening for breast cancer
- Cervical and ovarian cancer screening tests
- Prostatic Specific Antigen (PSA) testing

TREATMENT FOR DIABETES

Medical services and supplies provided for the treatment of diabetes are paid on the same basis as any other medical condition. Benefits will be provided for Covered Expenses for:

Diabetes Equipment and Supplies

- Blood glucose monitors, including monitors designed to assist the visually impaired and blood glucose testing strips
- Insulin pumps
- Pen delivery systems for insulin administration
- Podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes related complications
- Visual aids but not eyeglasses to help the visually impaired to properly dose insulin.
  These covered equipment and supplies are covered under your Policy's benefits for durable medical equipment. See the section MEDICAL SUPPLIES AND EQUIPMENT under this PART.

Diabetes Outpatient Self-Management Training Program

- Designed to teach an Insured, who is a patient, and covered Dependents of the patient's family about the disease process and the daily management of diabetic therapy.
- Includes self-management training, education and medical nutrition therapy to enable the Insured to properly use the equipment, supplies and medications necessary to manage the disease and
- Must be supervised by a Physician.

Note: Diabetes education services are covered under the Policy benefits for professional services by Physicians.

The following medications and supplies are covered under your Prescription Drug benefits:

- Insulin, glucagon and other prescription drugs for the treatment of diabetes
- Insulin syringes
- Urine testing strips and lancets

These items must be obtained either from a retail Pharmacy or through the mail service program. See YOUR PRESCRIPTION DRUG BENEFITS.

MEDICAL SUPPLIES and EQUIPMENT

Limited $5,000 per Year for Participating and Non-Participating Providers combined.

Rental or purchase of dialysis equipment and supplies, and other long lasting medical equipment and supplies when:

- Ordered by your Physician and
- Of no further use when medical needs end and
- Useable only by the patient and
- Not primarily for your comfort or hygiene and
- Not for environmental control and
- Not for exercise and
- Manufactured specifically for medical use

The equipment or supply must be for medical use to treat a health problem, and only for the use of the person for whom it was prescribed.

Note: Coverage does not include orthopedic shoes or shoe inserts, arch supports, disposable sheaths and supplies, correction appliances or support appliances and supplies such as stockings or personal comfort items as indicated in the part entitled EXCLUSIONS AND LIMITATIONS.

Rental charges that exceed the reasonable purchase price of the equipment are not covered. Anthem determines whether the item meets the above conditions.

PHYSICAL THERAPY and/or OCCUPATIONAL THERAPY

Physical Therapy and/or Occupational Therapy includes the therapeutic use of heat, cold, exercise, electricity, ultraviolet, manipulation of the spine, massage to improve circulation, strengthen muscles, encourage return of motion, or treatment of illness or injury.

Benefits for Physical Therapy and/or Occupational Therapy are payable only for services rendered by a Physician. Benefits for these services are limited to 24 visits per Year combined for Participating and Non-Participating Providers, these services include treatment for the following:

- post neurological surgery
- orthopedic surgery
- cerebral vascular accident
- third degree burns
- head trauma
- spinal cord injury

SPEECH THERAPY

Speech Therapy is the treatment of speech defects and disorders through the use of exercises and audio-visual aids that develop new speech habits.

Benefits for Speech Therapy are payable only for services rendered by a Physician. Benefits for these services are limited to a maximum of 50 visits per Year, combined for Participating and Non-Participating Providers.

DENTAL

- Up to three (3) days of inpatient Hospital services, when a Hospital stay is Medically Necessary, for dental treatment due to an unrelated medical condition of the Insured and has been ordered by a Physician (M.D.) and a Dentist (D.D.S.)
- Services of a Physician or Dentist treating an Accidental Injury to your natural teeth, while you are covered under this Policy when you receive treatment within one (1) Year following the injury. Damage to your teeth due to chewing or biting is not an Accidental Injury.
- General anesthesia and associated facility charges for dental procedures in a Hospital or surgery center for enrolled Insureds:
  - Under seven (7) years of age.
  - Developmentally disabled, regardless of age.
  - Whose health is compromised and general anesthesia is Medically Necessary, regardless of age.

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TREATMENT FOR SEVERE MENTAL ILLNESSES AND SERIOUS EMOTIONAL DISTURBANCES OF A CHILD (Preservice Review is required for Facility Based Treatment. Preservice Review is also required for outpatient professional services after the twelfth (12th) visit.)

Benefits for Covered Services and supplies provided for the treatment of specific Severe Mental Illnesses and Serious Emotional Disturbances of a Child will be provided at the same levels of coverage as other medical diagnoses. These services are subject to all other terms, conditions, limitations and exclusions, including Maximum Comprehensive Benefits. See the Part entitled DEFINITIONS.

Note: Severe Mental Illness, Serious Emotional Disturbances of a Child and any condition meeting the definition of "Mental or Nervous Disorders and Substance Abuse" is a Mental or Nervous Disorder no matter what the cause (please see the Part entitled "DEFINITIONS").

PHENYLKETONURIA (PKU)

Coverage for the testing and treatment of phenylketonuria (PKU) is paid on the same basis as any other medical condition. Coverage for treatment of phenylketonuria (PKU) shall include those formulas and special food products that are part of a diet prescribed by a licensed Physician and managed by a health care professional in consultation with a Physician who specializes in the treatment of metabolic disease and who participates in or is authorized by the Policy. The diet must be deemed Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of phenylketonuria (PKU).

Coverage for the cost of the necessary formulas and special food products is covered only as it exceeds the cost of a normal diet. "Formula" means an enteral product or products for use at home. The formula must be prescribed by a Physician, nurse practitioner or ordered by a registered dietician upon referral by a health care provider authorized to prescribe dietary treatments and as Medically Necessary for the treatment of phenylketonuria (PKU). Most formulas used in the treatment of PKU are obtained from a Pharmacy and are covered under your Policy's Prescription Drug benefits. Refer to the Part entitled YOUR PRESCRIPTION DRUG BENEFITS. Special food products and formulas that are not obtained from a Pharmacy are covered as medical supplies under your Policy's medical benefits.
"Special food product" means a food product that is all of the following:

- prescribed by a Physician or nurse practitioner for the treatment of phenylketonuria (PKU) and
- is consistent with the recommendations and best practices of qualified health professionals with expertise in the treatment and care of phenylketonuria (PKU) and
- is used in place of normal food products, such as grocery store foods, used by the general population.

Note: It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving.

INFUSION THERAPY/RADIATION THERAPY/CHEMOTHERAPY

If services are performed in the home, those services must be billed by and performed by a provider licensed by state and local laws.

A **Course of Therapy** is defined as Physician prescribed Infusion Therapy for a period of ninety (90) days or less.

Covered Services include:

- Drugs and other substances used in Infusion Therapy.
- Professional services to order, prepare, dispense, deliver, administer, train or monitor, including clinical Pharmacy support and any Drugs or other substances used in a Course of Therapy.
- All necessary durable, reusable supplies and durable medical equipment including, but not limited to, pump, pole and electric monitor.
- Blood transfusions, including blood processing and the cost of un-replaced blood and blood products.

Infusion Therapy benefits will not be provided for:

- Compounding fees such charges for mixing or diluting Drugs, medicines or solutions or incidental supplies including disposable items such as cotton swabs, tubing, syringes and needles for Drugs, adhesive bandages and intravenous starter kits.
- Drugs and medicines not requiring a Prescription.

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- Drugs labeled "Caution, limited by federal law to investigational use" or Drugs prescribed for experimental use.
- Drugs or other substances obtained outside the United States.
- Non-FDA approved homeopathic medications or other herbal medications.
- Charges by a Non-Participating Provider exceeding the Average Wholesale Price of a Drug as determined by the manufacturer. The Average Wholesale Price includes the preparation of the finished product.

Note: Medical Supplies and Equipment used in Infusion Therapy will not be reimbursed under any other benefit of this Policy.

Tier 3 Specialty Drugs. You can only have your prescription for a specialty drug filled through the Specialty Pharmacy Program unless you qualify for an exception. The Anthem Blue Cross Life and Health – Specialty Preferred Provider only fills specialty pharmacy drug prescriptions. The Specialty Preferred Provider will deliver up to a 30-day supply of your medication to you by mail or common carrier (you cannot pick up your medication at Anthem Blue Cross Life and Health). If your physician orders the specialty pharmacy drug to be administered in their office, only the medication needed for the visit will be delivered.

Non-duplication of benefits applies to specialty pharmacy drugs under this plan. When benefits are provided for specialty pharmacy drugs under the plan's medical benefits, they will not be provided for under YOUR PRESCRIPTION DRUG BENEFITS, if included. Conversely, if benefits are provided for specialty pharmacy drugs under YOUR PRESCRIPTION DRUG BENEFITS, if included, they will not be provided for under the plan's medical benefits.

To obtain a specialty pharmacy drug for home use, you must have a prescription for the drug that states the drug name, dosage, directions for use, quantity, the physician's name and phone number, the patient's name and address, that is signed by a physician. Your physician will be responsible for ordering the specialty pharmacy drug for administration in their office.

You or your physician may order your specialty pharmacy drug from the Specialty Preferred Provider by calling 1-800-870-6419. When you or your physician call Anthem Blue Cross Life and Health Insurance Company – Specialty Pharmacy Program, a Dedicated Care Coordinator will guide you or your physician through the process up to and including actual delivery of your specialty pharmacy drug to you or your physician. (If you order your specialty pharmacy drug by telephone, you will need to use a credit card or debit card to pay for it.) If you order a specialty pharmacy drug for home use, you may also submit your specialty pharmacy drug prescription with the appropriate payment for the amount of the purchase (you can pay by check, money order, credit card or debit card), and a properly completed order form to Anthem Blue Cross Life and Health – Specialty Pharmacy Program at the address shown below. Once you have met your deductible, if any, you will only have to pay the cost of your Copayment, if any. If your physician orders the specialty pharmacy drug for administration in their office, you will be responsible for any applicable Copayments.

If you order a specialty pharmacy drug for home use, the first time you get a prescription for a specialty pharmacy drug you must complete an Intake Referral Form. The Intake Referral Form is completed by telephone by calling 1-800-870-6419. You need only enclose the prescription or refill notice, and the appropriate payment for any subsequent specialty pharmacy drug prescriptions, or call the toll-free number, 1-800-870-6419. Copayments can be made by check, money order, credit card or debit card.

You or your physician may obtain a list of specialty pharmacy drugs available through the Specialty Pharmacy Program or order forms by contacting Member Services at the number shown below or online at www.anthem.com/ca.

Anthem Blue Cross Life and Health Insurance Company – Specialty Pharmacy Program

2825 Perimeter Road
Mail Stop – INRX01 A700
Indianapolis, IN 46241
Phone: (800) 870-6419
Fax: (800) 824-2642

Prior Authorization. Certain specialty pharmacy drugs require written prior authorization of benefits in order for you to receive them. Prior authorization criteria will be based on medical policy and the pharmacy and therapeutics established guidelines. You may need to try a drug other than the one originally prescribed if we determine that it should be clinically effective for you. However, if we determine through prior authorization that the drug originally prescribed is medically necessary, you will be provided the drug originally requested. (If, when you first become a member, you are already being treated for a medical condition by a drug that has been appropriately prescribed and is considered safe and effective for your medical condition, we will not require you to try a drug other than the one you are currently taking.) If approved, specialty pharmacy drugs requiring prior authorization for benefits will be provided to you after you make the required Copayment.

In order for you to get a specialty pharmacy drug that requires prior authorization, your physician must make a request to us for you to get it. The request may be made either by telephone or facsimile to us. At the time the request is initiated, specific clinical information will be requested from your physician based on Anthem Blue Cross' medical policy and/or clinical guidelines, based specifically on your diagnosis and/or the physician's statement in the request or clinical rationale for the specialty pharmacy drug.

If the request is for urgently needed drugs, after we get the request:

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

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

- Based on your medical condition, as medically necessary, we will review it and decide if we will approve benefits within 5-business days. We will tell you and your physician what we have decided in writing - by fax to your doctor, and by mail, to you.
- If more information is needed to make a decision, we will tell your physician in writing within 5-business days after we get the request what information is missing and why we cannot make a decision. If, for reasons beyond our control, we cannot tell your physician what information is missing within 5-business days, we will tell your physician that there is a problem as soon as we know that we cannot respond within 5-business days. In any event, we will tell you and your physician that there is a problem by telephone, and in writing by facsimile, to your physician, and in writing to you by mail.
- As soon as we can, based on your medical condition, as medically necessary, within 5-business days after we have all the information we need to decide if we will approve benefits, we will tell you and your physician what we have decided in writing - by fax to your physician and by mail to you.
  While we are reviewing the request for a specialty pharmacy drug, a 72-hour emergency supply of medication may be dispensed to you if your physician determines that it is appropriate and medically necessary. You may have to pay the applicable Copayment, if any, shown in the part entitled BENEFIT COPAYMENT/COINSURANCE LIST for the 72-hour supply of your drug. If we approve the request for the specialty pharmacy drug after you have received a 72-hour supply, you will receive the remainder of the 30-day supply of the drug after payment of any applicable additional Copayment that could apply.

If you have any questions regarding whether a specialty pharmacy drug requires prior authorization, please call 1-800-700-2533.

Questions? Visit www.MediCoverage.com or call (800) 930-7956

If we deny a request for prior authorization of a specialty pharmacy drug, you or your prescribing physician may appeal our decision by calling us at 1-800-700-2533. 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.

Exceptions to specialty pharmacy program. This program does not apply to:

a. The first month supply of a Specialty pharmacy drug which is available through a participating retail pharmacy;
b. Drugs, which due to medically necessity, must be obtained immediately; or
c. A member who is unable to pay for delivery of their medication (i.e., no credit card).

How to obtain an exception to the specialty pharmacy program. If you believe that you should not be required to get your medication through the specialty pharmacy program, for any of the reasons listed above, you must complete an Exception to Specialty Drug Program form to request an exception and send it to us. The form can be faxed or mailed to us. If you need a copy of the form, you may call us at 1-800-700-2533 to request one. You can also get the form on-line at www.anthem.com/ca. If we have given you an exception, it will be in writing and will be good for twelve months from the time it is given. After twelve months, if you believe that you should still not be required to get your medication through the specialty pharmacy program, you must again request an exception. If we deny your request for an exception, it will be in writing and will tell you why we did not approve the exception.

Urgent or emergency need of a specialty pharmacy drug subject to the specialty pharmacy program. If you are out of a specialty pharmacy drug which must be obtained through the specialty pharmacy program, we will authorize an override of the specialty pharmacy program requirement for 72-hours, or until the next business day following a holiday or weekend, to allow you to get an emergency supply of medication if your doctor decides that it is appropriate and medically necessary. You may have to pay the applicable Copayment shown in the part entitled BENEFIT COPAYMENT/COINSURANCE LIST for the 72-hour supply of your drug.

If you order your specialty pharmacy drug through the specialty pharmacy program and it does not arrive, if your physician decides that it is medically necessary for you to have the drug immediately, we will authorize an override of the specialty pharmacy program requirement for 30-day supply or less, to allow you to get an emergency supply of medication from a participating pharmacy near you. A Dedicated Care Coordinator from the specialty pharmacy program will coordinate the exception and you will not be required to make an additional Copayment.

UNLESS YOU QUALIFY FOR AN EXCEPTION, IF YOU DON'T GET YOUR SPECIALTY PHARMACY DRUG THROUGH THE SPECIALTY PHARMACY PROGRAM, YOU WILL NOT RECEIVE ANY BENEFITS UNDER THIS PLAN FOR THEM.

CANCER CLINICAL TRIALS

Coverage is provided, as described below, for Insureds diagnosed with cancer and accepted into a Phase I, Phase II, Phase III or Phase IV clinical trial for cancer if the treating Physician, who is providing the health care services, recommends participation in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the Insured. The clinical trial must have a therapeutic intent and not just be to test toxicity. Benefits are paid on the same basis as any other medical condition and are subject to any applicable Copayments, Coinsurance and Deductibles.

The treatment provided in a clinical trial must either:

- Involve a drug that is exempt under federal regulations from a new drug application or
- Be approved by one of the following:
  - One of the National Institutes of Health
  - The federal Food and Drug Administration, in the form of an investigational new drug application
  - The United States Department of Defense
  - The United States Veterans Administration

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Covered Services

- Costs associated with the provision of health care services, including drugs, items, devices and services which would otherwise be covered under this plan.
- Health care services typically provided absent a clinical trial.
- Health care services required solely for the provision of the investigational drug, item, device or service.
- Health care services required for the clinically appropriate monitoring of the investigational item or service.
- Health care services provided for the prevention of complications arising from the provision of the investigational drug, item, device or service.
- Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device or service, including the diagnosis or treatment of the complications.

Covered Services will not include the following:

- Drugs or devices that have not been approved by the federal Food and Drug Administration and that are associated with the clinical trial.
- Services other than health care services, such as travel, housing, companion expenses and other non-clinical expenses that an Insured may require as a result of the treatment being provided for purposes of the clinical trial.
- Any item or services that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.
- Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under this Policy.
- Health care services customarily provided by the research sponsors free of charge to Insureds enrolled in the trial.

CENTERS OF MEDICAL EXCELLENCE (CME) FOR TRANSPLANTS AND BARIATRIC SURGERY (requires Preservice Review)

Anthem is providing access to the following separate Centers of Medical Excellence (CME) networks. The facilities included in each of these CME network s are selected to provide the following specified medical services:

- **Transplant Facilities.** Transplant facilities have bee organized to provide services for the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. **These procedures are covered only when performed at a CME.**
- **Bariatric Facilities.** Hospital facilities have been organized to provide services for bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss programs. **These procedures are covered only when performed at a CME.**

Note: A Participating Provider in the Prudent Buyer Plan Network is not necessarily a CME facility. Information on CME facilities can be obtained by calling 1-800-333-0912.

Bariatric Surgery (requires Preservice Review): Services and supplies will be provided in connection with Medically Necessary surgery for weight loss, only for morbid obesity and only when performed at a CME facility. You or your Physician must obtain Preservice Review for all bariatric surgical procedures. **Preservice Review can be obtained by calling toll free 1-800-274-7767. When you or your Physician calls for the required Preservice Review, we will advise you that such services must be performed at an Anthem CME.**

Note: Charges for these bariatric surgical procedures and related services are covered only when the bariatric surgical procedures and related services are approved by Anthem and performed at an Anthem CME facility.

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Bariatric Travel Expense. The following travel expense benefits will be provided in connection with a covered bariatric surgical procedure only when the Insured's home is fifty (50) miles or more from the nearest bariatric CME. All travel expenses must be approved by Anthem in advance.

- Transportation for the Insured to and from the CME up to **$130** per trip for a maximum of three (3) trips (one pre-surgical visit, the initial surgery and one follow-up visit).
- Transportation for one companion to and from the CME up to **$130** per trip for a maximum of two (2) trips (the initial surgery and one follow-up visit).
- Hotel accommodations for the Insured and one companion not to exceed **$100** per day for the pre-surgical visit and the follow-up visit, up to two (2) days per trip or as Medically Necessary. Limited to one room, double occupancy.
- Hotel accommodations for one companion not to exceed **$100** per day for the duration of the Insured's initial surgery stay, up to four (4) days. Limited to one room, double occupancy.
- Other reasonable expenses not to exceed **$25** per day, up to four (4) days per trip. Meals, tobacco, alcohol and drug expenses are excluded from coverage.

Customer service will confirm if the bariatric travel benefit is provided in connection with access to the selected bariatric CME. Details regarding reimbursement can be obtained by calling the customer service toll free at 1-800-333-0912. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

Transplants (requires Preservice Review) You or your Physician must obtain Preservice Review for all services including, but not limited to preoperative tests and postoperative care related to the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, bone marrow/stem cell and similar procedures. Specified transplants must be performed at a Center of Medical excellence (CME). Charges for services provided for or in connection with a specified transplant performed at a facility other than a CME will not be considered covered expense. **Preservice Review can be obtained by calling toll free 1-888-613-1130.**

Note: Charges for these specified transplants and related services are covered only when the transplant and related services are performed at an Anthem CME.

The following **services and supplies** are provided to you in connection with a covered non-investigative organ or tissue transplant if you are:

- the recipient or
- the donor.

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

Transplant Travel Expense. Certain travel expenses incurred by the Insured, up to a maximum $10,000 Anthem payment per transplant will be covered for the recipient or donor in connection with an approved, specified transplant (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures) performed at a designated CME qualified to provide services, provided the expenses are authorized by us in advance. All travel expenses are limited up to the maximum set forth in Internal Revenue Code at the time services are rendered and must be approved by Anthem in advance. Travel expenses include the following for the recipient (and one companion) or the donor:

- Ground transportation to and from the CME when the designated CME is 75 miles or more from the recipient's or donor's place of residence.
- Coach airfare to and from the CME when the designated CME is 300 miles or more from the recipient's or donor's place of residence.
- Lodging, limited to one room, double occupancy.

Meals, tobacco, alcohol, drug expenses and other non-food items are excluded.

Note: When the member recipient is under 18 years of age, this benefit will apply to the recipient and two companions or caregivers.

When you request reimbursement of covered travel expenses, you must submit a completed travel reimbursement form and itemized, legible copies of all applicable receipts. Credit card slips are not acceptable. Covered travel expenses are not subject to Deductibles or Copayments/Coinsurance. Please call customer service at 1-800-333-0912 for further information and/or to obtain the travel reimbursement form.

Travel expenses that are not covered include, but are not limited to: meals, alcohol, tobacco, or any other non-food items; child care; mileage within the city where the CME is located, rental cars, buses, taxis or shuttle services, except as specifically approved by us; frequent flyer miles, coupons, vouchers or travel tickets; prepayments or deposits; services for a condition that is not directly related, or a direct result, of the transplant; telephone calls; laundry; postage; entertainment; travel expenses for a donor companion/caregiver; or return visits for the donor for a treatment of a condition found during the evaluation.

Unrelated Donor Searches

- For all charges for unrelated donor searches for covered Bone marrow/stem cell transplants — $30,000 per transplant

Each Year thousands of people's lives are saved by organ transplants. The success rate of transplants is rising but more donations are needed. This is a unique opportunity to give the Gift of Life. Anyone who is 18 years of age or older and of sound mind may become a donor when he or she dies. Minors may become donors with a parent or guardian's consent. Organ and tissue donation may be used for transplants and research. Today, it is possible to transplant about 25 different organs and tissues. Your decision to become a donor could someday save or prolong the life of someone you know, even a close friend or family member. If you decide to become a donor, talk it over with your family. Let your Physician know your intentions as well. Obtain a donor card from the Department of Motor Vehicles. Be sure to sign the donor card and keep it with your driver's license or identification card.

WIGS

We will pay up to $400 per Insured per calendar year with a Physician's prescription.

HOME HEALTH CARE

Home Health Care providers are included in our Participating Provider Network. The following services of a Home Health Agency or Visiting Nurse Association are provided up to sixty (60) visits per Year for Participating and Non-Participating Providers combined. A visit is defined as four (4) hours or less of service provided by one of the providers listed below.

- A registered nurse
- A licensed therapist for Physical Therapy, Occupational Therapy, speech or respiratory therapy
- A medical social service worker
- A health aide who is employed by, or under arrangement with, a Home Health Agency or Visiting Nurse Association. A health aid is covered only if you are also receiving the services of a registered nurse or licensed therapist employed by the same organization and the registered nurse is supervising the services.
- Necessary medical supplies provided by the Home Health Agency or Visiting Nurse Association.

Benefits are provided when you are confined at home under the active supervision of your Physician. The Physician must be treating the illness or injury necessitating the Home Health Care and renew the order for these services at least once every thirty (30) days. Providers in California must be a California licensed Home Health Agency or Visiting Nurse Association.

Note: We will not cover personal comfort items under this Home Health Care benefit. All Home Health services and supplies related to Infusion Therapy are included in the Infusion Therapy benefit section.

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HOSPICE

To be eligible for maximum benefits you must be suffering from a terminal illness for which the prognosis of life expectancy is six (6) months or less as certified by your Physician.

Your Physician must consent to your care by the Hospice and must be consulted in the development of your treatment plan. However, Preservice Review is **not** required.

To be eligible for this benefit, the provider must be appropriately licensed according to state and local laws to provide skilled nursing and other services to support and care for persons experiencing the final phases of terminal Illness. The provider must also be approved as a Hospice provider under Medicare and the Joint Commission on Accreditation of Healthcare Organizations or by the appropriate agency in the state of California.

Benefits for Home Health and/or Skilled Nursing Facility services cannot be used at the same time you are receiving Hospice benefits. Medical supplies and equipment used during Hospice care will not be reimbursed under any other benefit of this Policy.

Benefits for Hospice services are limited to a lifetime maximum of $10,000 per Insured Person for Participating and Non-Participating Providers combined.

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EXCLUSIONS AND LIMITATIONS

We will not furnish benefits for:

Acupuncture/Acupressure: Care or treatment provided through the use of acupuncture or acupressure.

Chiropractic Care: Care or treatment provided through the use of manual mechanical interventions.

Commercial Weight Loss: Weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Policy. This exclusion includes, but is not limited to commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to Medically Necessary treatments for morbid obesity.

Cosmetic Surgery or other services that are performed to alter or reshape normal structures of the body in order to improve appearance.

Custodial Care, domiciliary or rest cures for which facilities and/or services of a general acute Hospital are not medically required. Custodial Care is care that does not require the regular services of trained medical or health professionals, such as but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets and supervision of medications which are ordinarily self-administered.

Dental Services: Dentures, bridges, crowns, caps, clasps, habit appliances, partials or other Dental Prostheses, Dental Services, extraction of teeth or treatment to the teeth or gums, except as specifically stated for Dental care under the benefit sections of this Policy. **Dental Implants** (materials implanted into or on bone or soft tissue) or any associated procedure as part of the implantation or removal of implants. **Orthodontic Services**, braces, other orthodontic appliances, orthodontic services.

Diagnostic Admissions: 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.

Durable Medical Equipment including but not limited to orthopedic shoes or shoe inserts, air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators, supplies for comfort, hygiene or beautification, disposable sheaths and supplies, correction appliances or support appliances and supplies such as stockings.

Educational, Vocational or Training Services and Nutritional Counseling, except as specifically provided or arranged by us under the Diabetes Outpatient Self-Management Training Program provision in the Part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED.

Excess Amounts: Any amounts in excess of the maximum amounts stated in the benefit sections of this Policy.

Experimental or Investigative: Medical, surgical and/or other procedures, services, products, drugs or devices (including implants) except as specifically stated under CANCER CLINICAL TRIALS in the entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED, which are either:

- experimental or investigational or which are not recognized in accord with generally accepted professional medical standards as being safe and effective or use is in question or
- outmoded or not efficacious, such as those defined by the federal Medicare programs or drugs or devices that are not approved by the Food and Drug Administration or
- services associated with either the first or second bullet points above.

Food and/or Dietary Supplements: No benefits are provided for nutritional and/or dietary supplements, except as provided in this Policy or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.

Government Services: Any services you actually received that were provided by a local, state or federal government agency, or by a public school system or school district, except when payment under this Agreement is expressly required by federal or state law. Anthem will not cover payment for these services that you have actually received if you are not required to pay for them or they are given to you for free. Veterans' Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.

Health Clubs: Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

Hearing Aids: Hearing aids and routine hearing tests.

Infertility Services: All services related to the evaluation or treatment of Infertility, including all tests, consultations, medications, surgical, medical or laboratory procedures.

Maternity/Pregnancy Care: No benefits are provided for pregnancy, maternity care or abortions.

Mental or Nervous Disorders and Substance Abuse: Treatment of Mental or Nervous Disorders and Substance Abuse (including nicotine use) or psychological testing except as specifically stated under the benefit sections of this Policy. **However, medical services provided to treat medical conditions that are caused by behavior of the Insured that may be associated with mental or nervous conditions, for example self-inflicted injuries, and treatment for Severe Mental Illnesses and Serious Emotional Disturbances of a Child are not subject to these limitations.**

Non-Contracting Hospital: No benefits are provided for care or treatment furnished in a Non-Contracting Hospital except as described in the section entitled SPECIAL CIRCUMSTANCES under the Part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED, in this Policy. This exclusion applies **only** in California.

Non-Duplication of Medicare: We will not provide benefits that duplicate any benefits you would be entitled to receive under Medicare. This exclusion applies to all Parts of Medicare in which you can enroll without paying additional premium. However, if you have to pay an addition premium to enroll in Part A, B, C or D of Medicare this exclusion will apply to that particular Part of Medicare for which you must pay only if you have enrolled in that Part.

If you have Medicare, your Medicare coverage will not affect the services covered under this Agreement, except as follows:

1. Your Medicare coverage will be applied first (primary) to any services covered by both Medicare and under this Agreement.
2. If you receive a service that is covered both by Medicare and under this agreement, our coverage will apply only to the Medicare Deductibles, Coinsurance and other charges for Covered Services that you must pay over and above what's payable by your Medicare coverage.
3. For a particular claim, the combination of Medicare benefits and the benefits we will provide under this Agreement for that claim will not be more than the allowed Covered Expense you have incurred for the Covered Services you received.

We will apply toward your Deductible any expenses paid by Medicare for services covered under this Policy except for expenses paid under Medicare Part D.

Non-Licensed Providers: Treatment or services provided by a non-licensed health care provider and treatment or services for which a health care provider license is not required, This includes treatment for services provided by a non-licensed provider under the supervision of a licensed Physician, except as specifically provided or arranged by us.

Not Covered: Services received before your Effective Date or during an inpatient stay that began before your Effective Date. Services received after your coverage ends.

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Not Medically Necessary: Any services or supplies that are:

- not Medically Necessary,
- not specifically described in this Policy and
- part of a treatment plan for non-Covered Services or which are required to treat medical conditions which are a direct and predictable complication or consequence of non-Covered Services.

Orthopedic Shoes, except when joined to braces or shoe inserts.

Outdoor Treatment Programs

Outpatient Prescription Drugs: No benefits are provided for prescription or non-prescription drugs on an outpatient basis except as specifically stated in the sections, TREATMENT FOR DIABETES or HOSPITAL, under the Part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED.

Personal Comfort Items: Items which are furnished primarily for your comfort or convenience. Air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators and supplies for comfort, hygiene or beautification.

Pre-existing Conditions: No payment will be made for services or supplies for the treatment of a Pre-existing Condition during a period of six (6) months following your Effective Date. This limitation does not apply to a child born to or newly adopted by an enrolled Policyholder, enrolled spouse or enrolled Domestic Partner. However, we may apply Creditable Coverage to satisfy or partially satisfy the six (6) month period if the length of time between the ending date of your prior coverage and your Effective Date under this Policy did not exceed sixty-two (62) days.

Private Duty Nursing: Inpatient or outpatient services of a private duty nurse unless we determine in advance that such services are Medically Necessary.

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 Part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED.

Services For Which You Are Not Legally Obligated To Pay or for which no charge would be made if you did not have a health plan or insurance coverage, except services received at a non-governmental charitable research Hospital.

Services from Relatives: Professional services received from a person who lives in the Insured's home or who is related to the Insured by blood, marriage or adoption.

Services that Do Not Require Licensure: Services or the supervision of services that are not required to be rendered by a licensed Provider, except as specifically provided or arranged by us.

Sex Change: Procedures or treatments to change characteristics of the body to those of the opposite sex. This includes any medical, surgical or psychiatric treatment or study related to sex change.

Supervision of Non-Licensed Provider: Services or the supervision of a non-licensed Provider.

Surrogacy: No benefits are provided for any services or supplies provided to a person not covered under the Policy in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Telephone and Facsimile Machine Consultations

Unlisted Services: Services not specifically listed in this Policy as Covered Services.

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Vision Care: Optometric services, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams and routine eye refractions, except as specifically stated under the benefit sections of this Policy. **Certain Eye Surgeries** or any eye surgery solely for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia), astigmatism and/or farsightedness (presbyopia).

Weight Reduction: Services primarily for weight reduction or treatment of obesity or any care which involves weight reduction as the main method of treatment except Medically Necessary treatment of morbid obesity (which requires Preservice Review), including bariatric surgery as stated under the Part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED, in the CENTERS OF MEDICAL EXCELLENCE (CME) FOR TRANSPLANTS AND BARIATRIC SURGERY section.

Workers' Compensation: Any condition for which benefits are recovered or can be recovered either by any workers' compensation law or similar law even if you do not claim those benefits. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to Workers' Compensation law or similar law, we will provide the benefits of this plan for such conditions, subject to our right to a lien or other recovery under section 4903 of the California Labor Code or other applicable law.

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YOUR PRESCRIPTION DRUG BENEFITS

This section describes covered services and exclusions for outpatient pharmacy prescription drugs and medications when obtained through a retail pharmacy, mail service pharmacy or through the Specialty Pharmacy Program.

We will provide outpatient Prescription Drug benefits in accordance with this Part, subject to all other terms, conditions, limitations and exclusions of the Policy.

Coverage is limited to prescription drugs that are listed on Anthem's Plan Formulary (plan formulary) which contains a limited number of prescription drugs. Generally the plan formulary will include most generic drugs, but typically no more than one or two brand name prescription drugs in a therapeutic class. Certain therapeutic classes may have no brand name prescription drugs on the plan formulary because of the number of generic drugs available in those therapeutic classes. The plan formulary is subject to periodic review and amendment. Inclusion of a drug or related item on the plan formulary is not a guarantee of coverage. A list of the prescription drugs that are covered on the plan formulary is available from Customer Service or may be found on Anthem's website www.anthem.com.

Certain Drugs are dispensed in specific amounts based on our analysis of prescription drug dispensing trends and the Food and Drug Administration dosing recommendations. But, Medically Necessary Drugs will be provided based on our review consistent with professional practice and Food and Drug Administration guidelines.

Some medications may require Prior Authorization from Anthem. Please call our Pharmacy Benefit Manager toll free at 1-800-700-2533 for a list of these Drugs. You may also refer to the Prior Authorization section in this part for more information.

For an explanation of your Prescription Drug coverage when you are enrolled in Medicare Part D, see the section entitled Non-Duplication of Medicare under the part entitled EXCLUSIONS AND LIMITATIONS.

The Participating outpatient retail pharmacy and Participating mail order benefits available under this certificate for non-specialty medications on Anthem's Plan Formulary are managed by Anthem's pharmacy benefit manager, which is a pharmacy benefits management company. The Participating outpatient specialty pharmacy benefits available under this certificate are provided by Anthem's specialty pharmacy benefit manager.

As part of its services to Anthem, the pharmacy benefit manager offers a nationwide network of retail pharmacies, a mail service pharmacy, and clinical services. As part of its services to Anthem, the specialty pharmacy benefit manager is a full service Specialty pharmacy which ships medications to the member by overnight mail or common carrier for up to a 30-day supply (the member cannot pick up their medication from the specialty pharmacy benefit manager). Anthem's Specialty pharmacy benefit manager is not a retail pharmacy or a mail service pharmacy.

The member copayment and/or coinsurance amount depends on whether the drug a member receives is a Tier 1, Tier 2 or Tier 3 drug and whether it is obtained from a Participating or Non-Participating retail pharmacy, a Participating or Non-Participating mail service pharmacy or a Participating or Non-Participating Specialty pharmacy. See the sections entitled When You Go To A Participating Pharmacy, When You Go To A Non-Participating Pharmacy and When You Order By Mail to determine the associated copayment and/or coinsurance for each Tier.

For certain prescription drugs, the prescribing physician may be asked to provide additional information before Anthem will determine medical necessity. Anthem may, at its sole discretion, establish quantity limits for specific prescription drugs. Anthem retains the right at it's discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example by mouth, injections, topical, or inhaled) and may cover one form of administration and exclude or place other forms of administration on another tier. The pharmacy benefit manager in consultation with Anthem also promotes and enforces the appropriate use of medications by reviewing for improper dosage, potential drug to drug interactions or drug-disease state interactions.

DEFINITIONS

Anthem's Plan Formulary is a generic-based drug list that includes select brand-name alternatives in many therapeutic classes and is subject to change. A drug can move on or off the Plan Formulary or can move from Tier to Tier within the Plan Formulary.

Average Wholesale Price (AWP) is the average of the list prices that the manufacturers producing the Drug suggest that a wholesaler charge a Pharmacy for the Drug.

Drugs mean Prescription Drugs approved by the state of California or the Food and Drug Administration (FDA) for general use by the public. For purposes of this benefit, Insulin will be deemed a Prescription Drug.

Formulary is a list of Drugs which Anthem has determined to be safe and cost effective based on available medical literature.

Maintenance Prescription Drugs are Prescription Drugs that are prescribed for chronic, long-term conditions and are taken for an extended period of time to treat a medical condition.

Negotiated Fee is the fee that has been negotiated with the Participating Pharmacy under a Participating Pharmacy agreement for covered Prescriptions. Participating Pharmacies have agreed to charge eligible Insureds no more than the Negotiated Fee for covered Prescriptions.

Non-Participating Pharmacy is a Pharmacy that does not have a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. In most instances, you will be responsible for a larger portion of your pharmaceutical bill when you go to a Non-Participating Pharmacy. Please see the section entitled THE RATE OF REIMBURSEMENT BY ANTHEM for information on the percentages payable at a Non-Participating Pharmacy.

Participating Pharmacy is a Pharmacy that has a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. Call your local Pharmacy or call the customer service at (800) 700-2533. Some Participating Pharmacies display an Anthem "Rx" decal so that you can easily identify them.

Pharmacy means a licensed retail Pharmacy.

Prescription means a written order issued by a Physician.

Self-Administered Injectable Drugs are injectable Drugs which are self-administered by the subcutaneous route (under the skin) by the patient or family member.

Specialty drugs are defined as high-cost, injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of their effect on the patient's drug therapy by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail Pharmacies.

Tier-1 drugs —- means a drug that has the lowest copayment and/or coinsurance. This tier will contain low cost or preferred medications. This tier may include generic drugs, single source brand drugs, or multi-source brand drugs.

Tier-2 drugs —- means a drug that has a higher copayment and/or coinsurance than those in tier 1. This tier will contain preferred medications that generally are moderate in cost. This tier may include generic, single source, and multi-source brand drugs.

Tier-3 drugs — means a drug that has a higher copayment and/or coinsurance than those on tier 2. Many drugs on this tier are "specialty" drugs used to treat complex, chronic conditions and may require special handling and/or management.

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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. Also, a Participating Pharmacist can help arrange prior authorization or dispense an emergency amount. If there are patterns of over utilization or misuse of Drugs, we will notify your personal Physician and your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

PRIOR AUTHORIZATION
Certain Drugs require written prior authorization for you to obtain benefits even if the prescribing doctor writes "do not substitute" or "dispense as written" on the Prescription. Prior authorization criteria will be based on medical policy, clinical guidelines and established pharmacy and therapeutic guidelines.

You may need to try a Drug other than the one originally prescribed if we determine that it should be clinically effective for you. However, if we determine through the prior authorization process that the Drug originally prescribed is Medically Necessary, you will be provided the Drug originally requested at the applicable Copayment. If approved, Drugs requiring prior authorization will be provided to you after you make the required Copayment. (If, when you first become a Member, you are already being treated for a medical condition with a Drug that has been appropriately prescribed and is considered safe and effective for your medical condition and you underwent a prior authorization process under a prior plan which required you to take different Drugs, we will not require you to try a Drug other than the one you are currently taking.)

In order for you to obtain a Drug that requires prior authorization, your Physician must make a written request to us using a Drug Prior Authorization of Benefits form. The form can be faxed or mailed to us. If your Physician needs a copy of the form, he or she may call us at 1-888-831-2242 to request one. The form is also available online at www.anthem.com/ca.

If the request is for urgently needed Drugs, after we get the Drug Prior Authorization form:

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

If the request is not for urgently needed Drugs, after we get the Drug Prior Authorization form:

- Based on your medical condition, as Medically Necessary, we will review it and decide if we will approve benefits within five (5) business days. We will tell you and your Physician what we have decided in writing – by fax to your doctor and by mail to you.
- If more information is needed to make a decision, we will tell your Physician in writing within five (5) business days after we get the request what information is missing and why we cannot make a decision. If, for reasons beyond our control, we cannot tell your Physician what information is missing within five (5) business days, we will tell your Physician that there is a problem as soon as we know that we cannot respond within five (5) business days. In any event, we will tell you and your Physician that there is a problem in writing by fax, and when appropriate, by telephone to your Physician, and in writing to you by mail.
- As soon as we can, based on your medical condition, as Medically Necessary, within five (5) business days after we have all the information we need to decide if we will approve benefits, we will tell you and your Physician what we have decided in writing – by fax to your Physician and by mail to you.

While we are reviewing the Drug Prior Authorization form, a 72-hour emergency supply of medication or the smallest packaged quantity, whichever is greater, may be dispensed to you if your Physician or pharmacist determines that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment or coinsurance shown in this part for the 72-hour supply of your Drug. If we approved the request for the Drug after you have received a 72-hour supply, you will receive the remainder of the 30-day supply of the Drug. If you have paid the applicable Copayment for the 72-hour supply, you will have no additional Copayment. If not, you will be responsible to pay the applicable Copayment for the remainder of the 30-day supply.

If you have any questions whether a Drug is on our preferred Drug list or requires prior authorization, please call 1-800-700-2533.

If prior authorization of a Drug is not approved, you or your prescribing Physician may appeal our decision by calling us at 1-800-700-2533. 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 part entitled GRIEVANCE PROCEDURES.

Revoking or modifying a prior authorization

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

- Your coverage under this plan ends;
- You reach a benefit maximum that applies to prescription drugs, if the plan includes such a maximum;
- Your prescription drug benefits under the plan change so that prescription drugs are no longer covered or are covered in a different way.

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

TIER 2 AND TIER 3 PRESCRIPTION DRUG DEDUCTIBLE

Each Insured must meet a Tier 2 and Tier 3 Prescription Drug Deductible amount of $2,000 each Year. This Deductible is separate from the annual Deductibles for medical benefits and does not accumulate towards satisfying the medical Participating or Non Participating Provider Deductibles. This Tier 2 and Tier 3 Prescription Drug Deductible applies to Tier 2 and Tier 3 Prescription Drugs purchased at Participating Pharmacies and through the Mail Order Prescription Drug Program.

TIER 3 PRESCRIPTION DRUG OUT OF POCKET MAXIMUM

There is a $2,500 Tier 3 Prescription Drug Out of Pocket Maximum for Tier 3 Prescription Drugs per Insured per Year purchased from the Participating Pharmacies and through the mail order Prescription Drug program or through our Specialty Preferred Provider. Once the $2,500 Tier 3 Prescription Drug Out of Pocket Maximum is met, no further Tier 3 Coinsurance will be required for prescription drugs purchased from the Participating Pharmacies and through the mail order Prescription Drug program or through our Specialty Preferred Provider for the remainder of that Year. Copayments for Tier 1 and Tier 2 drugs and the Tier 2 and Tier 3 Drug Deductible **will not** accumulate towards the Tier 3 Prescription Drug Out of Pocket Maximum and will continue to be required even after the Tier 3 Prescription Drug Out of Pocket Maximum has been reached.

WHAT IS COVERED

Outpatient pharmacy benefits received from a pharmacy or mail service pharmacy or through our Specialty Preferred Provider are limited to:

- Outpatient Drugs and medications on the Anthem Plan Formulary which federal and/or state of California law restrict to sale by Prescription only.
- Injectable Insulin and Insulin syringes prescribed and dispensed for use with Insulin. Lancets and test strips for use in monitoring diabetes.
- Oral contraceptive Drugs prescribed for birth control. If your Physician determines that oral contraceptive Drugs are not medically appropriate, coverage for another FDA approved Prescription contraceptive method will be provided.
- Phenylketonuria (PKU) formulas and food products. These formulas are subject to the Copayment for Tier 2 Drugs and the Tier 2 and Tier 3 Prescription Drug Deductible.
- Certain supplies, equipment and appliances (such as those for diabetes and asthma). You may contact Anthem to determine approved supplies covered through a pharmacy.

Questions? Visit www.MediCoverage.com or call (800) 930-7956

Questions? Visit www.MediCoverage.com or call (800) 930-7956

CONDITIONS OF SERVICE

The Drug or medicine must:

- Be prescribed in writing by a Physician and be dispensed by a licensed retail pharmacist or by mail through the Mail Order Prescription Drug Program, or through our Specialty Pharmacy Program within one (1) year of being prescribed, subject to federal or state laws.
- Be approved for use by the Food and Drug Administration (FDA).
- Be for the direct care and treatment of the Insured's illness, injury or condition. Dietary supplements, health aids or Drugs for cosmetic purposes are not included.
- Be purchased from a licensed retail Pharmacy, dispensed by a Physician or ordered by mail through the mail order program or through our Specialty Pharmacy Program.
- Not be used while the Insured is an inpatient in any facility.
- Be dispensed by the Specialty Preferred Provider if it is a Specialty drug. See the section Specialty Pharmacy Program in this part for information on how to obtain Specialty drugs through The Specialty Preferred Provider.

Note: You will have to pay the full cost of any specialty drugs you get from a retail pharmacy that you should have obtained through the Specialty Preferred Provider.

When You Go To A Participating Pharmacy

When you present your identification card at a Participating Pharmacy, you will pay the following Copayment/Coinsurance for each covered Prescription and/or refill:

For Prescription Drugs on the Anthem Plan Formulary:
These benefits apply only to Prescription Drugs listed on the Plan Formulary. Drugs not shown on the Plan Formulary are not covered and you will be responsible for the full cost of the drug that is not on the Plan Formulary.

Participating Retail Pharmacy:

- **Tier 1 Prescription Drugs:** $15 Copayment for each Prescription and/or refill for a maximum thirty (30) day supply.
- **Tier 2 Prescription Drugs:** 100% of the Negotiated Fee per Insured per Year until the $2,000 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied. After the $2,000 per Insured Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied:
  - $35 Copayment for each prescription and/or refill for a maximum thirty (30) day supply for the Tier 2 Drug if a Tier 1 equivalent is not available.
  - $35 Copayment **plus** the difference in cost, based on the Negotiated Fee when purchased at a Participating Pharmacy, between the Tier 2 Drug and the Tier 1 equivalent drug if a Tier 1 equivalent drug is available for each prescription and/or refill for a maximum thirty (30) day supply.
- **Tier 3 Prescription Drugs:** 100% of the Negotiated Fee per Insured per Year until the $2,000 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied. After the $2,000Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied:
  - 25% of the Negotiated Fee, for each prescription and/or refill for a maximum thirty (30) day supply.

Note: Unless an exception is made, after the first month supply of a Specialty Drug has been obtained through a retail Pharmacy, the Drug will then be available only through the Specialty Preferred Provider. Please see the Specialty Pharmacy Program section in this Part for further information.

When You Go To A Non-Participating Pharmacy
No benefits are provided and you will be responsible for the full cost of the drug if you obtain your drugs from a Non Participating Pharmacy.

Non-Formulary Prescription Drugs are not covered.

Note: Charges for Non-Formulary Prescription Drugs will not be applied towards the Tier 2 and Tier 3 Prescription Drug Deductible or the Tier 3 Prescription Drug Out of Pocket Maximum.

Drugs obtained from pharmacies outside the United States will not be covered unless such drugs are prescribed in connection with Emergency Care.

WHEN YOU ORDER BY MAIL

Your mail order Prescription Drug program is administered by Anthem Blue Cross Life and Health Pharmacy Plan under contract with Anthem. Your mail order Prescriptions are filled by an independent, licensed Pharmacy. Anthem does not dispense Drugs or fill Prescriptions.

Maintenance Drugs, an ongoing Prescription, can be purchased by mail, requiring the following Copayment to be submitted for each Prescription:

- **Tier 1 Prescription Drugs:** $15 Copayment for each Prescription and/or refill for each thirty (30) day supply or a $45 Copayment for up to ninety (90) day supply.
- **Tier 2 Prescription Drugs:** 100% of the Negotiated Fee per Insured per Year until the $2,000 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied. After the $2,000 per Insured Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied:
  - $35 Copayment for each Prescription and/or refill for each thirty (30) day supply or a $105 Copayment for up to a maximum ninety (90) day supply.
- **Tier 3 Prescription Drugs:** 100% of the Negotiated Fee per Insured per Year until the $2,000 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied. After the $2,000 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied:
  - 25% of the Negotiated Fee, for each prescription and/or refill for a maximum ninety (90) day supply.

Note: Specialty Drugs will only be available through our Specialty Preferred Provider. Please see the Specialty Pharmacy Program section in this Part for further information.

Helpful Tip: We suggest that you order your refill two weeks before you need it to avoid running out of your medication. For any questions concerning the mail order program, you can call customer service toll-free at **(800) 281-5524**.

Non-Formulary Prescription Drugs are not covered.

Note: Charges for Non-Formulary Prescription Drugs will not be applied towards the Tier 2 and Tier 3 Prescription Drug Deductible or the Tier 3 Prescription Drug Out of Pocket Maximum.

Drugs obtained from pharmacies outside the United States will not be covered unless such drugs are prescribed in connection with Emergency Care.

The Prescription must state the dosage and your name and address and must be signed by your Physician.

The first mail order Prescription you submit must include a completed patient profile form. This form will be sent to you upon becoming eligible for this program. Any subsequent mail order Prescriptions for that Insured need only the Prescription and Copayment to be enclosed.

You must authorize the pharmacist to release information needed in connection with the filling of a Prescription to the designated mail order Prescription Drug program.

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail order Prescription Drug program including, but not limited to, antibiotics, Drugs not on the Plan Formulary, injectables, including Self-Administered Injectables except Insulin. Please check with the mail order Prescription Drug program customer service department at (866) 274-6825 for the availability of the Drug or medication.

Questions? Visit www.MediCoverage.com or call (800) 930-7956

Specialty Pharmacy Program

Specialty drugs are high-cost, injectable, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Many Tier 3 drugs are Specialty medications that have special handling, storage and shipping requirements, such as temperature control. Specialty drugs may require nursing services or special programs to encourage patient compliance. Specialty Drugs are covered only when purchased from the Specialty Preferred Provider.

Non-duplication of benefits applies to Specialty Drugs under this plan. This means when benefits are provided for Specialty Drugs under the plan's Specialty Pharmacy Program benefits, they will not be provided under the part entitled WHAT IS COVERED. Conversely, if benefits are provided for Tier 3 specialty Drugs under WHAT IS COVERED, they will not be provided under the plan's Specialty Pharmacy Program benefits.

Certain Specialty Drugs require written prior authorization. (Please see the Prior Authorization section in this part for more information).

When You Order Your Prescription Through the Specialty Preferred Provider.
You can only have your Prescription for a Specialty Drug filled through the Anthem's Specialty Preferred Provider, unless you qualify for an exception (please see the Exceptions to the Specialty Pharmacy Program paragraph below). Specialty Drugs are limited to a 30-day supply per fill. The Specialty Preferred Provider will deliver your specialty Drugs to you by mail or common carrier for self administration in your home. You cannot pick up your medication at Anthem.

The Prescription for the Specialty Drug must state the Drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address and be signed by a Physician. You or your physician may order your specialty Drug from the Specialty Preferred Program by calling 1-800-870-6419. When you call the Specialty Preferred Provider, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your specialty drug to you. When you order your specialty drug by telephone, you will need to use a credit or debit card to pay for it. You may also submit your specialty drug prescription with the appropriate payment for the amount of the purchase and a properly completed order form to the Specialty Preferred Provider at the address shown below. Once you have met your deductible, if any, you will only have to pay the cost of your Copayment. When you order your specialty drug by mail, you will need to use a check, money order, credit or debit card to pay for it.

You or your physician may obtain a list of specialty drugs available through the Specialty Preferred Provider network by contacting Member Services by calling toll free 1-800-870-6419 or online at www.anthem.com/ca. You or your physician may also obtain order forms by contacting Member Services or by accessing our web site at **www.anthem.com/ca**.

Attn: Anthem Specialty Pharmacy Program
2825 Perimeter Road
Mail Stop – INRX01 A700
Indianapolis, IN 46241
Phone: (800) 870-6419
Fax: (800) 824-2642

How to obtain an exception to the Specialty Pharmacy Program
If you believe that you should not be required to get your specialty drug through the Specialty Pharmacy Program, for any of the reasons listed above or others, you or your Physician must complete an Exception to the Specialty Pharmacy Program form to request an exception and send it to us. The form can be mailed or faxed to us. If you need a copy of the form, you may call us at 1-800-700-2533 to request one. You can also get the form online at www.anthem.com/ca. If we have given you an exception, it will be in writing for the approved amount of time as medically appropriate, not to exceed six (6) months. If you believe that you still should not be required to get your medication through the Specialty Pharmacy Program, when your prior exception approval expires, you must again request an exception. If we deny your request for an exception, it will be in writing and will tell you why we did not approve the exception.

Questions? Visit www.MediCoverage.com or call (800) 930-7956

Urgent or emergency need of a specialty drug subject to the Specialty Pharmacy Program
If you are out of a specialty drug which must be obtained through the Specialty Pharmacy Program, we will authorize an override of the Specialty Pharmacy Program requirement for 72-hours, or until the next business day following a holiday or weekend to allow you to get a 72-hour emergency supply of medication, or the smallest packaged quantity, whichever is greater, if your doctor decides that it is appropriate and medically necessary. You may have to pay the applicable Copayment/coinsurance, if any.

If you order your specialty drug through the Specialty Preferred Provider and it does not arrive, if your physician decides that it is medically necessary for you to have the drug immediately, we will authorize an override of the Specialty Pharmacy Program requirement for a 30-day supply or less to allow you to get an emergency supply of medication from a participating pharmacy near you. A customer service representative from the Specialty Preferred Provider will coordinate the exception and you will not be required to pay additional coinsurance.

Questions? Visit www.MediCoverage.com or call (800) 930-7956

SPECIAL PROGRAMS
Special Programs
From time to time, we may initiate various programs to encourage you to utilize more cost-effective or clinically-effective Drugs including, but, not limited to, Tier 1 Drugs, mail service Drugs, over-the counter drugs, or preferred Drug products. Such programs may involve reducing or waiving Copayments for those Tier 1 Drugs, over-the-counter drugs, or the preferred Drug products for a limited period of time. If we initiate such a program, and we determine that you are taking a Drug for a medical condition affected by the program, you will be notified in writing of the program and how to participate in it.

Half-Tablet Program
The Half-Tablet Program allows you to pay a reduced Copayment on selected “once daily dosage” medications. The Half-Tablet Program allows you to obtain a 30-day supply (15 tablets) of a higher strength version of your medication when the Prescription is written by the Physician to take “1/2 tablet daily” of those medications on a list approved by us. The WellPoint National Pharmacy and Therapeutics Committee will determine additions and deletions to the approved list. The Half-Tablet Program is strictly voluntary and your decision to participate should follow consultation with and the concurrence of your Physician. This program is only available through a retail pharmacy or a Participating mail services pharmacy. To obtain a list of the products available on this program call (866) 614-0147 or visit our internet website at **www.anthem.com/ca**.

The member may need to file their own claim if they need to have a prescription filled before they receive their health benefit ID card. The pharmacy may not submit the claim on the members’ behalf. Information on filing a prescription claim may be obtained by calling Customer Service at the number listed on the member ID card.

Anthem receives financial credits or rebates from drug manufacturers based on the total volume of claims processed for their products utilized by Anthem members. These credits are used to help stabilize rates. Reimbursements to pharmacies are not affected by these credits.

Prescription drugs will always be dispensed as ordered by the member’s provider and by applicable Sate Pharmacy Regulations, however the member may have higher out-of-pocket expenses. The member may request, or the member’s provider may order, a brand-name drug. However, if a Tier 1 drug is available, the member will be responsible for the cost difference between the Tier 1 and the Tier 2 drug, in addition to the member’s Tier 1 copayment and/or coinsurance. By law, Tier 1 and Tier 2 drugs must meet the same standards for safety, strength, and effectiveness and are typically lower in cost. Anthem reserves the right, at it’s discretion, to remove certain higher cost generic drugs for this policy.

PRESCRIPTION DRUG EXCLUSIONS AND LIMITATIONS

IN ADDITION TO ANY LIFETIME MAXIMUMS, LIMITATIONS ON PRE-EXISTING CONDITIONS OR ANY OTHER EXCLUSIONS OR LIMITATIONS CONTAINED IN THIS ENTIRE POLICY, PRESCRIPTION DRUGS AND REIMBURSEMENT WILL NOT BE FURNISHED FOR:

- Drugs or medications which may be obtained without a Physicians Prescription, except Insulin and Niacin for cholesterol lowering.
- All Prescription and non-Prescription herbs, botanicals and nutritional supplements which have not been approved by the Food and Drug Administration (FDA) to diagnose, treat, cure or prevent a disease. However, formulas prescribed by a Physician for the treatment of Phenylketonuria (PKU) are covered.
- Non-medicinal substances or items. **Including:** Pharmaceuticals to aid smoking cessation (e.g., Nicorette) or any Prescription product containing nicotine.
- Dietary supplements, vitamins, cosmetics, health or beauty aids or similar products which have not been approved by the Food and Drug Administration (FDA) to diagnose, treat, cure or prevent a medical condition. However, formulas prescribed by a Physician for the treatment of phenylketonuria are covered.
- Drugs taken while you are in a Hospital, Skilled Nursing Facility, rest home, sanatorium, convalescent Hospital or similar facility.
- Any expense incurred in excess of the Anthem Negotiated Fee at a Participating Pharmacy.
- Any Drug labeled "Caution, limited by federal law to investigational use" or non-FDA approved investigational Drugs. Any Drug or medication prescribed for experimental indications, for example, progesterone suppositories.
- Syringes and/or needles except those dispensed for use with Insulin.
- Durable medical equipment, devices, appliances, and supplies except lancets and test strips for use in the monitoring of diabetes.
- Immunizing agents, biological sera, blood, blood products or blood plasma. Oxygen.
- Professional charges in connection with administering, injecting or dispensing of Drugs. Infusion medications.
- Drugs and medications dispensed or administered in an outpatient setting, including, but not limited to, outpatient Hospital facilities, doctor's offices and home IV therapy.
- Drugs used for cosmetic purposes, for example Retin-A for wrinkles, Rogaine for hair growth.
- Drugs and medications used for pregnancy, maternity care or abortion, except as specifically stated in the section WHAT IS COVERED under this PART.
- Drugs used for the primary purpose of treating Infertility.
- Drugs used for weight loss except when Medically Necessary.
- Drugs obtained outside of the United States.
- Allergy desensitization products, allergy serum.
- All Infusion Therapy is excluded under this Policy except where specifically stated under Comprehensive Benefits.
- A Prescription dispensed in excess of a thirty (30) day supply, (unless ordered by mail through the Mail Order Prescription Drug Program, in which case the limit is a ninety (90) day supply).
- Prescription Drugs with a non-Prescription (over-the-counter) chemical and dose equivalent.
- Tier 3 drugs that must be obtained from the Specialty Pharmacy Program but which are obtained from a retail pharmacy. You will have to pay the full cost of the Tier 3 drugs you get from a retail pharmacy that you should have filled through the Specialty Pharmacy Program.
- Compound Medications.
- Drugs and medications prescribed for the treatment of impotence and/or sexual dysfunction.

Questions? Visit www.MediCoverage.com or call (800) 930-7956

Questions? Visit www.MediCoverage.com or call (800) 930-7956

CLAIMS AND CUSTOMER SERVICE

For **retail Pharmacy** information, please write to:

Anthem Blue Cross Life and Health Prescription Drug Program
P.O. Box 4165
Woodland Hills, CA 91365-4165
or call the toll free customer service phone number at (800) 700-2533

For **mail order Prescription Drug program** inquires, please write to:

Anthem Blue Cross Life and Health Mail Service Prescription Drug Program
P.O. Box 961025
Fort Worth, TX 76161-9863
or call the toll free customer service phone number at (866) 274-6825

Questions? Visit www.MediCoverage.com or call (800) 930-7956

UTILIZATION MANAGEMENT AND PRESERVICE REVIEW

IMPORTANT: Utilization Management and Preservice Review does not guarantee that you have coverage or that benefits will be paid, nor does it guarantee the amount of benefits to which you are entitled. The payment of benefits is subject to all other terms, conditions, limitations and exclusions of this Policy. All Covered Services are subject to review by Anthem for medical necessity.

The review processes which may be undertaken are listed below in paragraphs named Preservice Review, Admission Review, Continued Stay Review and Retrospective Review.

Preservice Review. You are always responsible for initiating Preservice Review. Anthem will determine **in advance** whether certain procedures and admissions are Medically Necessary and are the appropriate length of stay, if applicable. Whenever Preservice Review has not been performed you will be required to pay a $250 Copayment. **This Copayment is in addition to any other Copayment required by this Policy and will NOT apply toward satisfying your Yearly Out of Pocket Maximum. This Copayment is not required in Medical Emergencies.**

To initiate Preservice Review, instruct your Physician to request Preservice Review at least three (3) business days before any scheduled service by calling Anthem toll free at 1-800-274-7767. But remember, you are responsible to see that it is done.

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

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

Preservice Review is required for, but not limited to:

- All elective, urgent or emergent inpatient Hospital admissions (except for mastectomy surgery, including the length of Hospital stays associated with mastectomy).
- Facility Based Treatment for Severe Mental Illnesses and Serious Emotional Disturbances of a Child and Mental or Nervous Disorders or Substance Abuse. Outpatient professional services for Severe Mental Illness and Serious Emotional Disturbances of a Child after twelve (12) visits.
- Centers of Medical Excellence (CME) procedures (including Transplant Services and bariatric surgery)
- The following diagnostic and radiological procedures wherever performed:
  - Magnetic Resonance Imaging (MRI) scan
  - Magnetic Resonance Spectroscopy (MRS) scan
  - Computerized Tomography (CT) scan
  - Positron Emission Tomography (PET) scan
  - Nuclear Cardiology (NC) scan
- Other specific procedures, wherever performed, as specified by Anthem. For a list of current procedures, please contact Anthem toll free at 1-800-274-7767 or visit our website at www.anthem.com/ca.

Admission Review. Anthem will determine at the time of admission if the service is Medically Necessary in the event Preservice Review is not conducted (except for inpatient Hospital stays related to mastectomy surgery, including the length of Hospital stays associated with mastectomy).

Continued Stay Review. Anthem will also determine if a continued Hospital stay is Medically Necessary. The length of Hospital stays related to mastectomy will be determined by the treating Physician in consultation with the patient.

Retrospective Review. Anthem will determine if any service was Medically Necessary in the event that Preservice Review, admission review or continued stay review was not performed.

For a copy of the Medical Necessity Review Process, please contact our customer service department toll free at 1-800-333-0912.

ALTERNATIVE BENEFITS

In order for an Insured to obtain medically appropriate care in a more economical and cost effective way, Anthem may recommend an alternative plan of treatment which includes services not covered under this Policy.

Anthem makes treatment suggestions only. Any decision regarding treatment belongs to the Insured and the Insured's Physician.

Benefits are provided for such an alternative treatment plan only on a case-by-case basis. Anthem has absolute discretion in deciding whether or not to offer substitute benefits for any Insured, which alternative benefits may be offered and the terms of the offer. Anthem's substitution of benefits in a particular case in no way commits Anthem to do so in another case or for another Insured. Also, it does not prevent Anthem from strictly applying the express benefits, limitations and exclusions of the Policy at any other time or for any other Insured.

Benefits are provided only when all of the following criteria are satisfied:

- the Insured requires extensive long term treatment and
- Anthem anticipates that such treatment, utilizing services or supplies covered under the Policy, will result in considerable cost and
- a cost benefit analysis by Anthem determines that the benefits payable under the Policy for the alternative plan of treatment can be provided at a lower overall cost than the benefits the Insured would otherwise receive under the Policy and
- the Insured or the Insured's guardian and the Insured's Physician agree, in writing, with Anthem's recommended substitution of benefits with the specific terms and conditions under which the alternative benefits are to be provided.

Alternative benefits paid are accumulated toward any Annual or Lifetime Maximums under the Policy.

Questions? Visit www.MediCoverage.com or call (800) 930-7956

GENERAL PROVISIONS

Benefits Not Transferable: You and your eligible Dependents are the only persons entitled to receive benefits under this Policy. FRAUDULENT USE OF SUCH BENEFITS WILL RESULT IN CANCELLATION OF THIS POLICY AND APPROPRIATE LEGAL ACTION WILL BE TAKEN.

Conformity with Law: Any provision of this Policy which, on its Effective Date, is in conflict with any applicable statute, regulations or other law is hereby amended to conform to the minimum requirements of such law.

Content of the Policy: This Policy, including any endorsements or attached paper, is the entire contract of insurance. Its terms can only be changed by a written endorsement signed by one of our authorized officers. NO AGENT OR EMPLOYEE OF OURS IS AUTHORIZED TO CHANGE THE TERMS OR WAIVE ANY OF THE PROVISIONS OF THIS POLICY.

Continuation of Care after Termination of a Provider: Subject to the terms and conditions set forth below, Anthem will pay benefits to an Insured at the Participating Provider level for Covered Services (subject to applicable Copayments/Coinsurance, Deductibles and other terms) rendered by a provider whose participation we have terminated.

- The Insured must be under the care of the Participating Provider at the time of our termination of the provider's participation. The terminated provider must agree in writing to provide services to the Insured in accordance with the terms and conditions of his/her agreement with Anthem prior to termination. The provider must also agree in writing to accept the terms and reimbursement rates under his/her agreement with Anthem prior to termination. If the provider does not agree with these contractual terms and conditions, we are not required to continue the provider's services beyond the contract termination date.
- Anthem will furnish such benefits for the continuation of services by a terminated provider only for any of the following conditions:
  - An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services shall be provided for the duration of the acute condition.
  - A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Anthem in consultation with the Insured and the terminated provider and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the provider's contract termination date.
  - A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Services shall be provided for the duration of the pregnancy.
  - A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of Covered Services shall be provided for the duration of the terminal illness.
  - The care of a newborn child between birth and age thirty-six (36) months. Completion of Covered Services shall not exceed twelve (12) months from the provider's contract termination date.
  - Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the provider's contract termination date.
- Such benefits will not apply to providers who voluntarily leave their provider group network, providers who choose not to renew their agreement, or providers who have been terminated due to medical disciplinary cause or reason, fraud or other criminal activity.
- Please contact customer service toll free at 1-800-333-0912, to request continuation of care or to obtain a copy of the written policy. Eligibility is based on the Insured's clinical condition; it is not determined by diagnostic classifications. Continuation of care does not provide coverage for services not otherwise covered under the Policy.

Questions? Visit www.MediCoverage.com or call (800) 930-7956

We will notify you by telephone and the provider by telephone and fax, as to whether or not your request for continuation of care is approved. If approved, the Insured will be financially responsible only for applicable Deductibles, Coinsurance and/or Copayments under this Policy. Financial arrangements with terminated providers are negotiated on a case-by-case basis. We will request that the terminated provider agree to negotiate reimbursement and/or contractual requirements that apply to Participating Providers, including payment terms. If the terminated provider does not agree to the same reimbursement and/or contractual requirements, we are not required to continue that provider's services. If you disagree with our determination regarding continuation of care, please refer to the Part entitled INDEPENDENT MEDICAL REVIEW OF GRIEVANCES.

Governing Law: The laws of the state of California will be used to interpret any part of this Policy.

Legal Actions: No action at law or at equity may be brought to recover on this Policy sooner than sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action may be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

Notice: We will meet any notice requirements by mailing the notice to you at the address listed in our records. You will meet any notice requirements by mailing the notice to Anthem Blue Cross Life and Health Insurance Company at P.O. Box 9051 Oxnard, CA 93031-9051.

Out of California Providers: The Blue Cross and Blue Shield Association, of which we are a member/Independent Licensee, administers a program called the BlueCard Program, in which we participate, which allows our Insureds to have the reciprocal use of Participating Providers that contract with other Blue Cross and/or Blue Shield Plans. Providers available to you through the BlueCard Program have not entered into contracts with Anthem. If you have any questions or complaints about the BlueCard Program, please call us at 1-800-333-0912. If you are traveling outside of California and require medical care or treatment, you may use a local Blue Cross and/or Blue Shield Participating Provider. If you use one of these providers, your out-of-pocket expenses may be lower than those incurred when using a provider that does not participate with a local Blue Cross and/or Blue Shield Plan. In order for you to receive access to whatever reductions in out-of-pocket expenses may be available, we must abide by the BlueCard Program rules, as set by the Blue Cross and Blue Shield Association.

When you obtain health care services through the BlueCard Program outside of California, the amount you pay for Covered Services is calculated on the lower of:

- the billed charges for your Covered Services or
- the Negotiated Price that the on-site Blue Cross and/or Blue Shield ("Host Blue") passes on to us.

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

Statutes in a small number of states may require the Host Blue to use a basis for calculating Policyholder liability for Covered Services that does not reflect the entire savings realized or expected to be realized, on a particular claim or to add a surcharge. Should any state mandate Policyholder liability calculation methods that differ from the usual BlueCard method noted above in the preceding paragraph of this item or require a surcharge, we would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

When traveling outside the United States, in cases of emergencies only, call 1-800-810-BLUE (2583) to inquire about providers that may participate in the BlueCard Worldwide Program.

Questions? Visit www.MediCoverage.com or call (800) 930-7956

Questions? Visit www.MediCoverage.com or call (800) 930-7956

Payment to Providers and Provider Reimbursement: Covered Expenses for Participating Providers are based on the Negotiated Fee Rate. Participating Providers have a Prudent Buyer Participating Provider Agreement in effect with us and have agreed to accept the Negotiated Fee Rate as payment in full. Non-Participating Providers do not have a Prudent Buyer Participating Agreement with Anthem Blue Cross Life and Health Insurance Company. Your personal financial costs when using Non-Participating Providers may be considerably higher than when you use Participating Providers. You will be responsible for any balance of a provider's bill which is above the allowed amount payable under this Policy for Non-Participating Providers. Please read the benefit sections carefully to determine those differences. We pay the benefits of this Policy directly to Contracting Hospitals, participating Hospitals, participating Physicians, medical transportation providers, certified nurse midwives, registered nurse practitioners and other Participating Providers whether you have authorized assignment of benefits or not. We may pay Hospitals, Physicians and other providers of service, or the person or persons having paid for your Hospital or medical services directly when you assign benefits in writing no later than the time of filing proof of loss (claim). These payments fulfill our obligation to you for those services.

If you or one of your Dependents receives services from a Non-Participating Provider or Non-Contracting Hospital, payment may be made directly to the Policyholder and you will be responsible for payment to that provider. Any assignment of benefits, even if assignment includes the provider's right to receive payment, is void unless an Authorized Referral has been approved by Anthem. We will pay non-contracting Hospitals and other providers of service directly when emergency services and care are provided to you or one of your Dependents. We will continue such direct payment until the emergency care results in stabilization.

Physical Examination and Autopsy: At our own expense, we have the right and opportunity to examine an Insured claiming benefits when and as often as it may reasonably be required during the pendency of a claim and also to have an autopsy done in the case of death where it is not otherwise prohibited by law.

Prior Coverage: If within the same calendar Year, an Insured replaces any Anthem individual medical Policy with another Anthem individual medical Policy, any benefits applied toward the Deductible, Out of Pocket Maximums or any benefit maximums of that prior Policy will be applied toward the Deductible, Out of Pocket Maximums or any benefit maximums of this Policy.

Receipt of Information: We are entitled to receive from any provider of service information about you that is necessary to administer claims on your behalf. This right is subject to all applicable confidentiality requirements. By submitting an application for coverage, you have authorized every provider who has furnished or is furnishing care to disclose all facts, opinions or other information pertaining to your care, treatment and physical conditions, upon our request. You agree to assist in obtaining this information if needed. Failure to assist us in obtaining the necessary information when requested may result in the delay or rejection of your claims until the necessary information is received.

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. Contact our customer service department at 1-800-333-0912 for a copy.

Reinstatement: If this Policy lapses (cancels) because you do not pay your premium on time and if we, or an agent we have authorized to accept premium, then accepts a late premium payment from you without asking for an application for reinstatement, we will reinstate this Policy. However, if we require an application for reinstatement and give you a conditional receipt for your late premium payment, we will only reinstate this Policy if either we approve your reinstatement application or forty-five (45) days go by after the date on our conditional receipt without us notifying you in writing that we have disapproved your reinstatement application.

If this Policy is reinstated, benefits will be provided only for an Accidental Injury that occurs after the date of reinstatement or for a sickness that begins more than ten (10) days after the date of reinstatement. Otherwise, your rights and our rights under this Policy will be the same as they were just before the premium you did not pay on time was due, unless we amended this Policy in connection with reinstatement. Any premium we accept in connection with reinstatement will be applied to a period for which you have not paid premium due, but not to any period more than sixty (60) days before the date of reinstatement.

Reinstatement of Coverage for Members of the Military: Members of the United States Military Reserve and National Guard who terminate coverage as a result of being ordered to active duty on or after January 1, 2007, may have their coverage reinstated without waiting periods or exclusion of coverage for preexisting conditions. Please contact customer service toll free at 1-800-333-0912 for information on how to apply for reinstatement of coverage following active duty as a reservist.

Relationship of Parties: We are not responsible for any claim for damages or injuries suffered by the Insured while receiving care in any Hospital or Skilled Nursing Facility. Such facilities act as independent contractors.

Responsibility to Pay Providers: In accordance with California law, Insureds will not be required to pay any Participating Provider for amounts owed to that provider by Anthem (not including Copayment, Deductibles and services or supplies that are not a benefit of this Policy), even in the unlikely event that Anthem fails to pay the provider. Insureds are liable, however, to pay Non-Participating Providers for any amounts not paid to them by Anthem.

Right of Recovery: When the amount paid by us exceeds the amount for which we are liable under this Policy, we have the right to recover the excess amount from you unless prohibited by law.

Submission of Claims: Either the Policyholder or provider of service must claim benefits by sending Anthem properly completed claim forms itemizing the services or supplies received and the charges. These claim forms must be received by Anthem within fifteen (15) months from the date the services or supplies are received. Anthem will not be liable for benefits if a completed claim form is not furnished to Anthem within this time period, except in the absence of legal capacity. Claim forms must be used; cancelled checks or receipts are not acceptable.

Terms of Coverage

- In order for you to be entitled to benefits under this Policy, your coverage under this Policy must be in effect on the date you receive the service or supply except as specifically provided in the Part entitled TERMS OF YOUR POLICY. Under this Policy, an expense is incurred on the date the Policyholder or Dependent receives a service or supply for which the charge is made.
- This Policy, including all terms, benefits, conditions, limitations and exclusions, may be changed by us as provided in the Part entitled TERMS OF YOUR POLICY.
- The benefit to which you may be entitled will depend on the terms of coverage as set out in the Policy in effect on the date you receive the service or supply.

Time Limit on Certain Defenses: After you have been insured under this Policy for two (2) consecutive years we will not use any misstatements you may have made in your application for this Policy, except any fraudulent misstatements, to either void this Policy or to deny a claim for any Covered Expense for Covered Services incurred after the expiration of such two (2) year period.

Time of Payment of Claim: Any benefits due under this Policy shall be due once we receive proper written proof of loss together with any such additional information reasonably necessary to determine our obligation.

Workers' Compensation Insurance: This Policy does not take the place of or effect any requirement for or coverage by, workers' compensation insurance.

Questions? Visit www.MediCoverage.com or call (800) 930-7956

INDEPENDENT MEDICAL REVIEW OF GRIEVANCES

If an Insured has had any Covered Service denied, modified or delayed or has had coverage denied because proposed treatment is determined by us to be investigational or experimental or not Medically Necessary, the Insured may ask for review of that denial, modification or delay by an external independent medical review organization. To request a review, please call 1-800-333-0912 or write to us at Anthem Blue Cross Life and Health Insurance Company P.O. Box 9051 Oxnard, California 93031-9051. To request an Independent Medical Review (IMR) from the California Department of Insurance (DOI), all of the following conditions must be satisfied.

For Denials, Modifications or Delays Based on a Determination that a Service is Experimental or Investigative

The Insured must have a life threatening or seriously debilitating condition.

- A life threatening condition is a condition or disease where the likelihood of death is high unless the course of the condition or disease is interrupted and/or a condition or disease with a potentially fatal outcome where the end point of clinical intervention is survival.
- A seriously debilitating condition is a disease or condition that causes major, irreversible morbidity.

The proposed treatment must be recommended by a participating Physician or a board certified or board eligible Physician qualified to treat the Insured, who has certified in writing that it is more likely to be beneficial than standard treatment and who has provided the supporting evidence.

If IMR is requested by the Insured or by a qualified Non-Participating Physician, as described above, the requester must supply two (2) items of acceptable scientific support defined as follows.

"Acceptable scientific support" is the following sources:

- Peer reviewed scientific studies published in medical journals with national recognized standards,
- Medical journals recognized by the Secretary of Health and Human Services under Section 1861 (t) (2) of the Social Security Act,
- The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics and the United States Pharmacopeia-Drug Information,
- Medical literature meeting the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline, MEDLARS database Health Services Technology Assessment Research,
- Finding, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes and
- Peer reviewed abstracts accepted for presentation at major medical association meetings.

For Denials, Modifications or Delays Based on a Determination that a Service is not Medically Necessary

The DOI will review your application for IMR to confirm that:

- your provider has recommended a health care service as Medically Necessary,
- you have received urgent care or emergency services that a provider determined was Medically Necessary or
- you have been seen by a Participating Provider for the diagnosis or treatment of the medical condition for which you seek independent review.

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

you have filed a grievance with us and the disputed decision is upheld or the grievance remains unresolved after thirty (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.

Questions? Visit www.MediCoverage.com or call (800) 930-7956

General

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 not experimental or investigational or is Medically Necessary. You will receive a copy of the assessment made in your case. If the IMR determines the service is not experimental or investigational or is Medically Necessary, we will provide available benefits for the health care service.

Within three (3) business days of our receipt from the Department of Insurance of a request by a qualified Insured for an IMR, we will provide the IMR organization designated by the Department with a copy of all relevant medical records and documents for review and any information submitted by the Insured or the Insured's Physician. Any subsequent information received will be forwarded to the IMR organization within three (3) business days. Additionally, any newly developed or discovered relevant medical records identified by us or our Participating Providers after the initial documents are provided will be forwarded immediately to the IMR organization. The IMR organization will render its determination within thirty (30) days of the request (or seven (7) days in the case of an expedited review), except the reviewer may ask for three (3) more days if there was any delay in receiving the necessary records.

For non-urgent cases, the IMR organization designated by the DOI must provide its determination within thirty (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 three (3) business days.

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.

For more information regarding the IMR process or to request an application form please call 1-800-333-0912.

Questions? Visit www.MediCoverage.com or call (800) 930-7956

Questions? Visit www.MediCoverage.com or call (800) 930-7956

BINDING ARBITRATION

This Binding Arbitration provision does not apply to class actions:

ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. ***It is understood that any dispute including disputes relating to the delivery of services under the plan or any other issues related to the plan, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.*** **YOU AND ANTHEM BLUE CROSS LIFE AND HEALTH AGREE TO BE BOUND BY THIS ARBITRATION PROVISION AND ACKNOWLEDGE THAT THE RIGHT TO A JURY TRIAL IS WAIVED FOR BOTH DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN AND MEDICAL MALPRACTICE CLAIMS.**

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, state law governing agreements to arbitrate shall apply.

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

The arbitration is initiated by the Member making a written demand on Anthem Blue Cross Life and Health. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS"), according to its applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by agreement of the Member and Anthem Blue Cross Life and Health, or by order of the court, if the Member and Anthem Blue Cross Life and Health Insurance Company cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to whom the parties have agreed, in which cases, Anthem Blue Cross will assume all or a portion of the costs of the arbitration.

Please send all Binding Arbitration demands in writing to:

Anthem Blue Cross Life and Health Insurance Company
P.O. Box 9086
Oxnard, CA 93031-9086

Questions? Visit www.MediCoverage.com or call (800) 930-7956

COMPLAINTS

If you have a complaint about services from Anthem or your health care provider, contact:

Anthem Blue Cross Life and Health Insurance Company
At 1-800-333-0912 or at
P.O. Box 9051
Oxnard, CA 93031-9051

If you have any questions regarding your eligibility or membership, please contact our customer service department toll free at 1-800-333-0912, or you may write to us at:

Anthem Blue Cross Life and Health Insurance Company
P.O. Box 9051
Oxnard, CA 93031-9051

DEPARTMENT OF INSURANCE

If you or any Insured covered under this Policy have a problem regarding your coverage, please contact Anthem first to resolve the issue. If contacts between you (the complainant) and Anthem Blue Cross Life and Health Insurance Company (the Insurer) have failed to produce a satisfactory solution to the problem, you may wish to contact the Department of Insurance. They can be reached by writing to:

Department of Insurance, Consumer Affairs Bureau
300 South Spring St., South Tower
Los Angeles, CA 90013
Toll-free phone number 1-800-927-HELP (4357)

DURATION AND TERMINATION OF YOUR POLICY AND OUR RIGHT TO MODIFY YOUR POLICY

Questions? Visit www.MediCoverage.com or call (800) 930-7956

A. The Effective Date of your coverage is printed on your Anthem identification card which is issued together with this Policy and is a part of this Policy.

B. The duration of your coverage under this Policy depends on how your premiums are billed, and is equal to the length of time between billing cycles. For example, if we bill premiums on a bi-monthly basis, your coverage is for a two-month duration. If we bill premiums on a quarterly basis, your coverage is for a three-month duration. If you have chosen Anthem's monthly checking account deduction program, or are a member of a list bill program, or if we otherwise bill premiums on a monthly basis, your coverage is for a one-month duration. The duration of the Policy is determined by how you pay your premiums (measured from the effective date of coverage) and is unrelated to, and is not affected by, the use of other periods of time to measure or determine your rights or benefits, such as, for example, the use of a calendar year or other Deductibles.

C. Although your Policy expires at the end of each billing cycle, it will, upon timely payment of the billed premiums, automatically renew under the same terms and conditions unless (1) Anthem has terminated, canceled, or declined to renew the Policy pursuant to Paragraph D. below; or (2) Anthem has modified the Policy pursuant to Paragraph E. below. In the case of a modification under Paragraph E., the Policy will renew for the term specified in Paragraph B. above under the modified terms and conditions.

D. Anthem may, at any time, terminate, cancel or decline to renew this Policy in the event of any of the following:

1. When your premium is not paid within the grace period. The grace period for payment of future premiums is thirty-one (31) days. If you fail to pay premiums as they become due, Anthem may terminate this Policy as of the last day of the grace period described above. Nevertheless, Anthem will terminate this Policy only upon first giving you a written Notice of Cancellation at least fifteen (15) days prior to that termination. The Notice of Cancellation shall state that this Policy shall not be terminated if you make appropriate payment in full within fifteen (15) days after Anthem issues the Notice of Cancellation. You are not entitled to a grace period until you have made your first payment to us. If you need covered benefits during the grace period, coverage will be provided. However, we will deduct the premiums due for coverage continued during the grace period from any benefits we pay.

   The Notice of Cancellation also shall inform you that, if this Policy is terminated for non-payment of premiums, you may apply for reinstatement by submitting a new application and any premiums that are owed in addition to a $50 reinstatement fee, and you will be subject to medical underwriting. See the section Reinstatement under the Part entitled GENERAL PROVISIONS for information on our reinstatement provision.

2. On the first of the month following our receipt of your written notice to cancel.

3. For fraud or misrepresentation in certain situations. Misrepresentation or omissions on the application may result in termination or rescission of this Policy. This Policy may also be terminated if you knowingly participated in or permitted fraud or deception by any provider, vendor or any other person associated with this Policy. Termination for fraud or misrepresentation will be effective as of the Effective Date of coverage in the case of rescission.

   Please see ELIGIBILITY for information on continuing coverage for eligible Insureds on rescinded Policies.

4. For fraud or deception in the submission of claims or use of services or facilities or if you knowingly permit such fraud or deception by another. Termination is effective on the date of mailing the written notice.

5. Upon becoming ineligible for this coverage. See the Part entitled WHEN AN INSURED BECOMES INELIGIBLE.

E. Notice to Cancel or Cease Coverage

1. Before we will cease to provide any new or existing individual health benefit Policy:
   a. We will give you at least 180 days written notice prior to cessation of this Policy and
   b. Those individual health benefit Policies that are in effect shall not be canceled for 180 days, after the day of notification to cease coverage, except for specific non-compliance previously stated under B. of this PART.
2. We will give you ninety (90) days written notice before we withdraw this individual health benefit Policy from the health care market.
3. In addition to the right to terminate, cancel or decline to renew the Policy set forth in Paragraph D., Anthem has the right upon renewal, or at any time during the duration of your Policy, to modify or otherwise change the terms and conditions of your Policy, **including premiums**, provided that Anthem gives you thirty (30) days written notice of such modifications or changes. Such modifications or changes may alter any term or benefit of this Policy, including without limitation, premiums, covered benefits, Deductibles, copayments or coinsurance. Anthem can modify or change the terms and conditions of your Policy at any time during the Year on thirty (30) days written notice, regardless of whether your Deductible or other cost sharing provisions are calculated on an annual or calendar-year basis.
   a. In addition to the thirty (30) days written notice provision set forth above, Anthem's right to modify this Policy under Paragraph E. 3. is subject to the following conditions:
      i. We will not cancel or modify this Policy under this Paragraph E., 3. on an individual basis but only for all Insureds in the same class and covered under the same Policy as you, except:
         (a) if we discover any fraud or intentional misrepresentation of material fact under the terms of the coverage by an individual,
         (b) if we find out about any fraud or deception in the use of the benefits of this Policy by you, your enrolled family or anyone else if you or any Insured of your family knows about it.
      ii. The modifications or changes will take effect upon the next applicable renewal date occurring (determined as provided in Paragraph A. above) on or after the 30th day following the date of the above notice.
4. If, on the date we cancel your coverage on written notice (except for the reasons described in E., 1. a. and b.) you are suffering from either an injury sustained or an illness arising while your coverage under this Policy was in effect, benefits will continue, but limited by and subject to all of the following:
   a. These continued benefits cover only treatment of an injury sustained or an illness arising while your coverage under this Policy was in effect. When we refer to an injury sustained while your coverage under this Policy was in effect, we mean that the incident or accident directly causing the injury must have occurred while your coverage under this Policy was in effect. When we refer to an illness arising while your coverage under this Policy was in effect, we mean that either the illness was first diagnosed while your coverage under this Policy was in effect or your illness first manifested itself by signs or symptoms by which a Physician could have diagnosed the illness while your coverage under this Policy was in effect.
   b. These benefits will be provided only for treatment actually received during the ninety (90) day period following cancellation of your coverage under this Policy. If you are in a Hospital or Skilled Nursing Facility on the last day of that ninety (90) day period for treatment of a condition covered under these continued benefits, benefits will continue until the first of the following occurs:
      (i) the date of discharge from the Hospital or Skilled Nursing Facility or
      (ii) care or treatment is no longer Medically Necessary.
   c. All conditions, reductions, limitations and exclusions of this Policy, including any benefit maximums, will apply to these continued benefits. In no event will benefits in excess of any maximum benefits be provided.

F. Any written notice will be officially given by us when it is mailed to your address as it appears on our records.

G. You should address any written notice to us at Anthem Blue Cross Life and Health Insurance Company, P.O. Box 9051 Oxnard, California 93031-9051.

Questions? Visit www.MediCoverage.com or call (800) 930-7956

NON-DUPLICATION OF ANTHEM BENEFITS

If, while covered under this individual Policy, you are also covered by another Anthem Blue Cross Life and Health Insurance Company individual Policy:

- you will be entitled only to the benefits of the Policy with the greater benefits and
- we will refund any premiums received under the Policy with the lesser benefits, covering the time period both policies were in effect. However, any claims payments made by us under the Policy with the lesser benefits will be deducted from any such refund of premiums.

Questions? Visit www.MediCoverage.com or call (800) 930-7956

DEFINITIONS

Listed below are the Definitions which contain the meanings of key terms used in this Policy. Throughout this Policy the terms defined, printed in bold face below, will appear with the first letter of each word in capital letters. When you see these capitalized words, you should refer to these Definitions. The Definitions are listed in alphabetical order.

Accidental Death and Dismemberment Maximum Benefit is the total amount of the benefit that the Accidental Death and Dismemberment insurance provides.

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.

Attained Age is your age at the time of each of your premium billings. Your premiums are based upon your Attained Age. We will recalculate your age for each billing and your premiums will be adjusted accordingly.

Authorized Referral occurs when an Insured, because of his or her medical needs, requires the services of a specialist who is a non-participating Physician or requires special services or facilities not available at a participating Hospital but only when:

- there is no participating Physician who practices in the appropriate specialty or there is no Participating Hospital which provides the required services or has the necessary facilities within the county in which the Insured lives and
- the Insured is referred to the non-participating Hospital or Non-Participating Physician by a Participating Physician and
- the referral has been authorized by Anthem before services are rendered.

Anthem Blue Cross Life and Health Insurance Company (Anthem) is a life and disability insurance company regulated by the California Department of Insurance.

Beneficiary is a person or entity named to receive benefits.

BlueCard Program allows Anthem Policyholders to take advantage of discounts available through Blue Cross and Blue Shield Policies for Covered Services rendered in other states. Discounts may be available through Blue Cross and Blue Shield Policies for Covered Services in other countries, only when emergency treatment is required.

Centers of Medical Excellence (CME) are health care providers designated by us as a selected facility for specified medical services. A provider participating in a CME network has an agreement in effect with us at the time services are rendered or is available through our affiliate companies or our relationship with the Blue Cross and Blue Shield Association. CME providers agree to accept negotiated rate as payment in full for covered services. A participating provider in the Prudent Buyer Plan network is not necessarily a CME.

Coinsurance is the percentage amount you are responsible for (after your Deductible is satisfied) as stated in the Part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED. **Coinsurance does not include charges for services which are not covered or charges in excess of the amount we will allow for payment. These charges are your responsibility and are not included in the Coinsurance calculation.**

Contracting Hospital is a Hospital which has a contract with us to provide care to our Insureds. A Contracting Hospital is not necessarily a Participating Hospital. To determine whether a Hospital contracts with Anthem, you may contact the Hospital directly or call, 1-800-333-0912, which is printed on the back of your identification card and a list of Contracting Hospitals will be sent to you on request.

Copayment is the amount due and payable by the Insured to the provider of care.

Questions? Visit www.MediCoverage.com or call (800) 930-7956

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Cosmetic and Reconstructive Surgery: Cosmetic Surgery is surgery that is performed to alter or reshape normal structures of the body in order to improve appearance. **Reconstructive Surgery** is surgery that is Medically Necessary and appropriate surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or create a normal appearance, to the extent possible.[Reconstructive surgery includes Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for "cleft palate" procedures. "Cleft Palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.]
Note: Cosmetic Surgery does not become Reconstructive Surgery because of psychological or psychiatric reasons.

Covered Expense is the expense you incur for Covered Services. For some services, this amount will be limited to the maximum amount stated in the benefit sections of this Policy.

Covered Services are health care services that are Medically Necessary services or supplies which are listed in the benefit sections of this Policy and for which you are entitled to receive benefits.

Creditable Coverage

1. Any individual or group Policy, contract or program that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, Hospital, and surgical coverage not designed to supplement other plans. The term includes continuation or conversion coverage but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care, dental vision coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance Policy or equivalent self-insurance.
2. The federal Medicare program pursuant to Title XVIII of the Social Security Act.
3. The Medicaid program pursuant to Title XIX of Social Security Act.
4. Any other publicly sponsored program, provided in this state or elsewhere, of medical Hospital, and surgical care.
5. 10 U.S.C.A. Chapter 55 (commencing with Section 1071) (CHAMPUS).
6. A medical care program of the Indian Health Service or of a tribal organization.
7. A state health benefits risk pool.
8. A health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901) (FEHBP).
9. A public health plan as defined in federal regulations authorized by Section 2701 (c) (1) (I) of the Public Health Service Act, as amended by Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996.
10. A health benefit plan under 22 U.S.C.A. 2504 (e) of the Peace Corps Act.
11. Any other Creditable Coverage as defined by subdivision (c) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C Sec. 300gg (c)).

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 a medical professional.

Customary and Reasonable charge, as determined annually by the Host Blue Plan, 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 or which is justified based on the complexity or severity of treatment for a specific case.

Day Treatment Program is an outpatient Hospital based program that is licensed according to state and local laws to provide outpatient care and treatment of Mental or Nervous Disorders and Substance Abuse under the supervision of psychiatrists.

Deductible means the amount of charges you must pay for any Covered Services before any benefits are available to you under this Policy. Your Deductible is stated in the part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED. Your Tier 2 and Tier 3 Prescription Drug Deductible is stated in the part entitled YOUR PRESCRIPTION DRUG BENEFITS.

Dental Services are diagnostic, preventive or corrective procedures to treat on or to the teeth or gums, no matter why the services are provided and whether in treatment of a medical, dental or any other type of condition. **Dental Prostheses** are dentures, crowns, caps, bridges, clasps, habit appliances, partials, braces and orthodontic appliances.

Dependents are members of the Policyholder's family who are eligible and accepted under this Policy.

Diabetes Equipment and Supplies means the following items for the treatment of insulin using diabetes or non-insulin using diabetes and gestational diabetes as Medically Necessary or medically appropriate:

- blood glucose monitors
- blood glucose testing strips
- blood glucose monitors designed to assist the visually impaired
- insulin pumps and related necessary supplies
- ketone urine testing strips
- lancets and lancet puncture devices
- pen delivery systems for the administration of insulin
- podiatric devices to prevent or treat diabetes related complications
- insulin syringes
- visual aids, excluding eyewear to assist the visually impaired with proper dosing of insulin

Diabetes Outpatient Self-Management Training Program includes training provided to a qualified Insured after the initial diagnosis of diabetes in the care and management of that condition. This includes nutritional counseling and proper use of Diabetes Equipment and Supplies, additional training authorized on the diagnosis of a Physician or other health care practitioner of a significant change in the qualified Insured's symptoms or condition that requires changes in the qualified Insured's self-management regime and periodic or episodic continuing education training when prescribed by an appropriate health care practitioner as warranted by the development of new techniques and treatments for diabetes. Diabetes Outpatient Self-Management Training must be provided by a health care practitioner or provider who is licensed, registered or certified in California to provide appropriate health care services.

Domestic Partner shall mean a person who has established a domestic partnership pursuant to California law with the Insured.

Effective Date is the date on which your coverage under this Policy begins. It appears on your Anthem identification card.

Experimental Procedures are those that are mainly limited to laboratory and/or animal research but which are not widely accepted as proven and effective procedures within the organized medical community.

Family Policy means a Policy in which the Policyholder is enrolled with one or more dependents.

Home Health Agencies and Visiting Nurse Associations 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 or they must be approved as home health care providers under Medicare and the Joint Commission on Accreditation of Healthcare Organizations.

Hospices are providers that are licensed according to state and local laws to provide Skilled Nursing and other services to support and care for persons experiencing the final phases of terminal illness. They must be approved as Hospice providers under Medicare and the Joint Commission on Accreditation of Health Care Organizations.

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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 purpose of Severe Mental Illness and Serious Emotional Disturbances of a Child only, the term “Hospital” includes an acute psychiatric facility which is a Hospital specializing in psychiatric treatment or a designated psychiatric unit of a Hospital licensed by the state to provide 24-hour acute inpatient care for persons with psychiatric disorders. For the purpose of this Policy, the term acute psychiatric facility also includes a psychiatric health facility which is an acute 24-hour facility as defined in California Health and Safety Code 1250.2. It must be:

- licensed by the California Department of Health Services,
- qualified to provide short-term inpatient treatment according to state law,
- accredited by the Joint Commission on Accreditation of Health Care Organizations,
- staffed by an organized medical or professional staff which includes a Physician as medical director and
- actually providing an acute level care.

Individual Policy means a Policy in which only the Policyholder is enrolled.

Infertility means the presence of a demonstrated condition recognized by a licensed medical Physician as a cause of Infertility or the inability to conceive or carry a pregnancy to a live birth after a Year or more of regular sexual relations without contraception.

Infusion Therapy is the administration of drugs (prescription substances) by the intravenous (into a vein), intramuscular (into muscle), subcutaneous (under the skin) and intrathecal (into spinal canal) routes. For the purpose of this Policy, it shall also include drugs administered by aerosol (into the lungs) and by a feeding tube.

Insured shall mean both the Policyholder and all other Dependents who are enrolled for coverage under this Policy.

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

Medical Emergency means a sudden onset of a medical condition or psychiatric condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical or psychiatric attention could reasonably result in:

- permanently placing the Insured's health in jeopardy or
- causing other serious medical or psychiatric consequences or
- causing serious impairment to bodily functions or
- causing serious and permanent dysfunction of any bodily organ or part.

Medically Necessary shall mean health care services that a Physician, exercising professional clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease, and
- not primarily for the convenience of the patient, Physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

For these purposes “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Mental or Nervous Disorders and Substance Abuse 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. Some Mental or Nervous Disorders are: schizophrenia, manic depressive and other conditions usually classified in the medical community as psychosis; drug, alcohol or other substance addiction or abuse; depressive phobic, manic and anxiety conditions (including panic disorders); bipolar affective disorders including mania and depression; obsessive compulsive disorders; hypochondria; personality disorders (including paranoid, schizoid, dependent, anti-social and borderline); dementia and delirious states; post traumatic stress disorder; hyperkinetic syndromes (including attention deficit disorders); adjustment reactions; reactions to stress; anorexia nervosa and bulimia. Any condition meeting this definition is a Mental or Nervous Disorder no matter what the cause. One or more of these conditions may be specifically excluded in this Policy. **However, medical services provided to treat medical conditions that are caused by behavior of the Insured that may be associated with these mental conditions (for example self-inflicted injuries) and treatment for Severe Mental Illness and Serious Emotional Disturbances of a Child are not subject to these limitations.**

Negotiated Fee Rate is the amount participating providers agree to accept as payment in full for covered services. rate of payment that Anthem has negotiated with the Participating Provider under a Prudent Buyer Participating Agreement for Covered Services furnished to persons insured under a Prudent Buyer Policy.

Negotiated Price (out of state, or in cases of Emergency some foreign country providers only) often consists of a simple discount which reflects the actual price paid by the on-site Blue Cross and/or Blue Shield Licensee plan. However, sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or specified group of providers. The Negotiated Price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The Negotiated Price will also be adjusted in the future to correct for over or under estimation of past prices. However, the amount you pay is considered a final price.

Newborn is a recently born infant within thirty-one (31) days of birth.

Non-Contracting Hospital is a Hospital which has neither a standard contract nor a Prudent Buyer Participating Hospital Agreement with Anthem. **No benefits are available for care furnished in Non-Contracting Hospitals in California** except for Medical Emergencies.

Non-Participating Provider is one of the following providers which do **not** have a Prudent Buyer Plan Participating Provider Agreement with Anthem in effect at the time services are rendered:

- A Hospital
- A Physician
- An Ambulatory Surgical Center
- A Home Health Agency or Visiting Nurse Association
- A facility which provides diagnostic imaging services
- A clinical laboratory
- A home Infusion Therapy provider
- A Skilled Nursing Facility
- A licensed ambulance company
- A durable medical equipment outlet
- Hospice

They are not Participating Providers. Remember that benefits for Non-Participating Providers may result in a greater out-of-pocket expense to you except in the case of an Authorized Referral or Medical Emergency as defined in this same PART. The Insured will be responsible for any billed charges over the amount allowed under this Policy.

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Participating Provider is one of the following providers which has a Prudent Buyer Policy Participating Provider Agreement in effect with us and has negotiated certain charges as the Negotiated Fee Rate they will charge our Insureds for Covered Services under this Policy. The exception would be when Preservice Review is not obtained.

- A Hospital
- A Physician
- An Ambulatory Surgical Center
- A Home Health Agency or Visiting Nurse Association
- A facility which provides diagnostic imaging services
- A clinical laboratory
- A home Infusion Therapy provider
- A Skilled Nursing Facility
- A licensed ambulance company
- A durable medical equipment outlet
- A certified nurse midwife
- A Hospice

A directory of Participating Providers is available upon request through our customer service representatives.

Physical and/or Occupational Therapy/Medicine is the therapeutic use of physical agents other than drugs. It comprises the use of physical, chemical and other properties of heat, light, water, electricity, massage, exercise and radiation.

Physician means:

- A doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided or
- One of the following providers but only when the provider is licensed to practice where the health care service is provided and is rendering a Covered Service within the scope of that license. The provider must also be providing a Covered Service for which benefits are specified in this Policy and when benefits would be payable if the services were provided by a Physician as defined above:
  - A dentist (D.D.S.)
  - An optometrist (O.D.)
  - A dispensing optician
  - A podiatrist or chiropodist (D.P.M. or D.S.C.)
  - A clinical psychologist
  - A chiropractor (D.C.)
  - A certified registered nurse anesthetist (C.R.N.A.)
  - A clinical social worker (C.S.W. or L.C.S.W.)
  - A marriage, family and child therapist (M.F.C.T.)
  - A physical therapist (P.T. or R.P.T.)*
  - A speech pathologist*
  - A speech therapist*
  - An audiologist*
  - An occupational therapist (O.T.R.)*
  - A respiratory therapist*
  - A registered nurse practitioner (R.N.P.)*
  - A certified nurse midwife
  - A Psychiatric Mental Health Nurse*
  - An acupuncturist

  Note: The providers indicated by an asterisk (*) are covered only by referral of a Physician as defined above.

Policy is the set of benefits, conditions, exclusions and limitations described in this document.

Policyholder is the person whose individual enrollment application has been accepted by us for coverage under this Policy.

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Preferred Participating Hospital is a Hospital that has entered into a Preferred Participating Agreement with Anthem. A list of Preferred Participating Hospitals is available upon request from our customer service representatives.

Pre-existing Condition means an illness, injury, disease or physical condition for which medical advice, diagnosis, care or treatment, including the use of Prescription Drugs was recommended or received from a licensed health care provider during the six (6) months immediately preceding the Insured's Effective Date of coverage. If you have questions on whether a condition is covered, please call Anthem toll free at 1-800-274-7767.

Provider is someone who renders health care services to you, is licensed to practice where the health care service is provided, is rendering a health care service within the scope of that license, and is providing a healthcare service for which benefits are specified under the part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM.

Psychiatric Mental Health Nurse is a registered nurse having a master's degree in psychiatric mental health nursing who meets the qualifications for registration and is registered as a Psychiatric Mental Health Nurse with the California Board of Registered Nurses.

Serious Emotional Disturbances of a Child is defined by the presence of one or more mental disorders as identified in the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result 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:

- As a result of the mental disorder, the child has substantial impairment in at least two (2) of the following areas:
  - Self-care
  - School functioning
  - Family relationships
  - The 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 (6) months or is likely to continue for more than one (1) Year without treatment.
- The child is psychotic, suicidal or potentially violent.
- The child meets special education eligibility requirements under California law.

Severe Mental Illness includes the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder (manic-depressive illness)
- Major depressive disorders
- Panic disorder
- Obsessive-compulsive disorder
- Pervasive developmental disorder or autism
- Anorexia nervosa
- Bulimia nervosa

Note: Coverage for Severe Mental Illness and Serious Emotional Disturbances of a Child will be provided in accordance with the Policy provisions for Severe Mental Illnesses and not in accordance with the Policy provisions for Mental or Nervous Disorders.

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

For purposes of Severe Mental Illness and Serious Emotional Disturbances of a Child only, a Skilled Nursing Facility will also include a residential treatment center which is an inpatient treatment facility where the Insured resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation as the result of a Mental Disorder or Substance Abuse. The facility must be licensed to provide psychiatric treatment of mental disorders or rehabilitative treatment of Substance Abuse according to state and local laws.

Year is a twelve (12) month period starting each January 1 at 12:01 a.m. Pacific Standard Time.

Questions? Visit www.MediCoverage.com or call (800) 930-7956

MONTHLY PREMIUMS

The premiums printed on your individual rate sheet are payable in advance and due the first of the month.

There are different billing options available:

Paper Bill
- □ Quarterly (3 months)
- □ Bi-monthly (2 months)

Checking Account Deduction Program/Credit Card
- □ Monthly (1 month)

Note: An administrative fee of $5.00 may be added for a paper bill or credit card.

You will be responsible for an additional $25 service charge for any check which is returned or dishonored by the bank as non-payable to Anthem for any reason. You will also be responsible for a $15 manual processing fee if you call customer service to make your premium payment. This fee is waived if you choose to set up a recurring payment option or if you choose Auto Pay Interactive Voice Response (IVR). This fee would also be waived if you were unable to use the Auto Pay IVR.

Important: If you are enrolled in the checking account deduction program, your must give us thirty (30) days advance written notice to:
- change banks
- change account numbers
- change account names
- Stop deduction or
- re-start eligible deductions

Electronic Funds Transfer: If you receive billing statements by mail and you submit a personal check for premium payments, you automatically authorize Anthem to convert that check into an electronic payment. We will store a copy of the check and destroy the original paper check. Your payment will be listed on your bank or credit union account statement as an Electronic Funds Transfer (EFT). Converting your paper check into an electronic payment does not authorize us to deduct premiums from your account on a monthly basis unless you have given us prior authorization to do so.

If we do not receive your written request at least thirty (30) days in advance of your premium due date, we will not be able to make the requested change in time to coincide with your premium due date. For the above listed changes, a new authorization form is required. We will be happy to send you the necessary form upon request by calling us at 1-800-333-0912.

Premiums are the monthly charges the member must pay Anthem to establish and maintain coverage. Anthem determines and establishes the required premiums based on the member's age and the specific regional area in which the member resides. If the member changes residence, he or she may be subject to a change in premiums. Such change in premiums will be effective on the next billing date following Anthem's receipt of written notification of the change of residence. If the member does not notify Anthem of a change in residence and Anthem later learns of the change in residential address, Anthem may in its discretion bill the member for the difference in premium from the date the address changed. Anthem will recalculate your premium based upon the age of each Insured and your premium will be adjusted to the new rate. Prior to any other premium change, Anthem will send out written notification 30 days in advance of such change.

For children only contracts, rates will be based upon the age of the youngest child. The youngest child will be considered the Policyholder.

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We reserve the right to change the premiums on thirty (30) days written notice to the Policyholder prior to the close of any billing term. The change will become effective on the date shown in the notice and payment of the new charges will indicate acceptance of the change.

Please be sure to read the Part entitled DURATION AND TERMINATION OF YOUR POLICY AND OUR RIGHT TO MODIFY YOUR POLICY for additional terms and conditions.

This Policy will terminate without notice upon failure to pay premiums when due. A grace period of thirty-one (31) days will be allowed for the payment of premiums and this Policy will remain in effect during that time. However, we have the right to deduct the unpaid premiums from the payments for covered benefits.

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