ENDORSEMENT TO THE INDIVIDUAL POLICY

Individual SmartSense Generic Rx $500 - Z153, Z154
Individual SmartSense Generic Rx $1,500 – Z155, Z156
Individual SmartSense Generic Rx $2,500 – Z157, Z158
Individual SmartSense Generic Rx $5,000 – Z159, Z160
Individual SmartSense Full Rx $500 – Z161, Z162
Individual SmartSense Full Rx $1,500 – Z163, Z164
Individual SmartSense Full Rx $2,500 – Z165, Z166
Individual SmartSense Full Rx $5,000 – Z167, Z168

Issued by
ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

Effective March 1, 2010, the following revisions have been made to your Individual SmartSense Policy issued to you by Anthem Blue Cross Life and Health Insurance Company.

PLEASE NOTE: ~~STRIKETHROUGH~~ INDICATES TEXT THAT HAS BEEN REMOVED; UNDERLINE INDICATES TEXT THAT HAS BEEN ADDED.

I. Under the PART entitled ELIGIBILITY, the following changes have been made:

Under the section entitled Who is Eligible for Coverage, under Dependents, the first bullet has changed to read as follows:

- The Policyholder's lawful spouse ~~of the opposite sex~~.

Under the section entitled Newborns and Adopted Children, the language has changed to read as follows:

- Newborns of the Policyholder, the Policyholder's enrolled spouse or enrolled Domestic Partner are automatically enrolled for the first thirty-one (31) days of life. TO CONTINUE COVERAGE FOR A ~~,~~ ~~THE~~ NEWBORN BEYOND THE FIRST THIRTY ONE (31) DAYS OF LIFE, YOU MUST ~~BE ENROLLED AS A DEPENDENT BY~~ NOTIFY~~ING~~ US IN WRITING WITHIN ~~SIXTY~~THIRTY-ONE (~~60~~31) DAYS OF BIRTH. ~~AND~~ THE POLICYHOLDER WILL BE RESPONSIBLE FOR ANY ADDITIONAL PREMIUMS DUE EFFECTIVE FROM THE DATE OF BIRTH.

  NEWBORNS OF THE POLICYHOLDER'S DEPENDENT CHILDREN **ARE NOT** COVERED UNDER THIS POLICY.
- A child being adopted by the Policyholder will be automatically enrolled for coverage ~~have coverage~~ for up to thirty-one (31) days from the date on which the adoptive child's birth parent or appropriate legal authority signs a written document granting the Policyholder, enrolled spouse or enrolled Domestic Partner the right to control health care for the adoptive child, or absent this document, the date on which other evidence exists of this right. TO CONTINUE COVERAGE FOR AN~~, THE~~ ADOPTED CHILD YOU MUST ~~BE ENROLLED AS A DEPENDENT BY~~ NOTIFY~~ING~~ US IN WRITING WITHIN ~~SIXTY~~THIRTY-ONE (~~60~~31) DAYS OF THE DATE THE POLICYHOLDER'S AUTHORITY TO CONTROL THE CHILD'S HEALTH CARE IS GRANTED. ~~AND~~ THE POLICYHOLDER WILL BE RESPONSIBLE FOR ANY ADDITIONAL PREMIUMS DUE EFFECTIVE FROM THE DATE THE POLICYHOLDER'S AUTHORITY TO CONTROL THE CHILD'S HEALTH CARE IS GRANTED.

II. Under the PART entitled WHEN AN INSURED BECOMES INELIGIBLE, the following changes have been made:

Under the section entitled An Insured becomes ineligible for coverage, the following changes have been made:

An Insured becomes ineligible for coverage
~~-~~under this Policy and subject to termination pursuant to the part entitled "DURATION AND TERMINATION OF YOUR POLICY AND OUR RIGHT TO MODIFY YOUR POLICY" when:

- The Policyholder does not pay the premiums when due, subject to the grace period.

- The spouse is no longer married to the Policyholder.
- The Domestic Partnership has terminated and the Domestic Partner no longer satisfies all eligibility requirements specified for Domestic Partners.
- The ~~child~~Dependent fails to meet the eligibility rules listed in the ~~PART~~part entitled ELIGIBILITY.
- An Insured moves to and lives in a place outside of California.
- The Insured becomes enrolled under any other Anthem non-group Policy.

Under the section entitled Notice of Change in Eligibility the language has changed to read as follows:

You must notify us of all changes affecting any Insured's eligibility under this Policy except for the first and last bullets listed above under, **'An Insured becomes ineligible for coverage ~~under this Policy when~~.'** 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.

Under the section entitled Options in the Event of Changed Circumstances the fourth paragraph has changed to read as follows:

The written application must be submitted to us within thirty-one (31) days of the loss of eligibility. We will not need proof of good health. 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.

III. Under the part entitled MAXIMUM COMPREHENSIVE BENEFITS the following changes have been made:

Under the section entitled Lifetime Maximum, the following language has been added as the second paragraph:

If an Insured replaces any Anthem individual medical Policy with another Anthem individual medical Policy, any benefits applied toward the Insured's lifetime maximum benefit of the prior policy will be applied toward the Insured's lifetime maximum benefit of the new Policy.

Under the section entitled Deductible, the following changes have been made:

Under the Family Deductible Maximum bullet, the following language has been added:

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.

The section entitled Participating Provider Deductible carryover credit has been removed as illustrated:

~~**Participating Provider Deductible carryover credit**~~

~~If your Individual Deductible is not met entirely during October through December in a given Year, Covered Services incurred from October through December and applied toward the Individual Deductible for that Year will also be applied toward your Individual Deductible for the next Year. If your Individual Deductible is satisfied entirely during October through December in a given Year, we will not carryover any amount applied toward that Individual Deductible to the next Year's Individual Deductible.~~

Under the section entitled, 'Non-Participating Provider Deductible', under the 'Family Deductible Maximum,' the language has been added or revised as follows:

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 Deductible amounts. These Deductibles are not prorated for a partial Year. Only Covered Expense will apply toward the Deductibles. A claim must be submitted in order for us to record your eligible covered 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. 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.

If you submit a claim for services ~~rendered by a Non-Participating Provider~~ which have a maximum payment limit ~~(e.g., Mental or Nervous Disorders and Substance Abuse, not including the treatment of~~

~~Severe Mental Illnesses and Serious Emotional Disturbances of a Child)~~ and neither of your ~~Non-Participating Provider~~ Deductible~~s~~ ~~is~~are ~~not~~ satisfied, we will apply only the allowed per visit or per day amount, whichever applies, toward your Participating Provider or Non-Participating Provider Deductible, whichever applies.

The section entitled, 'Non-Participating Provider Deductible carryover credit' has been removed as illustrated:

~~**Non-Participating Provider Deductible carryover credit**~~

~~If your medical expenses during the last three months of the Year are less than the Non-Participating Provider Deductible amount required under the terms of this contract, the eligible charges incurred during that period can be applied to the Non-Participating Provider Deductible for the next benefit Year. If you are covered under a Family Contract, any Insureds who had no Non-Participating Provider Deductible carryover credited to their next benefit Year will have to meet their individual Non-Participating Provider Deductible amounts again for that benefit Year.~~

Under the section entitled, 'YEARLY COPAYMENT/COINSURANCE MAXIMUMS,' the following changes have been made:

Under the section entitled, 'Participating Provider Yearly Copayment/Coinsurance Maximum,' under the 'Family Yearly Copayment/Coinsurance Maximum,' the following language has been added:

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

Under the section entitled, 'Non-Participating Provider Yearly Copayment/Coinsurance Maximum,' under the 'Family Yearly Copayment/Coinsurance Maximum,' the following language has been added:

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

IV. Under the part entitled BENEFIT COPAYMENT/COINSURANCE LIST the following changes have been made:

Under the section entitled SKILLED NURSING FACILITY the paragraph under the title has changed to read as follows:

This does not include treatment for Mental or Nervous Disorders or Substance Abuse **(except for the treatment of Severe Mental Illnesses and Serious Emotional Disturbances of a Child)**.

Under the section entitled OFFICE VISITS, the paragraph has changed to read as follows:

The first three (3) office visits from Participating Providers are covered at a $30 copay per insured, per year regardless of the type of provider seen. The total number of visits covered at the $30 copay is combined for all Participating providers. The Office Visit will not include any other services while at the office or a Physician (e.g., any surgery, Infusion Therapy, immunizations, diagnostic X-ray, laboratory, pathology and radiology) or any other services performed. No Participating Provider Deductible is required. After the first three (3) office visits, once the Participating Provider Deductible is satisfied, your benefits from all Participating Providers will be as stated in this PART.

Under the section entitled MENTAL OR NERVOUS DISORDERS AND SUBSTANCE ABUSE the paragraph under the title has changed to read as follows:

This does not include the treatment for Severe Mental Illnesses and Serious Emotional Disturbances of a Child. Preservice review required for all facility based treatment, as well as outpatient professional services after the twelfth (12^{th}) visit. The payments for this benefit will not be applied toward the Insured's Participating and Non-Participating Provider Yearly Copayment/Coinsurance Maximums.

Under the section entitled SEVERE MENTAL ILLNESSES AND SEROUS EMOTIONAL DISTURBANCES OF A CHILD the paragraph under the title has changed to read as follows:

Preservice review required for outpatient professional services after the twelfth (12th) visit and all facility based treatment. Benefits provided as any other medical condition.

Under the section entitled SPECIAL CIRCUMSTANCES, under the subsection 'For Medical Emergencies Within California' the 'Non-Participating Provider' benefit for 'Hospitals and Non-Contracting Hospitals' has changed to read as follows:

Non-Participating Provider	**Hospitals and Non-Contracting Hospitals:** 30% of Customary and Reasonable Charges or billed charges, whichever is less, **plus** all charges in excess of Customary and Reasonable, ~~for the first 48 hours. After 48 hours you pay all charges in excess of $650 per day.*~~

The note paragraph has been removed as illustrated below:

~~* If the Insured can demonstrate to Anthem that his/her medical condition reasonably prevented transfer to a Participating facility after the first 48 hours, then the Insured's payment will remain at 30% of the Customary and Reasonable Charge **plus** all charges in excess of Customary and Reasonable until his/her condition permits transfer to a Participating facility.~~

Under the section entitled BLUECARD PROGRAM under 'Medical Emergencies Outside California' under 'Hospital or Ambulatory Surgical Center' the 'Non-Participating Provider' benefit for 'Hospital' has changed to read as follows:

Non-Participating Provider	**Hospital:** 30% of the Customary and Reasonable Charge **plus** all charges in excess of Customary and Reasonable. ~~for the first 48 hours. After 48 hours you pay all charges in excess of $650 per day. **~~

The note paragraph has been removed as illustrated below:

~~**If an Insured can demonstrate to Blue Cross and/or Blue Shield that his/her medical condition reasonably prevented transfer to a BlueCard PPO or Traditional facility after the first 48 hours, then the Insured's payment will remain at 30% of Customary and Reasonable Charges **plus** all charges in excess of Customary and Reasonable, until his/her medical condition permits transfer to a PPO or Traditional facility.~~

V. Under the PART entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED the following changes have been made:

Under the section entitled OFFICE VISITS the following language has been added to the paragraph under the heading:

The first three (3) office visits from Participating Providers are covered at a $30 copay per insured, per year regardless of the type of provider seen. The total number of visits covered at the $30 copay is combined for all Participating providers. The office visit will not include any other services while at the office of a Physician (e.g., any surgery, Infusion Therapy, immunizations, diagnostic X-ray, laboratory, pathology, and radiology) or any other services performed. No Participating Provider Deductible is required. After the first three (3) office visits, once the Participating Provider Deductible is satisfied, your benefits from all Participating Providers will be as stated in the PART entitled BENEFIT COPAYMENT/COINSURANCE LIST.

Under section entitled MENTAL OR NERVOUS DISORDERS AND SUBSTANCE ABUSE, the section has been combined with TREATMENT FOR SEVERE MENTAL ILLNESS AND SERIOUS EMOTIONAL DISTURBANCES OF A CHILD and will read as follows:

~~**MENTAL OR NERVOUS DISORDERS AND SUBSTANCE ABUSE**~~

~~This does not include the treatment for Severe Mental Illnesses and Serious Emotional Disturbances of a Child.~~

- ~~Services must be for treatment of Substance Abuse, such as drug or alcohol dependence, or a Mental or Nervous Disorder which can be improved by standard medical practice.~~
- ~~Inpatient Hospital services and Day Treatment Program Centers are limited to $175 per day up to a maximum Anthem payment of $5,250 per Year, thirty (30) days per Year for Participating and Non-Participating Providers combined.~~
- ~~Inpatient or outpatient Physician's services are limited to $25 per visit (one visit per day) and twenty (20) visits per Year. This includes either inpatient or outpatient visits and/or psychological testing.~~

MENTAL OR NERVOUS DISORDERS AND SUBSTANCE ABUSE, INCLUDING TREATMENT FOR SEVERE MENTAL ILLNESS 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.)

Mental or Nervous Disorders and Substance Abuse: Covered Services must be for the treatment of Substance Abuse (such as drug or alcohol dependence) or a Mental or Nervous Disorder which can be improved by standard medical practice.

~~**TREATMENT FOR SEVERE MENTAL ILLNESSES AND SERIOUS EMOTIONAL DISTURBANCES OF A CHILD**~~

Severe Mental Illness and Serious Emotional Disturbances of a Child: 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").

Under the section entitled CENTERS OF MEDICAL EXCELLENCE (CME) FOR TRANSPLANTS AND BARIATRIC SURGERY the section has changed to read as follows:

Anthem ~~has established a network of Hospital facilities known as~~is providing access to the following separate Centers of Medical Excellence (CME) networks~~to provide services for specified organ and tissue transplants and bariatric surgical procedures~~. The facilities included in each of these CME networks are selected to provide the following specified medical services:

- Transplant Facilities. Transplant facilities have been 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 procedure and related services are approved by Anthem and ~~performed by a Participating Provider and~~ performed at an Anthem CME facility. ~~Preservice Review is required.~~

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.

Organ and Tissue 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 organ and tissue transplants: (heart, liver, lung, combination heart/lung, kidney, pancreas, kidney, simultaneous pancreas/kidney, bone marrow harvest and transplant, including autologous bone marrow transplant, peripheral /stem cell replacement 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 organ or tissue recipient or
- The organ or tissue 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.

- You are an enrolled Insured who needs to store cord blood and the storage is considered Medically Necessary according to the Anthem criteria for cord blood storage at an Anthem designated facility.

Other reasonable expenses, such as meals.

The following **travel expense benefits** will be provided for the recipient or donor in connection with a covered organ or tissue transplant if the specific CME, approved by Anthem, is 250 miles or more from the recipient's or donor's home. All travel expenses must be approved by Anthem in advance.]

Travel expenses will be provided for the **recipient** and one companion per transplant but are limited to six (6) trips per transplant. Travel expenses include:

- Transportation to and from the CME not to exceed $250 per trip for each person for round trip coach airfare.
- Hotel accommodations not to exceed $100 per day for up to seven twenty-one (721) days limited to one (1) room.]
- Meal expenses not to exceed $25 per day for each person for up to twenty-one (21) days per trip. Tobacco, alcohol and Drug expenses are excluded from coverage.

Travel expenses will be provided for the **donor** per transplant and are limited to one (1) trip per transplant. Travel expenses include:

- Transportation to and from the CME not to exceed $250 for round trip coach airfare.
- Hotel accommodations not to exceed $100 per day for up to twenty-oneseven (217) days limited to one (1) room.]
- Meal expenses not to exceed $25 per day up to seven (7) days limited to one (1) person. Tobacco, alcohol and Drug expenses are excluded from coverage.

Unrelated Donor Searches

- For all charges for unrelated donor searches for covered Bone marrow/stem cell transplants will not exceed $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.

VI. Under the PART entitled EXCLUSIONS AND LIMITATIONS the following terms have been added or revised:

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.

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

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.~~for formulas and special food products as specifically stated under Phenylketonuria (PKU) under the PART entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED. They must be prescribed by a Physician in consultation with a metabolic disease specialist and deemed Medically Necessary to prevent complications of PKU. Coverage is only to the extent that the prescribed formulas and special food products exceeded the cost of a normal diet.~~ 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 Policy 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 Hospital 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.

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 or services provided by a non-licensed provider under the supervision of licensed Physician, except as specifically provided or arranged by us.

Services that do not Require Licensure: Services or the supervision of services that are not required to be rendered by a licensed Provider unless specifically listed as being covered under the part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM.

Supervision of Non-licensed Provider: Services for 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).

Transportation and Travel Expense: Expense incurred for transportation, except as specifically stated in the AMBULANCE, TRANSPLANT TRAVEL EXPENSE and BARIATRIC TRAVEL EXPENSE provisions of COMPREHENSIVE BENEFITS: WHAT IS COVERED. Mileage reimbursement except as specifically stated in the TRANSPLANT TRAVEL EXPENSE and BARIATRIC TRAVEL EXPENSE provisions of COMPREHENSIVE BENEFITS: WHAT IS COVERED and approved by us. Charges incurred in the purchase or modification of a motor vehicle. Charges incurred for child care, telephone calls, laundry, postage or entertainment. Frequent flyer miles; coupons, vouchers or travel tickets; prepayments of deposits.

VII. Under the part entitled YOUR PRESCRIPTION DRUG BENEFITS the entire part has changed to read as follows:

We will provide outpatient Prescription Generic Drug benefits in accordance with this Part, subject to all other terms, conditions, limitations and exclusions of the Policy.
Anthem uses a preferred list of Drugs, sometimes called a Formulary, to help your doctor make prescribing decisions. Your Prescription Drug benefits cover only Prescription Generic Drugs listed on the Generic Prescription Drug Formulary. This list of Drugs is updated quarterly by a committee consisting of doctors and pharmacists so that the list includes Drugs that are safe and effective in the treatment of disease. The presence of a drug on the plan's formulary does not guarantee that it will be prescribed. If you have a question regarding whether a Drug is on the Generic Prescription Drug Formulary, please call toll free (800) 700-2533.

Some medications may require Prior Authorization from Anthem. Please call toll free (800) 700-2533 for a list of these Drugs.

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.

DEFINITIONS

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.

~~**Brand Name Prescription Drug** (Brand Name) is a Prescription Drug that has been patented.~~

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.

Drug Limited Fee Schedule is the maximum amount that we will consider for payment when your Prescription is filled at a Non-Participating Pharmacy and is the lesser of billed charges or the Average Wholesale Price.

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

Generic Prescription Drug (Generic) is a pharmaceutical equivalent of one or more Brand Name Drugs and must be approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the Brand Name Drug.

Maintenance Prescription Drugs are Prescription Drugs that 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 1-800-700-2533. 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.

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.

Note: The covered Prescription Drug list is subject to periodic review and amendment, which may cause a drug to be moved off the covered prescription drug list or move from one tier to another. If a drug is removed from the covered prescription drug list or if it changes tiers, your costs may change due to changes in your coinsurance and copayments. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage. If you have any questions about a particular drug, you may call 1-800-700-2533

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

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. (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.
- 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.
- 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 require 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 policy ends;
- You reach a benefit maximum that applies to prescription drugs, if the plan includes such a maximum;
- Your prescription drug benefits under the policy 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.

This paragraph applies to only
Individual SmartSense Generic Rx $500 - Z153, Z154
Individual SmartSense Generic Rx $1,500 – Z155, Z156
Individual SmartSense Generic Rx $2,500 – Z157, Z158
Individual SmartSense Generic Rx $5,000 – Z159, Z160

TIER 2, TIER 3 AND SPECIALTY PRESCRIPTION DRUG DEDUCTIBLE

Each Insured must meet a Tier 2, Tier 3 and Specialty Prescription Drug Deductible amount of $7500 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, Tier 3 and Specialty Prescription Drug Deductible will apply to Tier 2, Tier 3 and Specialty Prescription Drugs purchased through Participating Pharmacies, the Mail Order Prescription Drug Program or through Specialty Preferred Provider and at Participating and Non-Participating Pharmacies combined. However, any Copayment made for a Tier 2 Drug that has been specified by your Physician to "dispense as written" or "do not substitute" when a Tier 1 Drug equivalent exists, the Anthem Negotiated Fee (Participating Pharmacies) or the Drug Limited Fee Schedule (Non-Participating Pharmacies) for that Tier 2 Drug will **not** be applied towards the Tier 2, Tier 3 and Specialty Prescription Drug Deductible.

This paragraph applies to only
Individual SmartSense Full Rx $500 – Z161, Z162
Individual SmartSense Full Rx $1,500 – Z163, Z164
Individual SmartSense Full Rx $2,500 – Z165, Z166
Individual SmartSense Full Rx $5,000 – Z167, Z168

~~**BRAND NAME**~~**TIER 2, TIER 3 AND SPECIALTY PRESCRIPTION DRUG DEDUCTIBLE**

Each Insured must meet a ~~Brand Name~~Tier 2, Tier 3 and Specialty Prescription Drug Deductible amount of $500 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 ~~Brand Name~~Tier 2, Tier 3 and Specialty Prescription Drug Deductible applies to ~~Brand Name~~Tier 2, Tier 3 and Specialty Prescription Drugs purchased through the Mail Order Prescription Drug Program or through Specialty Preferred Provider and at Participating and Non-Participating Pharmacies combined. However, any Copayment made for a ~~Brand Name~~Tier 2 Drug that has been specified by your Physician to "dispense as written" or "do not substitute" when a ~~Generic~~Tier 1 Drug equivalent exists, the Anthem Negotiated Fee (Participating Pharmacies) or the Drug Limited Fee Schedule (Non-Participating Pharmacies) for that ~~Brand Name~~Tier 2 Drug will **not** be applied towards the ~~Brand Name~~Tier 2, Tier 3 and Specialty Prescription Drug Deductible. ~~The first two (2) Insureds of an enrolled family to satisfy their Brand Name and Specialty Prescription Drug Deductible in full will satisfy this Deductible for the entire family. Once the family Brand Name and Specialty Prescription Drug Deductible is satisfied, no further Brand Name and Specialty Prescription Drug Deductible is required for the remainder of that Year. However, we will not credit any Brand Name and Specialty Prescription Drug Deductible over and above the family Brand Name and Specialty Prescription Drug Deductible maximum that was applied but did not satisfy an individual Insured's Brand Name and Specialty Prescription Drug Deductible amount in full.~~

This paragraph applies to only
Individual SmartSense Generic Rx $500 - Z153, Z154
Individual SmartSense Generic Rx $1,500 – Z155, Z156
Individual SmartSense Generic Rx $2,500 – Z157, Z158
Individual SmartSense Generic Rx $5,000 – Z159, Z160

SPECIALTY PRESCRIPTION DRUG COINSURANCE MAXIMUM

There is a $10,000 Specialty Prescription Drug Coinsurance Maximum for Specialty Prescription Drugs per Insured per Year purchased from Participating Pharmacies and through the mail order Prescription Drug program or through our Specialty Preferred Provider. Once the $10,000 Specialty Prescription Drug Coinsurance Maximum is met, no further Specialty Prescription Drug Coinsurance will be required for Specialty Prescription Drugs purchased through Participating Pharmacies, mail order Prescription Drug

program or through our Specialty Preferred Provider for the remainder of that Year. Copayments for Tier 1, Tier 2 and Tier 3 drugs and the Tier 2, Tier 3 and Specialty Drug Deductible **will not** accumulate towards the Specialty Prescription Drug Coinsurance Maximum and will continue to be required even after the Specialty Prescription Drug Coinsurance Maximum has been reached.

This paragraph applies to only
Individual SmartSense Full Rx $500 – Z161, Z162
Individual SmartSense Full Rx $1,500 – Z163, Z164
Individual SmartSense Full Rx $2,500 – Z165, Z166
Individual SmartSense Full Rx $5,000 – Z167, Z168

~~BRAND NAME AND~~ SPECIALTY PRESCRIPTION DRUG ~~COPAYMENT/~~COINSURANCE MAXIMUM
There is a $3,000~~5000 Brand Name and~~ Specialty Prescription Drug ~~Copayment/~~Coinsurance Maximum for Specialty Prescription Drugs per Insured per Year purchased from Participating Pharmacies and through the mail order Prescription Drug program or ~~PrecisionRx~~through our Specialty Preferred Provider~~Solutions~~. ~~You will not be required to pay more than $5000 per Year for Prescription Drugs purchased from Participating Pharmacies or through the mail order Prescription Drug program or PrecisionRx Specialty Solutions~~. Once the $3,000~~5000 Brand Name and~~ Specialty Prescription Drug ~~Copayment/~~Coinsurance Maximum is met, no further Specialty Prescription Drug Coinsurance will be required for Specialty Prescription Drugs purchased through Participating Pharmacies, ~~or through the~~ mail order Prescription Drug program or through our~~PrecisionRx~~ Specialty Preferred Provider~~Solutions~~ for the remainder of that Year. Copayments for Tier 1, Tier 2 and Tier 3 drugs and the Tier 2, Tier 3 and Specialty Drug Deductible **will not** accumulate towards the Specialty Prescription Drug Coinsurance Maximum and will continue to be required even after the Specialty Prescription Drug Coinsurance Maximum has been reached.

The subsequent language in this part applies to all SmartSense policies

WHAT IS COVERED
~~If listed on the Generic Prescription Drug Formulary, the following Generic Prescription Drugs are covered under this PART:~~
Outpatient pharmacy benefits received from a pharmacy or mail service pharmacy or through our Specialty Preferred Provider are limited to:

- Outpatient ~~Generic~~ Drugs and medications 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.
- All non-infused compound ~~Generic~~ Tier 1 Prescriptions which contain at least one covered Prescription ingredient.
- Drugs and medications prescribed for the treatment of impotence and/or sexual dysfunction are covered only after the Insured has been covered under this Policy for twelve (12) consecutive months. These Drugs and medications must be authorized in advance by the Anthem and are limited to eight (8) tablets/units per thirty (30) day period. **(Not covered under mail order Prescription Drug program).**
- Oral contraceptive ~~Generic~~ 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, Tier 3 and Specialty Prescription Drug Deductible.

Note: Tier 1 Drugs will be dispensed by Participating Pharmacies unless the Prescription specifies a Tier 2 and states "dispense as written" or "no substitutions" or no Tier 1 Drug equivalent exists. However, any Copayment made for a Tier 2 Drug that has been specified by your Physician to "dispense as written" or "do not substitute" when a Tier 1 Drug equivalent exists, the Anthem Negotiated Fee (Participating Pharmacies) or the Drug Limited Fee Schedule (Non-Participating Pharmacies) for that Tier 2 Drug will **not** be applied towards the Tier 2, Tier 3 and Specialty Prescription Drug Deductible.

CONDITIONS OF SERVICE

The Drug or medicine must:

~~•Be a Generic form of the Prescription and listed on the Generic Prescription Drug Formulary.~~

- 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.
- Not be used while the Insured is an inpatient in any facility.
- Be dispensed by a participating pharmacy if it is an approved compound medication. You may call 1-800-700-2541 or go to **www.anthem.com/ca** to find out where to take your prescription for an approved compound medication to be filled.

  Note: Some compound medications must be approved before you can get them. You will have to pay the full cost of the compound medications that you get from a pharmacy that is not a participating pharmacy.
- Be dispensed by the specialty pharmacy program if it is a specialty pharmacy drug. See the section Specialty Drug Fulfillment in this part for how to get your drugs by using the specialty pharmacy program.

  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.

Note: The Prescription must not exceed a thirty (30) day supply ~~(~~unless ordered by mail through the mail order Prescription Drug program, in which case the limit is a sixty (60) day supply.

WHEN YOU GO TO A PARTICIPATING PHARMACY

Note: The covered Prescription Drug list is subject to periodic review and amendment, which may cause a drug to be moved off the covered prescription drug list or move from one tier to another. If a drug is removed from the covered prescription drug list or if it changes tiers, your costs may change due to changes in your coinsurance and copayments. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage. If you have any questions about a particular drug, you may call 1-800-700-2533.

When you present your identification card at a Participating Pharmacy, you will pay the following Copayment/Coinsurance for each covered Prescription and/or refill listed on the ~~Generic~~Tier 1 Prescription Drug Formulary:

This paragraph applies to only
Individual SmartSense Generic Rx $500 - Z153, Z154
Individual SmartSense Generic Rx $1,500 – Z155, Z156
Individual SmartSense Generic Rx $2,500 – Z157, Z158
Individual SmartSense Generic Rx $5,000 – Z159, Z160

For Prescription Drugs on the 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 a drug that is not on the Plan Formulary. Anthem discounts will apply to non-formulary drugs.

Participating Retail Pharmacy:

~~**For Drugs on the Generic Prescription Drug Formulary:**~~

- ~~Generic~~ **Tier 1 Drugs:** $15 Copayment~~ or 40% of the Negotiated Fee, whichever is greater~~.
- **Tier 2 Drugs:** 100% of the Negotiated Fee per Insured per Year until the $7500 Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied. After the $7,500 per Insured Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied:
  - Tier 2 Drugs: $40 Copayment for the Tier 2 Drug if a Tier 1 equivalent is not available.
- **Tier 3 Drugs:** 100% of the Negotiated Fee per Insured per Year until the $7,500 Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied. After the $7,500 per Insured Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied: $60 Copayment for the Tier 3 Drug if a Tier 1 equivalent is not available.
  - Tier 2 or Tier 3 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 Drug equivalent if a Tier 1 equivalent is available.
- **Specialty Drugs:** 100% of the Negotiated Fee per Insured per Year until the $7,500 Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied. After the $7,500 Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied then 25% of the Negotiated Fee Rate.
- **Self-Administered Injectable Drugs:** 25~~40~~% of the Negotiated Fee for Self-Administered Injectable Drugs and any combination kit or package containing both oral and Self-Administered Injectable Drugs, except for Insulin.

This paragraph applies to only
Individual SmartSense Full Rx $500 – Z161, Z162
Individual SmartSense Full Rx $1,500 – Z163, Z164
Individual SmartSense Full Rx $2,500 – Z165, Z166
Individual SmartSense Full Rx $5,000 – Z167, Z168

For Prescription Drugs on the 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 a drug that is not on the Plan Formulary. Anthem discounts will apply to non-formulary drugs.

Participating Retail Pharmacy:

~~**For Drugs on the Generic Prescription Drug Formulary:**~~

- ~~Generic~~ **Tier 1 Drugs:** $15 Copayment~~ or 40% of the Negotiated Fee, whichever is greater~~.
- **Tier 2 Drugs:** 100% of the Negotiated Fee per Insured per Year until the $500 Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied. After the $500 per Insured Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied:
  - Tier 2 Drugs: $40 Copayment for the Tier 2 Drug if a Tier 1 equivalent is not available.
- **Tier 3 Drugs:** 100% of the Negotiated Fee per Insured per Year until the $500 Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied. After the $500 per Insured Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied: $60 Copayment for the Tier 3 Drug if a Tier 1 equivalent is not available.
  - Tier 2 or Tier 3 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 Drug equivalent if a Tier 1 equivalent is available.
- **Specialty Drugs:** 100% of the Negotiated Fee per Insured per Year until the $500 Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied. After the $500 Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied then 25% of the Negotiated Fee Rate.
- **Self-Administered Injectable Drugs:** 40% of the Negotiated Fee for Self-Administered Injectable Drugs and any combination kit or package containing both oral and Self-Administered Injectable Drugs, except for Insulin.

The following paragraph applies to all SmartSense policies

WHEN YOU GO TO A NON-PARTICIPATING PHARMACY

No benefits are provided and you will be responsible for the full cost of a drug if you obtain your drugs from a Non Participating Pharmacy (retail and mail order).

~~If you purchase a Generic Prescription Drug from a Non-Participating Pharmacy, you will have to pay for the full cost of the Drug and submit a claim to:~~

~~Anthem Blue Cross Life and Health Prescription Drug Program~~
~~P.O. Box 4165~~
~~Woodland Hills, CA 91365-4165~~

~~Claim forms and customer service are available by calling (800) 700-2533. Mail the claim form with the appropriate portion completed and signed by the pharmacist to Anthem no later than fifteen (15) months after the date of dispensing.~~

~~**The rate of reimbursement by Anthem when your Prescription is filled at a Non-Participating Pharmacy** will be 60% of the Drug Limited Fee Schedule amount less the Copayment/Coinsurance as stated for Participating Pharmacies.~~

Non-Formulary Prescription Drugs are not covered.

Drugs obtained from Non-Participating Pharmacies will not be covered unless such drugs are prescribed in connection with a Medical Emergency.

This paragraph applies to only
Individual SmartSense Generic Rx $500 - Z153, Z154
Individual SmartSense Generic Rx $1,500 – Z155, Z156
Individual SmartSense Generic Rx $2,500 – Z157, Z158
Individual SmartSense Generic Rx $5,000 – Z159, Z160

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:

~~**Generic**~~**Tier 1 Drugs:** You pay a $~~15~~45 Copayment ~~or 40% of the Negotiated Fee, whichever is greater~~ for each Prescription and/or refill for each ~~thirty~~ninety (~~30~~90) day supply ~~or a $30 Copayment or 40% of the Negotiated Fee, whichever is greater for up to a maximum sixty (60) day supply~~.

Tier 2 Drugs: 100% of the Negotiated Fee per Insured per Year until the $7,500 Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied. After the $7,500 per Insured Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied:

- You pay a $120 Copayment for each Prescription and/or refill for each ninety (90) day supply if a Tier 1 equivalent is not available.

Tier 3 Drugs: 100% of the Negotiated Fee per Insured per Year until the $7,500 Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied. After the $7,500 per Insured Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied: $180 Copayment for each Prescription and/or refill for each ninety (90) day supply if a Tier 1 equivalent is not available.

- You pay the Tier 2 or Tier 3 Copayment, **plus** the difference in cost between the Tier 2 and the Tier 1 equivalent for each Prescription and/or refill up to a maximum ninety (90) day supply if a Tier 1 equivalent is not available.

Specialty Drugs: 100% of the Negotiated Fee per Insured per Year until the $7,500 Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied. After the $7,500 Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied then 25% of the Negotiated Fee Rate.

This paragraph applies to only
Individual SmartSense Full Rx $500 – Z161, Z162
Individual SmartSense Full Rx $1,500 – Z163, Z164
Individual SmartSense Full Rx $2,500 – Z165, Z166
Individual SmartSense Full Rx $5,000 – Z167, Z168

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:

~~**Generic**~~**Tier 1 Drugs:** You pay a $~~15~~45 Copayment ~~or 40% of the Negotiated Fee, whichever is greater~~ for each Prescription and/or refill for each ~~thirty~~ninety (~~30~~90) day supply ~~or a $30 Copayment or 40% of the Negotiated Fee, whichever is greater for up to a maximum sixty (60) day supply~~.

Tier 2 Drugs: 100% of the Negotiated Fee per Insured per Year until the $500 Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied. After the $500 per Insured Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied:

- You pay a $120 Copayment for each Prescription and/or refill for each ninety (90) day supply if a Tier 1 equivalent is not available.

Tier 3 Drugs: 100% of the Negotiated Fee per Insured per Year until the $500 Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied. After the $500 per Insured Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied: $180 Copayment for each Prescription and/or refill for each ninety (90) day supply if a Tier 1 equivalent is not available.

- You pay the Tier 2 or Tier 3 Copayment, **plus** the difference in cost between the Tier 2 and the Tier 1 equivalent for each Prescription and/or refill up to a maximum ninety (90) day supply if a Tier 1 equivalent is not available.

Specialty Drugs: 100% of the Negotiated Fee per Insured per Year until the $500 Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied. After the $500 Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied then 25% of the Negotiated Fee Rate.

The subsequent language in this endorsement applies to all SmartSense policies

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 **1-800-281-5524**.

Non-Formulary Prescription Drugs are not covered.

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

Drugs obtained from Non-Participating pharmacies will not be covered unless such drugs are prescribed in connection with a Medical Emergency.

The Prescription must state the dosage and your name and address, it 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 Formulary, Drugs and medications to treat Infertility, impotence and/or sexual dysfunction, injectables,

including Self-Administered Injectables except Insulin. Please check with the mail order Prescription Drug program customer service department at (866) 274-6825 for availability of the Drug or medication.

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 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 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 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. 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: 1-800-870-6419
Fax: 1-800-824-2642

Unless you qualify for an exception, if Specialty Drugs are not obtained through the Specialty Pharmacy Program, you will not receive any benefits for them under this plan. You will have to pay the full cost of any specialty drugs you get from a retail pharmacy that you should have obtained from the Specialty Preferred Provider. Please note that Specialty Drugs are not covered though the mail service drug program; however, if you do order a Specialty Drug through the mail service prescription drug program, the order will be forwarded to the Specialty Preferred Provider for processing and will be processed according to Specialty Pharmacy Program rules.

Exceptions to the Specialty Pharmacy Program

This requirement does not apply to:
The first month supply of a specialty drug which is available through a participating pharmacy;

Drugs, which due to medical necessity, are needed urgently and must be administered to the Insured immediately.

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.

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.

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 in-network mail services pharmacy. To obtain a list of the products available on this program call 1-866-614-0147 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 member’s 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 its 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 expense incurred in excess of billed charges or the Average Wholesale Price, which ever is less, at a Non-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.
- ~~Brand Name Drugs unless a Generic equivalent does not exist or if your Physician requests no substitutions~~.
- All Drugs and medications prescribed for the treatment of impotence and/or sexual dysfunction are covered only after the Insured has been covered under this Policy for twelve (12) consecutive months. Treatment of impotence and/or sexual dysfunction must be Medically Necessary and evidence of a

contributing medical condition must be submitted to Anthem Blue Cross Life and Health Pharmacy Plan for review. Drugs and medications for the treatment of impotence and/or sexual dysfunction are limited to eight (8) tablets/units per thirty (30) day period. **(Not covered under mail order program).**

- 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 sixty (60) day supply).
- Prescription Drugs with a non-Prescription (over-the-counter) chemical and dose equivalent.

CLAIMS AND CUSTOMER SERVICE

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

Anthem 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 Mail Order 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

All subsequent language in this endorsement applies to all contracts listed on the top of the first page of this endorsement, unless otherwise specified.

VIII. Under the part entitled UTILIZATION MANAGEMENT AND PRESERVICE REVIEW the following changes have been made:

The following language has been added as a fifth paragraph:

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

Under the section entitled 'Preservice Review is required for, but not limited to' the second bullet has changed to read as follows:

- Facility Based Treatment for Severe Mental Illness~~es~~ 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, outpatient professional services for Mental or Nervous Disorders or Substance Abuse after twelve (12) visits.

IX. Under the part entitled GENERAL PROVISIONS under the term entitled 'Terms of Coverage,' the 1st and 2nd bullet have been changed to read as follows:

- 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~~DURATION AND TERMINATION OF YOUR POLICY AND OUR RIGHT TO MODIFY 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~~DURATION AND TERMINATION OF YOUR POLICY AND OUR RIGHT TO MODIFY YOUR POLICY.

X. Under the part entitled INDEPENDENT MEDICAL REVIEW OF GRIEVANCES under the section entitled "For Denials, Modifications or Delays Based on a Determination that a Service is Experimental or Investigative" the 3rd and 4th paragraphs have changed to read as follows:

If an 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 medical and scientific evidence~~support~~ defined as follows.

"Acceptable medical and scientific evidence~~support~~" ~~is~~means 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,
- ~~Either of the following reference compendia:~~ The American Hospital Formulary Service's-Drug Information~~,~~ and ~~the American Medical Association Drug Evaluation,~~ the American Dental Association Accepted Dental Therapeutics ~~and the United States Pharmacopeia-Drug Information~~,
- Any of the following reference compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen:
  - The Elsevier Gold Standard's Clinical Pharmacology.
  - The National Comprehensive Cancer Network Drug and Biologics Compendium.
  - The Thomson Micromedex DrugDex.

All subsequent bullets will remain the same.

XI. Under the PART entitled BINDING ARBITRATION the language has been changed to read as follows:

This Binding Arbitration provision does not apply to class actions.

ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE ~~PLAN~~POLICY OR ANY OTHER ISSUES RELATED TO THE ~~PLAN~~POLICY AND CLAIMS OF MEDICAL MALPRACTICE ~~MUST BE RESOLVED BY BINDING ARBITRATION~~, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. ~~California Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: "~~*It is understood that any dispute including disputes relating to the delivery of services under the policy or any other issues related to the policy, 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 Policyholder~~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 Policyholder~~Member~~ and Anthem Blue Cross Life and Health, or by order of the court, if the Policyholder~~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 Life and Health will assume all or a portion of the costs of the arbitration.
All subsequent language will remain the same.

XII. Under the part entitled DURATION AND TERMINATION OF YOUR POLICY AND OUR RIGHT TO MODIFY YOUR POLICY the 2nd paragraph under item D.1. has changed to read as follows:

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.

XIII. Under the part entitled DEFINITIONS the following terms have been added alphabetically, revised or deleted:

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 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.

Customary and Reasonable Charge, ~~as determined annually by us,~~ is a charge which falls within the common range of fees billed by a majority of Physicians for a procedure in a given geographic region or which is justified based on the complexity or severity of treatment for a specific case.

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

Domestic Partner shall mean a person who has established a domestic partnership pursuant to California law with the Insured~~meets the plan's eligibility requirements for Domestic Partners outlined in the section Who is Eligible for Coverage under the PART entitled ELIGIBILITY~~.

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

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

Under the term entitled 'Medical Emergency,' the 1st paragraph only has been revised, the subsequent language in the definition has not changed.

Medical Emergency as determined means a Psychiatric Emergency Medical Conditions or a sudden onset of a medical condition ~~or psychiatric condition~~ manifesting itself by acute symptoms of sufficient severity including, without limitation, sudden and unexpected severe pain that the absence of immediate medical or psychiatric attention could reasonably result in:

Under the term entitled 'Physician,' the 2nd bullet only has been revised, the subsequent language in the definition has not changed.

- 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 ~~s~~Service within the scope of that license. The provider must also be providing a Covered ~~s~~Service for which benefits are specified in this Policy and those benefits would be payable if the services had been provided by a Physician as defined above:

~~**Policy Anniversary Date** is the date that base premiums for your policy with Anthem Blue Cross Life and Health are adjusted. **Note:** Premium changes due to change of address to a new regional area will be effective on the next billing date following written notification of the change of residence.~~

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 Emergency Medical Conditions means a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

- An immediate danger to himself or herself or to others, or
- Immediately unable to provide for, or utilize, food, shelter or clothing, due to the mental disorder.

XIV. Under the part entitled MONTHLY PREMIUMS the following changes have been made:

The 6th paragraph has changed to read as follows:

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.

XV. Under the paragraph entitled, 'Electronic Funds Transfer,' the 2nd and last paragraphs have been revised to read as follows:

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~~, without prior written notice from Anthem~~. 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 ~~on your Policy Anniversary Date~~ and your premium will be ~~automatically~~ adjusted to the new rate prior to any other premium change~~.~~ . Anthem will send out written notification 30 days in advance of such change.

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

This endorsement, effective March 1, 2010, is part of your Anthem Blue Cross Life and Health Individual SmartSense Policy. Please keep all of your documents together. Authorized officers of Anthem Blue Cross Life and Health Insurance Company have approved this endorsement as of the effective date.

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

Leslie A. Margolin
Chief Executive Officer
Anthem Blue Cross Life and Health
Insurance Company

Kathy Kiefer
Secretary
Anthem Blue Cross Life and Health
Insurance Company