Thrill-seeker

- $20 copay
- $5,000 deductible
- **$70-$121 per month***

*Depending on where you live, your age, and your medical history the amount may vary. But most people 19-29 pay about $70-$121. And you can cancel anytime.

Current as of March 1, 2009. Benefits subject to change.

BENEFITS SUMMARY LIST THRILL-SEEKER DN15 (T775)			
YOUR PAYMENT AFTER DEDUCTIBLE IS MET (unless otherwise noted)			
YOUR MEDICAL BENEFITS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER	INFORMATION YOU SHOULD KNOW
DEDUCTIBLE	$5,000 per calendar Year.		
LIFETIME MEDICAL BENEFIT MAXIMUM	$5,000,000 lifetime maximum benefits paid by Anthem Blue Cross Life and Health Insurance Company.		
OUT-OF-POCKET MAXIMUM	$5,000 Deductible per calendar Year, Participating and Non-Participating Providers combined.	$10,000 per calendar Year.	
OFFICE VISITS	You pay a $20 Copayment per Office Visit for the first four (4) Office Visits in a calendar Year. For subsequent Office Visits, you pay all of the Negotiated Fee Rate. After your Deductible has been satisfied, you do not pay any Copayment or Coinsurance for Office Visits for the remainder of that calendar Year.	You pay 50% of Covered Expense plus all charges in excess of Covered Expense after meeting your annual deductible.	No Deductible is required for the first four (4) Office Visits when you go to a participating provider. An Office Visit is when you go to the Physician's office and have one or more of **ONLY** the following three services provided: 1. History 2. Examination 3. Medical Decision Making The Office Visit will not include any other services while at the office of a Physician (e.g., any surgery, Infusion Therapy, diagnostic X-ray, laboratory, pathology, and radiology) or any other services performed other than or in addition to any of the three services specifically listed above.

			When you go to a Participating Provider, Copayments paid for the first four (4) Office Visits in a calendar Year will not be applied to the Deductible or out-of-pocket maximum.
PROFESSIONAL SERVICES	You do not pay any Coinsurance after meeting your annual deductible.	You pay 50% of Covered Expense plus all charges in excess of Covered Expense after meeting your annual deductible.	This benefit is separate from professional services covered under the Office Visit benefit (see above). Refer to the section PROFESSIONAL SERVICES under the PART called WHAT IS COVERED for a detailed description of Covered Services.
EMERGENCY ROOM	You do not pay any coinsurance.	You pay 50% of covered expense plus all charges in excess of covered expense.	
INPATIENT HOSPITAL	You do not pay any Coinsurance.	You pay all charges except $650 per day.	A Center of Medical Excellence (CME) Network has been established for transplants and bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss. These procedures are covered only when performed by a Participating Provider at an approved CME facility, except for Medical Emergencies. For more information, please see the section entitled CENTERS OF MEDCIAL EXCELLENCE (CME) FOR TRANSPLANTS AND BARIATRIC SURGERY under the PART called WHAT IS COVERED. Does not include treatment for Mental or Nervous Disorders and Substance Abuse (except for Severe Mental Illness and Serious Emotional Disturbances of a Child).
OUTPATIENT HOSPITAL AMBULATORY	You do not pay any Coinsurance.	You pay all charges except $380 per day.	Does not include treatment for Mental or Nervous

SURGICAL CENTER			Disorders and Substance Abuse (except for Severe Mental Illness and Serious Emotional Disturbances of a Child).
VISION	You pay all charges except $50 per calendar Year.		No Deductible is required. Covered Services received under this benefit are separate from Covered Services received under any other benefit described in this Policy. For a description of Covered Services, please see the VISION section in the PART called WHAT IS COVERED. For additional benefits, please see the vision section.
PREVENTIVE CARE			
Adult Preventive Services are provided at your Physician's office and not at the HealthyCheck Centers. Adult preventive services include an annual pap examination, breast exams, mammography testing, appropriate screening for breast cancer, cervical and ovarian cancer screening tests, PSA (Prostatic Specific Antigen) testing, and the Office Visit related to these services.	Office Visits: You pay a $20 Copayment per Office Visit for the first four (4) Office Visits in a calendar Year. For subsequent Office Visits, you pay all of the Negotiated Fee Rate. After your Deductible has been satisfied, you do not pay any Copayment or Coinsurance for Office Visits for the remainder of that calendar Year.	Office Visits: You pay 50% of Covered Expense plus all charges in excess of Covered Expense after meeting your annual deductible.	No Deductible is required for the first four (4) Office Visits when you go to a participating provider Copayments paid for the first four (4) Office Visits in a calendar Year will not be applied to the Deductible or out-of-pocket maximum.
	Professional Services (in the absence of an Office Visit): After your Deductible has been satisfied, you do not pay any Coinsurance.	Professional Services (in the absence of an Office Visit): After your Deductible has been satisfied, you pay 50% of Covered Expense plus all charges in excess of Covered Expense.	
HealthyCheck Centers (for the Policyholder age 7 years and above)	You pay $25 per HealthyCheck Center visit. You pay $75 per HealthyCheck Center visit for the additional services option (for	This benefit does not apply to Non-Participating Providers.	No Deductible applies. Copayments paid at HealthyCheck Centers do not accumulate towards satisfying your annual deductible.

	adults age 18 and above).		
PHYSICAL THERAPY OCCUPATIONAL THERAPY AND/OR CHIROPRACTIC CARE	You do not pay any Coinsurance.	You pay all charges except $25 per visit.	Limited to 24 visits per calendar Year, Participating and Non-Participating Providers combined. Payments for Non-Participating Providers will not be applied to your out-of-pocket maximum, and you will continue to be required to pay these amounts even after your out-of-pocket maximum has been satisfied.
DENTAL INJURY	You do not pay any Coinsurance.	You pay 50% of Covered Expense plus all charges in excess of Covered Expense.	
AMBULANCE	You do not pay any Coinsurance.	You pay 50% of Covered Expense plus all charges in excess of Covered Expense.	
MENTAL HEALTH CARE AND SUBSTANCE ABUSE			
Professional Services (inpatient and outpatient Physician services)	You pay all of the Negotiated Fee Rate except $25 per visit.	You pay all charges except $25 per visit.	Professional Services: Limited to 1 visit per day, 20 visits per calendar Year, Participating and Non-Participating Providers combined.
Inpatient Hospital and Day Treatment Program	You pay all of the Negotiated Fee Rate except $175 per day.	You pay all charges except $175 per day.	Inpatient Hospital and Day Treatment Program: Benefits are provided up to a maximum Anthem Blue Cross Life and Health Insurance Company payment of $5,250 per calendar Year (up to a maximum of 30 days per calendar Year), Participating Providers and Non-Participating Providers combined. Benefit is for treatment of Mental or Nervous Disorders or Substance Abuse and does not

			include treatment for Severe Mental Illness and Serious Emotional Disturbances of a Child. Payments for Non-Participating Providers will not be applied to your out-of-pocket maximum, and you will continue to be required to pay these amounts even after your out-of-pocket maximum has been satisfied.
	Services for Severe Mental Illness and Serious Emotional Disturbances of a Child: Benefits provided the same as for any other medical condition.	Services for Severe Mental Illness and Serious Emotional Disturbances of a Child: Benefits provided the same as for any other medical condition.	
PROGRAMS TO STOP SMOKING	You pay all charges except a $50 lifetime reimbursement.		
OTHER ELIGIBLE PROVIDERS * Blood Bank * Dentist (D.D.S.) * Dispensing Optician * Speech Pathologist * Speech Therapist * Audiologist * Respiratory Therapist	You pay all charges in excess of Covered Expense.		These providers do not enter into participating agreements with us, and they must be licensed according to state and local laws to provide covered medical services. Covered Services received from a dispensing optician under this benefit are separate from Covered Services received from a dispensing optician under the "VISION" benefit.
MEDICAL SUPPLIES EQUIPMENT AND FOOTWEAR	You do not pay any Coinsurance.	You pay 50% of Covered Expense plus all charges in excess of Covered Expense.	Footwear is limited to a maximum Anthem Blue Cross Life and Health Insurance Company payment of $400 per calendar Year, Participating and Non-Participating Providers combined.
SKILLED NURSING FACILITY	You do not pay any Coinsurance.	You pay all charges except $150 per day.	Limited to 100 days per calendar Year, Participating and Non-Participating Providers combined. Does not include treatment

			for Mental or Nervous Disorders and Substance Abuse (except for Severe Mental Illness and Serious Emotional Disturbances of a Child).
HOME HEALTH CARE	You do not pay any Coinsurance.	You pay all charges except $75 per visit.	Limited to 60 visits per calendar Year, up to four (4) hours each visit, Participating and Non-Participating Providers combined.
INFUSION THERAPY	You do not pay any Coinsurance.	Administrative and Professional Services: You pay all charges in excess of $50 per day for all expenses (except Drugs). Drugs: You pay all charges in excess of the Average Wholesale Price (AWP) of the Drug. Combined maximum Anthem Blue Cross Life and Health Insurance Company payment (for administrative, professional and Drugs) will not exceed $500 per day.	
HOSPICE	You do not pay any Coinsurance.	You pay 50% of Covered Expense plus all charges in excess of Covered Expense.	Limited to a lifetime maximum Anthem Blue Cross Life and Health Insurance Company payment of $10,000, Participating and Non-Participating Providers combined.
FOREIGN COUNTRY PROVIDER	For initial treatment of a Medical Emergency only. You pay all charges in excess of Covered Expense.		You are responsible, at your expense, for obtaining an English language translation of foreign country provider claims and medical records.
SPECIAL CIRCUMSTANCES FOR AUTHORIZED REFERRALS	This benefit does not apply to Participating Providers.	You pay all charges in excess of Covered Expense.	Non-Participating Providers: Physician, Hospital (inpatient or outpatient), Ambulatory Surgical Center

SPECIAL CIRCUMSTANCES FOR MEDICAL EMERGENCIES WITHIN CALIFORNIA	Benefits are the same as non-Medical Emergency benefits.	Professional Services: You pay all charges in excess of Covered Expense.	
		Emergency Room: You do not pay any coinsurance.	
		Hospital and Non-Contracting Hospital: You pay all charges in excess of Covered Expense for the first 48 hours. After 48 hours, you pay all charges except $650 per day.* Ambulatory Surgical Center: You pay all charges in excess of Covered Expense. Ambulance: You pay all charges in excess of Covered Expense.	Hospital and Non-Contracting Hospital: *If you can demonstrate to Anthem Blue Cross Life and Health Insurance Company that your medical condition reasonably prevented transfer to a Participating facility after the first 48 hours, then your payment will remain at all charges in excess of Covered Expense until your medical condition permits transfer to a Participating facility.
SPECIAL CIRCUMSTANCES FOR MEDICAL EMERGENCIES OUTSIDE CALIFORNIA			
Physician	PPO Provider: You do not pay any Coinsurance. Traditional Provider: You do not pay any Coinsurance.	You pay all charges in excess of Covered Expense.	BLUECARD PROGRAM For information about the BlueCard Program, including descriptions of the types of providers you may encounter outside California (i.e., PPO, Traditional and Non-Participating Providers), please see the PART called WHEN YOU TRAVEL OUTSIDE CALIFORNIA. Deductible is required (including emergency room services received outside California). Amounts you pay for Covered Expense will be applied to the calendar Year Deductible and out-of-pocket maximum.
Hospital, Ambulatory Surgical Center, Ambulance or Emergency Room	PPO Provider: You do not pay any Coinsurance.	Hospital: You pay all charges in excess of Covered Expense for the first 48 hours.	**If you can demonstrate to Blue Cross and/or Blue Shield that your medical condition reasonably

	Traditional Provider: You do not pay any Coinsurance.	After 48 hours, you pay all charges except $650 per day.** Ambulatory Surgical Center Ambulance or Emergency Room: You pay all charges in excess of Covered Expense.	prevented transfer to a BlueCard PPO or Traditional facility after the first 48 hours, then your payment will remain at all charges in excess of Covered Expense until your medical condition permits transfer to a PPO or Traditional facility.
ELECTIVE SERVICES OUTSIDE CA (NON-MEDICAL EMERGENCY)			
Office visits	PPO Provider: You pay a $20 Copayment per Office Visit for the first four (4) office visits. For subsequent office visits, you pay all of the Negotiated Fee Rate. After your deductible has been satisfied, you do not pay any copayment or coinsurance for office visits for the remainder of that calendar year. Traditional Provider: You pay 50% of the BlueCard Provider's Negotiated Price.***	You pay 50% of the BlueCard provider's Negotiated Price **plus** all charges in excess of the BlueCare provider's Negotiated Price after meeting your annual Deductible.	No Deductible is required for the first four (4) Office Visits when you go to a BlueCard provider. An Office Visit is when you go to the Physician's office and have one or more of **ONLY** the following three services provided: 1. History 2. Examination 3. Medical Decision Making The Office Visit will not include any other services while at the office of a Physician (e.g., any surgery, Infusion Therapy, diagnostic X-ray, laboratory, pathology, and radiology) or any other services performed other than or in addition to any of the three services specifically listed above. When you go to a BlueCard provider, payments paid for the first four (4) office visits in a calendar year will not be applied to the deductible or out of pocket maximum.
Professional Services	PPO Provider: You do	You pay 50% of the	BLUECARD PROGRAM

	not pay any Coinsurance after meeting your annual deductible. Traditional Provider: You pay 50% of the BlueCard provider's Negotiated Price.***	BlueCard provider's Negotiated Price plus all charges in excess of the BlueCard provider's Negotiated Price after meeting your annual deductible.	For information about the BlueCard Program, including descriptions of the types of providers you may encounter outside California (i.e., PPO, Traditional and Non-Participating Providers), please see the PART called WHEN YOU TRAVEL OUTSIDE CALIFORNIA. ***If there are no BlueCard PPO providers in the area, you do not pay any Coinsurance.
* Hospital or Ambulatory Surgical Center	PPO Provider: You do not pay any Coinsurance. Traditional Provider: You pay 50% of the BlueCard provider's Negotiated Price.***	Inpatient Hospital: You pay all charges except $650 per day. Outpatient Hospital and/or Ambulatory Surgical Centers: You pay all charges except $380 per day.	

YOUR PAYMENT - NO DEDUCTIBLE REQUIRED			
YOUR GENERIC PRESCRIPTION DRUG BENEFITS	WHEN YOU GO TO A PARTICIPATING PHARMACY	WHEN YOU GO TO A NON-PARTICIPATING PHARMACY	INFORMATION YOU SHOULD KNOW
RETAIL PHARMACIES			
* Generic Drugs	You pay a $15 Copayment for each Prescription and/or refill for each 30-day supply.	The rate of reimbursement is 50% of the Drug Limited Fee Schedule amount, less the Copayment/Coinsurance as stated for Participating Pharmacies.	Your Prescription Drug benefit (including mail service Prescription Drugs) covers only Generic Prescription Drugs listed on the Anthem Generic Prescription Drug Formulary. Outpatient Generic Prescription Drug benefits are separate from your medical benefits. This is a just a brief description of your Prescription Drug benefits; for detailed information, including exclusions, limitations and conditions of coverage, please see the PART called YOUR GENERIC PRESCRIPTION DRUG BENEFITS.
* Self-Administered Injectable Drugs	You pay 30% of the Negotiated Fee (except for Insulin) for Drugs listed on the Anthem Generic Prescription Drug Formulary.		
WHEN YOU ORDER BY MAIL			
* Generic Drugs	You pay a $15 Copayment for each Prescription and/or refill for each 30-day supply. You pay a $30 Copayment for each Prescription and/or refill up to a maximum 60-day supply.	Not Applicable.	

WHAT IS NOT COVERED

We will not furnish benefits for the following services and supplies. They are considered to be exclusions and limitations, which include, but are not limited to the following:

Acupuncture and Acupressure

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

Custodial Care
or 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.

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 Services and Nutritional Counseling
except as specifically provided or arranged by us under the Diabetes Outpatient Self-Management Training Program provision in the PART called WHAT IS COVERED.

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

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 PART called 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 point above.

Food and/or Dietary Supplements
except for formulas and special food products as specifically stated under Phenylketonuria (PKU) in the PART called 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 exceed the cost of a normal diet.

Government Services
Any services provided by a local, state or federal government agency.

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 (for Mental Health Care and Substance Abuse) in this Policy. However, medical services provided to treat medical conditions that are caused by behavior of the Policyholder that may be associated with mental or nervous 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.

Non-Contracting Hospital
No benefits are provided for care or treatment furnished in a Non-Contracting Hospital, except for a Medical Emergency as defined in the PART called IMPORTANT TERMS TO KNOW. 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 additional 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 Policy, except as follows:

1. Your Medicare coverage will be applied first (primary) to any services covered by both Medicare and under this Policy.
2. If you receive a service that is covered both by Medicare and under this Policy, 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 Policy 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.

The Policyholder who is Medicare disabled and/or 65 years of age or older may apply for an Anthem Blue Cross Plan which supplements Medicare benefits. SERVICES, BENEFITS AND PREMIUMS UNDER A MEDICARE SUPPLEMENT PLAN WILL NOT BE THE SAME AS THOSE PROVIDED UNDER THIS POLICY.

Not Covered Before Your Effective Date or After Your Coverage Ends
Services received before your Effective Date or during an inpatient stay that began before your Effective Date. Services received after your coverage ends.

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.

Dental Services
Dentures, bridges, crowns, caps, clasps, habit appliances, partials or other dental prostheses, Dental Services, extractions 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, and other orthodontic appliances.

Other Vision Care and Certain Eye Surgeries
Optometric services, eye exercises including orthoptics, and 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), except as specifically stated under the Vision sections in the PARTS called BENEFITS SUMMARY and WHAT IS COVERED.

Outdoor Treatment Programs

Outpatient Drugs and Medications Not from a Pharmacy
Any Drugs, medications or other substances dispensed or administered in any outpatient setting, except as specifically stated under the PART called YOUR GENERIC PRESCRIPTION DRUG BENEFITS.

Outpatient Speech Therapy
except following surgery, injury or non-congenital organic disease.

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. 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 provided during Office Visits as described in the Office Visits section under the PART called BENEFITS SUMMARY.

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 for Someone Other Than the Policyholder
Any person other than the Policyholder, including but not limited to the Policyholder's dependents, such as spouse, domestic partner, newborn, legal ward, natural and /or adopted child.

Services from Relatives
Professional services received from a person who lives in your home or who is related to you by blood, marriage or adoption.

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.

Telephone and Facsimile Machine Consultations

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

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 called WHAT IS COVERED, in the section entitled CENTERS OF EXPERTISE (COE) FOR TRANSPLANTS AND BARIATRIC SURGERY.

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.

DENTAL BENEFITS

WHAT IS COVERED

A. DEDUCTIBLE

Deductible is the amount of charges you will pay before we begin to pay for certain Covered Services.

Your Yearly Deductible for Covered Services is $25.00. During each Year, you are responsible for all expense incurred up to the Deductible amount. Only Covered Expense counts toward the Deductible so amounts over Covered Expense a Non-Participating Dentist may charge you won't count. The Deductible does not apply to diagnostic and preventive services when performed by a Participating Dentist.

B. YEARLY MAXIMUM BENEFIT

All dental benefits are limited to a maximum payment of $500.00 for expense incurred by you during a Year.

C. PAYMENT

Payment is provided as follows for Covered Expense incurred. All payments are subject to any maximum amounts, limitations and exclusions as indicated in this Policy. If a Participating Dentist provides services, any billed amount above Covered Expense will be a savings to you. Participating Dentists have agreed to accept the Negotiated Fee Rate as payment in full. Non-Participating Dentists have no such policy with Anthem Blue Cross Life and Health Insurance Company, therefore, they will bill You for any amounts over Covered Expense in addition to any deductible.

BENEFITS WILL BE PROVIDED ONLY FOR THE SERVICES SPECIFIED IN THIS BENEFIT SCHEDULE. NO BENEFITS WILL BE PROVIDED FOR ANY THING ELSE.

At a Participating Prudent Buyer Dentist benefits will be paid for Covered Expenses as follows:

100% of the Covered Expense you incur for diagnostic and preventive services (see Benefit Schedule below for a list of Covered Services) (Deductible is waived); and

80% of the Covered Expense you incur in excess of the Deductible for fillings (see Benefit Schedule below for a list of Covered Services).

At a Non-Participating Dentist:

Benefits will be paid as indicated in the following Benefit Schedule (after the deductible has been satisfied). Please note, you may have a greater share of the costs if services are performed by a Non-Participating Dentist.

BENEFIT SCHEDULE

Diagnostic and Preventive care

Procedure Code and Brief Description	At a Non-Participating Dentist, the Plan Pays
*D0120 Periodic oral exam	$18
*D0140 Limited oral exam-problem focused	$28
*D0150 Initial oral exam	$25
*D0160 Detailed and extensive oral exam-new or established patient	$49
*D0170 Re-evaluation exam-limited, problem focused	$28
*D0180 Comprehensive periodontal exam-new or established patient	$28
**D0210 Full mouth X-rays	$60
D0220 Single (periapical) X-rays – first film	$13
D0230 Single X-rays – additional films	$8
D0240 Single X-rays – Occusal	$17
D0250 Extraoral-first film	$16
D0260 Extraoral-each additional film	$10
D0270 Bitewing X-ray – single film	$16
D0272 Bitewing X-rays – two films	$18
D0274 Bitewing X-rays – four films	$26

D0277 Vertical bitewing X-rays..... $16

**D0290 Posterior-anterior or lateral skull and facial bone survey film..... $50

**D0330 Panoramic X-ray..... $36

**D0340 Cephalometric film..... $38

D1110 Prophylaxis (teeth cleaning adult) (limited to 2 per Year)..... $39

D1120 Prophylaxis (teeth cleaning child-through age 18) (limited to 2 per Year)..... $30

D1201 Prophylaxis (teeth cleaning child-through age 18) with fluoride (limited to 2 per Year)..... $35

D1203 Topical fluoride only (child through age 18) (limited to 2 per Year)..... $14

D1205 Topical fluoride with Prophylaxis (teeth cleaning adult) (limited to 2 per Year).... $39

* Exams are limited to two per Year.
** Full mouth X-rays or its equivalent are limited to one set every three (3) Years.

Fillings

After the Deductible has been satisfied, benefits will be paid for fillings as specified in the following Benefit Schedule. Please note, you may have a greater share of the costs if services are performed by a Non-Participating Dentist.

Procedure Code and Brief Description	**At a Non-Participating Dentist, the Plan Pays**
D2140 Amalgam filling – one surface, primary or permanent.....	$42
D2150 Amalgam filling –two surfaces, primary or permanent.....	$55
D2160 Amalgam filling – three surfaces, primary or permanent.....	$72
D2161 Amalgam filling – four or more surfaces, primary or permanent.....	$84
D2330 Resin-based composite filling – one surface, anterior.....	$42
D2331 Resin-based composite filling – two surfaces, anterior.....	$55
D2332 Resin-based composite filling – three surfaces, anterior.....	$72
D2335 Resin-based composite filling – four surfaces, incisal.....	$84
D2390 Resin-based composite crown, anterior.....	$85
***D2391 Resin-based composite filling – one surface, posterior.....	$42

***D2392 Resin based composite filling – two surfaces, posterior..... $55

***D2393 Resin based composite filling – three surfaces, posterior..... $72

***D2394 Resin based composite filling – four surfaces, posterior..... $84

*** If a tooth or teeth can be restored with amalgam (with the exception of composite resin on anterior teeth) any amount exceeding the cost of that material is not covered if another material is used. Anterior teeth exhibiting pathology eligible for composite restorations are central incisors, lateral incisors, cuspids and the facial surface of bicuspids.

WHAT IS NOT COVERED

No benefits are provided for or in connection with the following. They are considered to be exclusions and limitations, which include, but are not limited to the following:

Unlisted Services: Services not specifically listed in the "Benefit Schedule" section of this Policy

Excess Amounts: Any amounts in excess of the maximum amounts stated in the PART called "WHAT IS COVERED".

Any amounts which exceed the **Covered Expense** as determined by Anthem Blue Cross Life and Health Insurance Company.

Expenses Before Coverage Begins: Services received before your Effective Date or during an inpatient stay that began before your Effective Date.

End of Coverage: Services received after your coverage ends.

Services For Which You Are Not Legally Obligated To Pay: Services for which no charge is made to you in the absence of insurance coverage.

Services for someone other than the Policyholder: Any person other than the Policyholder, including but not limited to the Policyholder's dependent's such as spouse, domestic partner, newborn, legal ward, natural and/or adopted child.

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 worker's compensation law or similar law, we will provide the benefits of this plan for such conditions, subject to the right to a lien or other recovery under section 4903 of the California Labor Code or other applicable law.

Governmental Service: Any services provided by a local, state, county or federal government agency including any foreign government.

Services From Relatives: Professional services received from a person who lives in your home or who is related to you by blood, marriage or adoption.

Cosmetic Dentistry including services done or made for the sake of appearance: Any services performed for cosmetic purposes (including but not limited to external bleaching, bleaching of non-

vital discolored teeth, composite restorations, veneers, crowns on teeth not exhibiting pathology and facings on crowns on posterior teeth).

Charges for treatment by other than a licensed dentist, except charges for dental prophylaxis performed by a licensed dental hygienist.

Orthodontic services, braces appliances and all related services.

Diagnosis or Treatment of the Joint of the Jaw and/or Occlusion: Services, supplies or appliances provided in connection with:

1. Any treatment to alter, correct, fix, improve, remove, replace, reposition, restore or otherwise treat the joint of the jaw (temporomandibular joint) or associated musculature, nerves and other tissues for any reason or by any means; or

2. Any treatment, including crowns, and/or bridges to change the way the upper and lower teeth meet (occlusion); or

3. Treatment to change vertical dimension (the space between the upper and lower jaw) for any reason or by any means including the restoration of vertical dimension because teeth have worn down due to attrition, abrasion, abfraction, erosion or bruxism.

Procedures requiring restorations (other than those for replacement of structure loss from tooth decay) that are necessary to alter, restore or maintain occlusions. These include but are not limited to:

1. Changing the vertical dimension.
2. Replacing or stabilizing lost tooth structure by attrition, abrasion, abfraction, erosion or bruxism.
3. Realignment of teeth.
4. Gnathological recording.
5. Occlusal equilibration.
6. Periodontal splinting.

Oral examinations exceeding two visits per year.

Prophylaxis (teeth cleaning) exceeding two treatments per Year.

More than one set of full-mouth X-rays or its equivalent in a three (3) Year period.

Fluoride applications:

- if you are over eighteen (18) years of age.
- exceeding two visits per year.

Periapical and bite wing x-rays submitted singly will be combined and paid up to the amount of a full mouth series and are subject to the full-mouth x-ray limitation. No more than two (2) bite wing x-ray series for standard in a Year will be covered. No more than eight (8) films for vertical bite wings in a 36 month period will be covered.

Correction of congenital or development malformation including but not limited to supernumery and/or over retained deciduous teeth, cleft palate, maxillary or mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth).

Fillings exceeding one per Year per surface per tooth if you are under the age of 19 and one every three (3) Years per Surface per tooth if you are over the age of 19.

If a tooth or teeth can be restored with amalgam (with the exception of composite resin on anterior teeth) any amount exceeding the cost of that material is not covered if another material is used. Anterior teeth exhibiting pathology eligible for composite restorations are central incisors, lateral incisors, cuspids and the facial surface of bicuspids.

Replacement of existing fillings for any purpose other than restoring active decay.

Transfer of care: If a Policyholder transfers from the care of one dentist to that of another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, Anthem Blue Cross Life and Health Insurance Company shall be liable only for the amount it would have been liable for had one dentist rendered the services.

Prescribed drugs, pre-medication or analgesia (including nitrous oxide) are excluded.

Oral hygiene instruction includes instructions or guidance regarding home care. Some Examples of oral Hygiene instructions includes instructions or guidance on tooth brushing technique, flossing, and/or use of special oral hygiene aids.

Malignancies and Neoplasms: Services for treatment of malignancies and neoplasms are not Covered Services.

All hospital costs and any additional fees charged by the dentist for hospital treatment.

Implants: (Materials implanted into or on bone or soft tissue), or the removal of implants are not benefits under this Policy.

Services or Supplies That Are Not Medically Necessary.

Services for oral surgery, for example, tooth extractions.

Services for endodontics, for example, root canals. Endodontics means the branch of dentistry dealing with diseases of the tooth pulp.

Services for periodontics, for example, scaling and root planning. Periodontics is the dental specialty of treating periodontal disease.

Services for prosthodontics, for example, crowns. Prosthodontics is the branch of dentistry dealing with the construction of artificial appliances for the mouth, especially for the purpose of replacing missing teeth with bridges and dentures.

Space maintainers. Space maintainers are appliances that are designed to prevent tooth movement.

BLUE VIEW VISION BENEFITS

WHAT IS COVERED

This section describes the Covered Services available under your vision care benefits when provided and billed by Blue View Vision Participating Providers. All Covered Services are subject to the exclusions listed in the Part called WHAT IS NOT COVERED and all other conditions and limitations of the Policy. The amount payable for Covered Services varies depending on whether you receive your care from a Blue View Vision Participating Provider or a Non Participating Vision Care Provider and whether or not you choose optional services and/or custom materials rather than standard eyewear. Payment amounts are specified in this Part.

Covered Services

- Standard prescription eyeglass lenses (pair)
- Frame
- Contact lenses in lieu of eyeglass lenses

Services and materials obtained through a Non Participating Vision Care Provider are subject to the same exclusions and limitations as services obtained through a Blue View Vision Participating Provider. If you choose a frame or contact lenses that are valued at more than the Maximum Allowable Charge you are responsible for the amount over the plan allowance.

Vision Care Benefits

Your vision care benefits cover eyewear only. You can choose to have your eyewear services provided by Blue View Vision Participating Providers or by Non Participating Vision Care Providers; however, your benefits will be affected by this choice.

Copayments

Blue View Vision Participating Provider Copayments

- Standard prescription eyeglass lenses*****.....$25
- Frames..... No Copayment
- Contact lenses .....No Copayment

***** If you select standard progressive lenses, there will be an additional **$65** Copayment.

Note: In addition to the Copayment shown above, you will be required to pay any amount in excess of the Maximum Benefit for vision care services. But, when you go to a Blue View Vision Participating Provider your cost for vision care eyewear in excess of the Maximum Benefit will be at discount prices.

Vision Care Maximum Benefits

We will pay benefits for the following services and materials, up to the maximum dollar amounts and Benefit Periods shown below:

Blue View Vision Participating Providers

Frames.....$100
one frame per 24-month period******

Standard Prescription Lenses
one pair per 24-month period**

- Single vision lenses .....Covered in full after Copayment
- Bi-focal lenses .....Covered in full after Copayment
- Tri-focal lenses .....Covered in full after Copayment

Non-Elective Contact Lenses* $250
once per 24-month period**

Elective Contact Lenses* $80
once per 24-month period**

** From the Last Date of Service.
*** Contact lenses are in lieu of eyeglass lenses. If you choose Elective Contact Lenses in a Benefit Period, we will not pay benefits for eyeglasses (lenses and frame) during that same Benefit Period.

Non-Participating Vision Care Providers

Frames $45
one frame per 24-month period**

Standard Prescription Lenses
one pair per 24-month period**

- Single vision lenses $25
- Bi-focal lenses $40
- Tri-focal lenses $55

Non-Elective Contact Lenses* $210
once per 24-month period**

Elective Contact Lenses* $80
once per 24-month period**

** From the Last Date of Service.
*** Contact lenses are in lieu of eyeglass lenses. If you choose Elective Contact Lenses in a Benefit Period, we will not pay benefits for eyeglasses (lenses and frame) during that same Benefit Period.

WHAT IS NOT COVERED

No payment will be made under this Plan for expenses incurred for or in connection with any of the items below. (The titles given to these exclusions and limitations are for ease of reference only; they are not meant to be an integral part of the exclusions and limitations and do not modify their meaning.)

Cosmetic Options
Blended lenses/no line, oversize lenses, progressive multifocal lenses, photochromatic lenses, tinted lenses, coated lenses, cosmetic lenses or processes, and UV-protected lenses, and other lens options.

Crime or Nuclear Energy
Conditions that result from: (1) your commission of or attempt to commit a felony; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy.

Excess Amounts
Any amounts in excess of Covered Vision Expense**.**

Experimental or Investigational
Any Experimental or Investigative services or materials.

Eye Surgery
Any medical or surgical treatment of the eyes and any diagnostic testing. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Governmental Service
Any services actually given to you by a local, state or federal government agency, except when payment under this Plan is expressly required by federal or state law. We will not cover payment for these services if you are not required to pay for them or they are given to you for free.

Hospital Care
Inpatient or outpatient hospital vision care.

Lost or Broken Lenses or Frames
Any lost or broken lenses or frames, unless you have reached a new Benefit Period.

Non-Prescription Lenses
Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.

Not Specifically Listed
Services not specifically listed in this Plan as Covered Services.

Orthoptics
Orthoptics or vision training and any associated supplemental testing.

Private Contracts
Services or supplies provided pursuant to a private contract between the Policyholder and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Safety Glasses
Safety glasses and accompanying frames.

Services for Someone Other Than the Policyholder
Any person other than the Policyholder, including but not limited to the Policyholder's dependent's such as spouse, domestic partner, newborn, legal ward, natural and/or adopted child.

Services From Relatives
Professional services or supplies received from a person who lives in your home or who is related to you by blood or marriage or adoption.

Sunglasses
Sunglasses and accompanying frames.

Uninsured
Services received before your Effective Date or after your coverage ends.

Vision Exams or Tests
Vision examinations or vision tests.

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

Work-Related
Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation employer's liability law or occupational law even if you do not claim those benefits.

Other Discounts
Benefits may not be combined with coupon offers, or other promotional offers other than discounts associated with this program.

RIGHTS AND OBLIGATIONS

No-Obligation Review Period
After you enroll in a plan offered by Anthem Blue Cross Life and Health Insurance Company, you will receive a Policy booklet that explains the exact terms and conditions of coverage, including the plan's exclusions and limitations. You have 10 full days to examine your plan's features. During that time, if you are not fully satisfied, you may decline by returning your Policy booklet along with a letter notifying us that you wish to discontinue coverage. Policy booklets are available for you to examine prior to enrolling. Ask your agent or Anthem Blue Cross Life and Health Insurance Company.

Guarding Your Privacy
Anthem Blue Cross is fully committed to protecting our members' privacy. Our complete Notice of Privacy Practices provides a comprehensive overview of the policies and practices we enforce to preserve our members' privacy rights and control use of their health care information, including: the right to authorize release of information; the right to limit access to medical information; protection of oral, written and electronic information; use of data; and information shared with employers. You may obtain our complete Notice of Privacy Practices from our Web site at **www.anthem.com/ca**. You may also call the Customer Service number listed on your member ID card or prospective members can call 1-866-333-4820.

Utilization Management and Pre-Service Review
The Anthem Blue Cross Utilization Management and Pre-Service Review Program helps members receive coverage for appropriate treatment in the appropriate setting. Four review processes are included:

1) Pre-Service Review assesses medical necessity before services are provided;
2) Admission Review determines at the time of admission if the stay or surgery is Medically Necessary in the event Pre-Service Review is not conducted;
3) Continued Stay Review determines if a continued stay is Medically Necessary;
4) Retrospective Review determines if the stay or surgery was Medically Necessary after care has been provided if none of the first three reviews were performed.

Utilization Management and Pre-Service Review is not the practice of medicine or the provision of medical care to you. Only your doctor can provide you with medical advice and medical care.

Requirement for 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 SERVICE 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. California Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: "It is understood that 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.

California Department of Insurance
If you have a problem regarding your coverage, please contact Anthem Blue Cross Life and Health Insurance Company to resolve the issue. If you are unable to resolve the matter, you may request a review by the California Department of Insurance (CDI) at the following address and telephone number:

California Department of Insurance
Consumer Affairs Bureau
300 South Spring Street, South Tower
Los Angeles, California 90013
1-800-927-HELP (4357).

You may also be eligible for an Independent Medical Review (IMR) of disputed health care services from the California Department of Insurance if you believe that Anthem Blue Cross Life and Health Insurance Company has improperly denied, modified, or delayed health care services. A disputed health care service is any health care service eligible for coverage and payment under your plan

that has been denied, modified or delayed by Anthem Blue Cross Life and Health Insurance Company, in whole or in part because the service is not medically necessary.
The IMR process is in addition to any other procedures or remedies that may be available to you.

If you need additional information about IMR or require help in completing the form, you may call (818) 234-3353 or you may write to:

Anthem Blue Cross Life and Health Insurance Company
P.O. Box 4310
Woodland Hills, CA 91365.

Your Anthem Blue Cross Life and Health Insurance Company Policy contains an arbitration clause. Disagreements between you and Anthem Blue Cross Life and Health Insurance Company which exceed small claims court jurisdictional limits will be resolved through arbitration. To initiate arbitration, a written request must be submitted to your dedicated processing unit who will provide you with information to initiate arbitration.

Incurred Medical Care Ratio
As required by law, we are advising you that Anthem Blue Cross and its affiliated companies' incurred medical care ratio for 2006 was 81.53 percent. This ratio was calculated after provider discounts were applied.

Enrollment Guidelines
To enroll, you must be

- age 64 ¾ or younger;
- a permanent legal resident of California;
- a U.S. resident for at least the last 3 months;

The Tonik plans are designed and priced for an Individual policyholder. Only the named policyholder is eligible for benefits under the policy. Other persons, including, but not limited to, the policyholder's dependents, such as spouse, newborn, legal ward, natural and/or adopted child, are not eligible for coverage under the same policy as the policyholder. They may, however, apply separately for their own coverage by completing their own online enrollment application.

Medical Underwriting Requirement
We believe that the cost of our plans should be consistent with a member's expected health care needs and risk factors. That's why Anthem Blue Cross offers various levels of coverage. To determine individual medical risk factors, all applications are subject to medical underwriting. Depending on the results of underwriting review, a number of things may happen:

- you may be offered coverage at the standard premium charge, or
- you may be offered the plan you selected at a higher rate, or
- you may not qualify for the plan listed in this brochure, or
- you may be offered an alternative plan.

If you have a significant medical condition and do not qualify for the plan in this brochure or if you have discontinued group coverage, please contact your Anthem Blue Cross representative for information regarding other Individual coverage options.

Waiting Periods
For the Tonik plans, there is a specific six-month waiting period for coverage of any condition, disease or ailment for which medical advice or treatment was recommended or received within six months preceding the effective date of coverage. If you apply for coverage within 63 days of terminating your membership with another "creditable" health care plan, then you can use your prior coverage for credit toward the six-month waiting period. Anthem Blue Cross will credit the time you

were enrolled on the previous plan. Consult with your Anthem Blue Cross agent or representative if you have a question about the underwriting process.

Terms of Coverage
Coverage remains in force as long as you pay the required premiums on time and for as long as you remain eligible for membership. Coverage will cease if you become ineligible because of residency requirements or duplicate Individual coverage with Anthem Blue Cross.

Anthem Blue Cross may change or terminate coverage for all covered persons with the same plan, rating area and deductible (if applicable), including changing rates, with 30 days prior written notice. Anthem Blue Cross does not change coverage or rates unless the change applies to all covered persons of the same class.