



**ENDORSEMENT TO THE INDIVIDUAL
LUMENOS CONTRACTS**

**Issued by
ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY**

Effective December 9, 2010, the following revisions have been made to your Individual Policy issued to you by Anthem Blue Cross Life and Health Insurance Company as follows:

The following provisions apply under the Policy and Certificate of Insurance for Lumenos Contracts beginning on or after September 23, 2010, to ensure compliance with Federal health care reform known as the Patient Protection and Affordable Care Act, including any amendments, regulations, rules or other guidance issued with respect to the act ('Act'):

1. The contract code for the Policy is changed to 06BN.
2. This Policy contains no lifetime dollar limits or annual dollar limits on essential health benefits.
3. Coverage cannot be rescinded unless the individual (or person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact. After 24 months following issuance, the policy may not be rescinded for any reason.

If coverage of an individual is rescinded, written notice will be sent explaining the basis for the decision and the individual's appeal rights.

4. Dependent child coverage will continue until the end of the month in which the Dependent child turns age 26 regardless of the marital status of such Dependent child and regardless of:
 - the child's financial dependency on the Policyholder or on any other person;
 - the child's residency with the Policyholder or with any other person;
 - the child's status as a student;
 - the child's employment; or
 - any combination of the above factors.

Coverage does not include the spouse or child of such Dependent child unless that child meets other coverage criteria established under state law.

5. No pre-existing condition waiting period, limitation or exclusion will be applied to any Insured under the age of 19.
6. Coverage for preventive benefits, as defined in the Act, does not require payment of any Deductible, Copayment, or Coinsurance if obtained from a Participating Provider. If obtained from a Non-Participating Provider, the member will pay 50% of the Negotiated Fee Rate, plus all charges in excess of the Negotiated Fee Rate. The following are covered preventive benefits:

(a) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association. © Anthem is a registered trademark. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

(b) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

(c) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

(d) with respect to women, such additional preventive care and screenings not described in paragraph (a) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

(e) the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued on or around November 2009.

7. Except where an Insured's life or health would be seriously jeopardized, you must first exhaust our internal grievance process before we will grant your request for an external review. In no event shall your rights to an external review be any more restrictive than that set forth in the Uniform External Review Model Act established by the National Association of Insurance Commissioners (NAIC), by the Secretary of Health and Human Services (HHS) or within your state external review act, as applicable under state and federal law. There is no fee for an external review. If you have a question about our internal grievance process, filing a grievance, or the external review process, please call customer service at 1-800-333-0912, or you may write to us. Please address your correspondence to Anthem Blue Cross Life and Health Insurance Company, P.O. Box 9051, Oxnard, CA 93031-9051, marked to the attention of the Customer Service Department.
8. Insureds covered under this Policy are not required to designate a primary care physician.
9. Emergency services from Non-Participating Providers will be covered at the same benefit and cost sharing level as services provided by Participating Providers. Prior authorization for emergency services is not required.
10. The following definitions have been added or changed:

Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency services means, with respect to an emergency medical condition:

1. A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and
2. Within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment to stabilize the patient.

Stabilize means, with respect to an emergency medical condition:

To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions, the term “stabilize” also means to deliver (including the placenta), if there is inadequate time to affect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

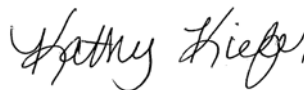
This Endorsement is part of your Anthem Blue Cross Life and Health Individual Policy. Please keep all of your documents together. This Endorsement terminates concurrently with the Policy to which it is attached.

This Endorsement is subject to all the definitions, limitations, exclusions and conditions of the Policy except as stated herein. This Endorsement applies notwithstanding any other provisions of the Policy or Certificate and to the extent there is a conflict between the Policy and this Endorsement, the terms of this Endorsement shall apply. 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



Pam Kehaly
Chief Executive Officer
Anthem Blue Cross Life and Health
Insurance Company



Kathy Kiefer
Secretary
Anthem Blue Cross Life and Health
Insurance Company

ENDORSEMENT TO THE FOLLOWING INDIVIDUAL LUMENOS POLICIES

PPO Lumenos HSA Compatible 1500/100 – DX26, DX27, DX28
PPO Lumenos HSA Compatible 2500/100 – DX32, DX33, DX34
PPO Lumenos HSA Compatible 3000/100 – DX38, DX39, DX40
PPO Lumenos HSA Compatible 5000/100 – DX44, DX45, DX46
PPO Lumenos HSA Compatible 1500/70 – Z126, Z127, Z128
PPO Lumenos HSA Compatible 3000/100 – Z132, Z133, Z134
PPO Lumenos HSA Compatible 5000/100 – Z129, Z130, Z131

PPO Lumenos HIA+ 2500/100 – DX47, DX48, DX49
PPO Lumenos HIA+ 3000/100 – DX53, DX54, DX55
PPO Lumenos HIA+ 5000/100 – DX59, DX60, DX61
PPO Lumenos HIA+ 1500/70 – Z135, Z136, Z137
PPO Lumenos HIA+ 3000/70 – Z141, Z142, Z143
PPO Lumenos HIA+ 5000/100 – Z138, Z139, Z140

PPO Lumenos HIA 1500/100 – DX62, DX63, DX64
PPO Lumenos HIA 2500/100 – DX68, DX69, DX70
PPO Lumenos HIA 3000/100 – DX74, DX75, DX76
PPO Lumenos HIA 5000/100 – DX80, DX81, DX82
PPO Lumenos HIA 1500/70 – Z144, Z145, Z146
PPO Lumenos HIA 3000/70 – Z150, Z151, Z152
PPO Lumenos HIA 5000/100 – Z147, Z148, Z149

Issued by
ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

Effective July 1, 2010, the following revisions have been made to your Individual Lumenos 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 YOUR PRESCRIPTION DRUG BENEFITS, the language has changed to read as follows:**

YOUR PRESCRIPTION DRUG BENEFITS

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

If you have a question regarding your Prescription Drug benefits, please call Anthem Prescription Drug Plan toll free 1-888-224-4911.

Some medications may require prior authorization from Anthem. Please call ~~Anthem Prescription Drug Plan~~ the Pharmacy Benefits Manager toll free 1-800-338-6180 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.~~

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 WHEN YOU GO TO A NON-PARTICIPATING PHARMACY for information on the percentage 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. To identify a Participating Pharmacy, call your local Pharmacy directly or call Anthem Prescription Drug Plan toll free 1-888-224-4911. 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.

[Prescription Drug Maximum Allowed Amount](#) is the maximum amount we allow for Prescription Drugs. The amount is determined by Anthem using cost information provided to Anthem by the Pharmacy Benefits Manager. The Prescription Drug Maximum Allowed Amount is subject to change. You may determine the Prescription Drug Maximum Allowed Amount of a particular Prescription Drug by calling 1-800-700-2533.

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

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.

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.

PRESCRIPTION DRUG DEDUCTIBLE

Prescription Drugs are subject to the same **Deductible** as indicated in the PART entitled MAXIMUM COMPREHENSIVE BENEFITS.

PRESCRIPTION DRUG OUT OF POCKET MAXIMUMS

Prescription Drugs purchased [by mail or](#) from Participating Pharmacies ~~and WellPoint NextRX mail service~~ are subject to the same **Out of Pocket Maximum** as indicated for Participating Providers in the Part entitled MAXIMUM COMPREHENSIVE BENEFITS.

Prescription Drugs purchased from Non-Participating Pharmacies are subject to the same **Out of Pocket Maximum** as indicated for Non-Participating Providers in the Part entitled MAXIMUM COMPREHENSIVE BENEFITS.

WHAT IS COVERED

- Outpatient Drugs and medications which federal and/or state of California law restrict to sale by Prescription only.
- Insulin and Insulin syringes prescribed and dispensed for use with Insulin. Lancets and test strips for use in monitoring diabetes.
- All non-infused compound 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 Anthem and are limited to eight (8) tablets/units per thirty (30) day period. **(Not covered under the mail service prescription drug program.)**
- Oral contraceptive Drugs prescribed for birth control. If your Physician determines that oral contraceptive Drugs are not medically appropriate, coverage for another FDA approved Prescription contraceptive method will be provided.
- Phenylketonuria (PKU) formulas and food products. These formulas are subject to the Coinsurance for Brand Name Drugs and the Deductible.

CONDITIONS OF SERVICE

The Drug or medicine must:

- Be prescribed in writing by a Physician and be dispensed 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 service prescription drug program.
- Not be used while the Insured is an inpatient in any facility.

Note: The Prescription must not exceed a thirty (30) day supply (unless ordered by mail through the mail service prescription drug program, in which case the limit is a ninety (90) day supply).

WHEN YOU GO TO A PARTICIPATING PHARMACY

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

You will pay 100% of the ~~Negotiated Fee~~ [Prescription Drug Maximum Allowed Amount](#) per Insured per Year until the Deductible has been satisfied. After the Deductible has been satisfied, you will have the applicable Coinsurance for each covered Prescription and/or refill listed below until your Participating Provider Out-of-Pocket Maximum has been satisfied. Once your Participating Provider Out-of-Pocket Maximum has been satisfied, Anthem will provide benefits at 100% of the [Prescription Drug Maximum Allowed Amount](#) ~~Negotiated Fee~~ for Prescription Drugs incurred by the Insured for the remainder of the Year.

Prescription Drugs including Self-Administered Injectable Drugs:

No Coinsurance required.

Note: Self-Administered Injectable Drugs include any combination kit or package containing both oral and Self-Administered Injectable Drugs, except for Insulin.

WHEN YOU GO TO A NON-PARTICIPATING PHARMACY

You will pay 100% of the cost of the Drug per Insured per Year until the Deductible has been satisfied. After the Deductible has been satisfied, you will have the applicable Coinsurance for each covered Prescription and/or refill listed below until your Non-Participating Provider Out-of-Pocket Maximum has been

satisfied. Once your Non-Participating Provider Out-of-Pocket Maximum has been satisfied, Anthem will provide benefits at 100% of the [Prescription Drug Maximum Allowed Amount](#)~~Drug Limited Fee Schedule~~ for Prescription Drugs for the remainder of the Year.

Remember you will always have to continue to pay any charges over the [Prescription Drug Maximum Allowed Amount](#)~~Drug Limited Fee Schedule~~ for all Prescription Drugs received from Non-Participating Pharmacies, even after your Out of Pocket Maximum has been reached.

If you purchase a Prescription Drug from a Non-Participating Pharmacy, you will have to pay for the full cost of the Drug.

Prescription Drugs

Reimbursement is 70% of the [Prescription Drug Maximum Allowed Amount](#)~~Drug Limited Fee Schedule~~.

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

Anthem Prescription Drug Plan
P.O. Box 145433
Cincinnati, OH 45250-4880

Claim forms and customer service are available by calling 1-888-224-4911. 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.

Many Prescription Drugs are available in Generic form, which is more cost-effective for you. It makes good sense to ask your Physician to prescribe, and your pharmacist to dispense, Generic Drugs whenever possible.

WHEN YOU ORDER BY MAIL

Your mail service prescription drug program is administered by ~~WellPoint NextRX~~[the Pharmacy Benefits Manager](#). Your mail service 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. You will pay 100% of the [Prescription Drug Maximum Allowed Amount](#)~~Negotiated Fee~~ per Insured per Year until the Deductible has been satisfied. After the Deductible has been satisfied you will pay the applicable Coinsurance amount, as listed below, for each covered Prescription and/or refill. Once your Participating Provider Out of Pocket Maximum has been satisfied, Anthem will provide benefits at 100% of the [Prescription Drug Maximum Allowed Amount](#)~~Negotiated Fee~~ for Prescription Drugs for the remainder of the Year.

Generic and Brand Name Drugs:

No Coinsurance required.

Note: The Prescription must not exceed a ninety (90) day supply.

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

The first mail service 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 Coinsurance to be enclosed.

You must authorize the pharmacist to release information needed in connection with the filling of a Prescription to the mail service prescription drug program.

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail service prescription drug program including, but not limited to, antibiotics, Drugs and medications to treat Infertility, impotence and/or sexual dysfunction, injectables, including Self-Administered Injectables except Insulin. Please check with ~~WellPoint NextRX~~[the Pharmacy Benefits Manager](#) customer service department at 1-866-595-9844 for availability of the Drug or medication.

Specialty Drug Fulfillment

~~PrecisionRx~~[The](#) Specialty [Preferred Provider Solutions](#) will be the sole specialty pharmacy available in our network. Specialty drugs will be covered only when obtained through [the PrecisionRx](#) Specialty [Preferred](#)

ProviderSolutions. Specialty drugs are defined as high-cost, injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of the patient's drug therapy. These drugs often require special handling such as temperature controlled packaging and overnight delivery and are often unavailable at retail stores. ~~PrecisionRx-The~~ Specialty **Preferred ProviderSolutions** is currently available to provide specialty drugs to Members. ~~PrecisionRx-The~~ Specialty **Preferred ProviderSolutions** network will fill a thirty (30) day supply of specialty drugs at your retail Coinsurance.

You or your doctor can order your specialty medication direct from ~~PrecisionRxthe~~ Specialty **Preferred ProviderSolutions** by simply calling 1-800-870-6419.

You may obtain a list of specialty drugs available through the ~~PrecisionRx-Specialty~~ **Preferred ProviderSolutions** network by contacting Member Services by calling toll free 1-800-870-6419 or online at www.precisionrxspecialtysolutionsanthem.com/ca.

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 Physician's 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.
- 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~~ **Prescription Drug Maximum Allowed Amount** at a Participating Pharmacy.
- ~~Any expense incurred in excess of billed charges or the Average Wholesale Price, whichever 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 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 the PARTS entitled BENEFIT COINSURANCE LIST and WHAT IS COVERED.
- 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 Prescription Drug 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 the mail service prescription drug program).

- A Prescription dispensed in excess of a thirty (30) day supply (unless ordered by mail through the mail service prescription drug program, in which case the limit is a ninety (90) day supply).
- Prescription Drugs with a non-Prescription (over-the-counter) chemical and dose equivalent.

CLAIMS AND CUSTOMER SERVICE

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

Anthem Prescription Drug Plan
P.O. Box 145433
Cincinnati, OH 45250-4880

or call the toll free customer service phone number at 1-888-224-4911

For **mail service prescription drug program** information, please write to:

Anthem Blue Cross Mail Service Prescription Drug Program
~~c/o PrecisionRx~~
P.O. Box 961025
Fort Worth, TX 76161-9863

or call the toll free customer service phone number at 1-866-595-9844

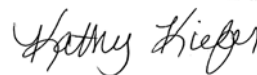
web site: www.anthem.com/ca

This endorsement, effective July 1, 2010, is part of your Anthem Blue Cross Life and Health Individual Lumenos 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

ENDORSEMENT TO THE FOLLOWING INDIVIDUAL LUMENOS POLICIES

PPO Lumenos HSA Compatible 1500/100 – DX26, DX27, DX28
PPO Lumenos HSA Compatible 2500/100 – DX32, DX33, DX34
PPO Lumenos HSA Compatible 3000/100 – DX38, DX39, DX40
PPO Lumenos HSA Compatible 5000/100 – DX44, DX45, DX46
PPO Lumenos HSA Compatible 1500/70 – Z126, Z127, Z128
PPO Lumenos HSA Compatible 3000/100 – Z132, Z133, Z134
PPO Lumenos HSA Compatible 5000/100 – Z129, Z130, Z131

PPO Lumenos HIA+ 2500/100 – DX47, DX48, DX49
PPO Lumenos HIA+ 3000/100 – DX53, DX54, DX55
PPO Lumenos HIA+ 5000/100 – DX59, DX60, DX61
PPO Lumenos HIA+ 1500/70 – Z135, Z136, Z137
PPO Lumenos HIA+ 3000/70 – Z141, Z142, Z143
PPO Lumenos HIA+ 5000/100 – Z138, Z139, Z140

PPO Lumenos HIA 1500/100 – DX62, DX63, DX64
PPO Lumenos HIA 2500/100 – DX68, DX69, DX70
PPO Lumenos HIA 3000/100 – DX74, DX75, DX76
PPO Lumenos HIA 5000/100 – DX80, DX81, DX82
PPO Lumenos HIA 1500/70 – Z144, Z145, Z146
PPO Lumenos HIA 3000/70 – Z150, Z151, Z152
PPO Lumenos HIA 5000/100 – Z147, Z148, Z149

Issued by

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

Effective March 1, 2010, the following revisions have been made to your Individual Lumenos 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 part entitled ELIGIBILITY, the following changes have been made:

Under the section entitled ‘Dependents,’ the 1st bullet has changed read as follows:

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

Under the section entitled ‘Newborns and Adopted Children,’ 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 NOTIFYING US ANTHEM IN WRITING WITHIN ~~SIXTY (60)~~ THIRTY-ONE (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 for ~~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 NOTIFYING US IN WRITING WITHIN ~~SIXTY (60)~~ THIRTY-ONE (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 section titled ‘An Insured becomes ineligible for coverage when,’ has changed to read as follows:

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:

Under the same section, the 4th bullet has changed and language has been added as the 5th bullet as follows:

- 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.](#)

Under the section entitled ‘Notice of Change in Eligibility,’ the paragraph 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 Even of Changed Circumstances,’ the 4th 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 2nd 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 language has been added as the 3rd paragraph:

[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.](#)

Under the section entitled, ‘Annual Out of Pocket Maximums,’ under the Non-Participating Provider Out of Pocket Maximum, the following language has been added as the 4th paragraph:

[The automatic enrollment of a Newborn or Adopted Children under the Eligibility section may cause the applicable copayment/coinsurance 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 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 \(12th\) visit.](#) Non Participating Provider payments for this benefit will not be applied toward the Insured’s Non-Participating Provider Out of Pocket Maximum.

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

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

Under the section entitled, 'Special Circumstances,' under the subsection entitled, 'For Medical Emergencies Within California,' under the benefit 'Non- Participating Providers,' the benefit entitled, 'Hospitals and Non-Contracting Hospitals' has been changed to read as follows:

For Medical Emergencies Within California
Hospitals and Non-Contracting Hospitals:

All charges in excess of Customary and Reasonable Charges ~~for the first 48 hours. After 48 hours, all charges in excess of \$650 per day.*~~

The 'Note' paragraph at the end of the section 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 all charges in excess of Customary and Reasonable Charges, 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:
All charges in excess of the Customary and Reasonable Charge. ~~for the first 48 hours. After 48 hours, all charges in excess of \$650 per day.**~~

The 'Note' paragraph at the end of the section 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 all charges in excess of Customary and Reasonable Charges, until his/her medical condition permits transfer to a PPO or Traditional facility.~~

V. Under the part entitled WHAT IS COVERED the following changes have been made:

The two sections entitled MENTAL AND NERVOUS DISORDERS AND SUBSTANCE ABUSE and SEVERE MENTAL ILLNESS AND SERIOUS EMOTIONAL DISTURBANCES OF A CHILD have been combined 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 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 following changes have been made:

Anthem ~~has established a network of Hospital facilities~~ is providing access to the following separate (called Centers of Medical Excellence) (CME) network 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 **1-888-224-4911**.

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 ~~by a Participating Provider~~ at an approved 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~~ at an Anthem approved CME facility.

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 (1) pre-surgical visit, the initial surgery and one (1) 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 (1) 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, ~~T~~obacco, 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 ~~approved by Anthem and~~ performed at an Anthem ~~approved~~ 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.~~

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 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 twenty-one (21) days per trip and is 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 seven (7) 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, revised or deleted:

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 exceed 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 section entitled DRUG UTILIZATION REVIEW the following language has been added:

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.

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

Under the paragraph Preservice Review a new section has been added and will read as follows:

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 been changed to read as follows:

- Facility Based Treatment for Severe Mental Illnesses and Serious Emotional Disturbances of a Child and Mental or Nervous Disorders or Substance Abuse. Outpatient professional services for Severe Mental Illness and Serious Emotional Disturbances of a Child after twelve (12) visits, outpatient professional services for Mental or Nervous Disorders or Substance Abuse after twelve (12) visits.

IX. Under the part entitled GENERAL PROVISIONS, the 1st two bullets under the term, 'Terms of Coverage,' have 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 DURATION AND TERMINATION OF YOUR POLICY AND OUR RIGHT TO MODIFY YOUR POLICY~~TERMS OF YOUR POLICY~~. Under this Policy, an expense is incurred on the date the Policyholder or Dependent receives a service or supply for which the charge is made.
- This Policy, including all terms, benefits, conditions, limitations and exclusions, may be changed by us as provided in the PART entitled DURATION AND TERMINATION OF YOUR POLICY AND OUR RIGHT TO MODIFY YOUR POLICY~~TERMS OF YOUR POLICY~~.

X. Under the part entitled INDEPENDENT MEDICAL REVIEW OF GRIEVANCES, under the paragraph 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 IMR review 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 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 [Member Policyholder](#) 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 Policyholder](#) and Anthem Blue Cross Life and Health, or by order of the court, if the [Member Policyholder](#) 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.

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 as follows:

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.](#) ~~Contract is a contract consisting of two (2) or more enrolled Insureds.~~

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 by us](#) 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 sService](#) within the scope of that license. The provider must also be providing a [Covered sService](#) 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 the 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 and/or adding or deleting dependent(s) will be effective on the next billing date following written notification of the change of residence or addition/deletion of a family member.~~

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:

Language has been added to the 5th paragraph and will 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.

Under the paragraph entitled 'Electronic Funds Transfer,' the 4th paragraph has changed 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.

The 2nd to the last paragraph has changed to read as follows:

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 Lumenos 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



**Individual PPO Lumenos[®] HSA - Compatible \$1,500/70%
Z126, Z127, Z128**

Dear Anthem Blue Cross Life and Health Insurance Company Insured,

We would like to welcome you to Anthem Blue Cross Life and Health Insurance Company (Anthem Blue Cross Life and Health) (Anthem) and extend our thanks for choosing our product as your coverage. Anthem Blue Cross Life and Health Insurance Company is an affiliate of Anthem Blue Cross and Anthem Blue Cross will administer this Policy for Anthem Blue Cross Life and Health Insurance Company.

This booklet describes the benefits of your coverage and various limitations, exclusions and conditions on those benefits. It is important for you to read this booklet carefully and understand it so that you will have an idea of what is not covered and the terms and limitations of your coverage. Additionally, please keep this booklet in a convenient place so you may refer to it whenever you have a question about your coverage.

If you have any questions regarding your eligibility or membership please feel free to contact our customer service department toll free at 1-888-224-4911 or you may write to us at Anthem Blue Cross Life and Health Insurance Company, P.O. Box 9051, Oxnard, California 93031-9051.

If you have any questions regarding claims status or your benefits under this Policy, please feel free to contact us at 1-888-224-4911 or write to us at Anthem Blue Cross Life and Health Insurance Company, P.O. Box 60007, Los Angeles, CA 90060-0007.

Thank you for choosing Anthem Blue Cross Life and Health Insurance Company.

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

A handwritten signature in black ink, appearing to read "Leslie A. Margolin".

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

A handwritten signature in black ink, appearing to read "Nancy L. Purcell".

Nancy L. Purcell
Secretary
Anthem Blue Cross Life and Health
Insurance Company

3-01-2009

Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association. [®]
Anthem is a registered trademark. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

HEALTH PROGRAMS

At Anthem Blue Cross Life and Health Insurance Company we believe it is important for you to have control of your health care and have access to health programs to help you establish or maintain good health habits.

The following Health Programs are available to insured persons, as specified below, at no out-of-pocket cost:

Health Assessment. You and any insured family members may complete the Health Assessment available on our website at www.anthem.com/ca each year.

Personal Health Coach Program. You and any insured family members who qualify may enroll in our designated Personal Health Coach Program once each year. You are qualified to enroll in the Personal Health Coach Program if you have a health condition that requires ongoing attention and for which we have a Personal Health Coach Program available. Health conditions may include but are not limited to asthma, depression, diabetes, high blood pressure, heart disease and pregnancy. If you have multiple health conditions, you may be enrolled in one, holistic Personal Health Coach Program. You graduate from the Personal Health Coach Program by reaching your goals and successfully completing the program. If you remain 'qualified' you can enroll in and graduate from the Personal Health Coach Program in subsequent Years. You can get information about the Personal Health Coach Programs by calling customer service toll free at 1-888-224-4911.

Smoking Cessation Program. Any insured over age 18 may enroll in our designated Smoking Cessation Program. The Smoking Cessation Program helps you through the "quit process" to manage withdrawal symptoms, identify triggers and learn new behaviors and skills to remain tobacco free. You can enroll in the Smoking Cessation Program by calling customer service toll free at 1-888-224-4911.

Weight Management Program. Any insured who qualifies may enroll in our designated Weight Management Program. You are qualified to enroll in this program if you are over age 18 with a BMI of 25 or greater. This Weight Management Program is a personalized phone course designed to help you adopt lifestyle changes necessary to lose weight and maintain weight loss. You can see if you are qualified to enroll in the Weight Management Program by calling customer service toll free at 1-888-224-4911.

THE FOREGOING HEALTH PROGRAMS ARE PROVIDED BY ANTHEM AS A SERVICE TO OUR INSUREDS; THESE SERVICES DO NOT CONSTITUTE BENEFITS UNDER THIS POLICY AND ARE SUBJECT TO CHANGE OR WITHDRAWAL WITHOUT NOTICE.

TABLE OF CONTENTS

	INTRODUCTION.....	1
PART I	ELIGIBILITY.....	3
PART II	WHEN AN INSURED BECOMES INELIGIBLE.....	5
PART III	MAXIMUM COMPREHENSIVE BENEFITS.....	6
PART IV	BENEFIT COINSURANCE LIST.....	8
PART V	WHAT IS COVERED.....	16
PART VI	EXCLUSIONS AND LIMITATIONS	25
PART VII	YOUR PRESCRIPTION DRUG BENEFITS.....	28
PART VIII	UTILIZATION MANAGEMENT AND PRESERVICE REVIEW	33
PART IX	ALTERNATIVE BENEFITS.....	34
PART X	GENERAL PROVISIONS.....	35
PART XI	INDEPENDENT MEDICAL REVIEW OF GRIEVANCES.....	39
PART XII	BINDING ARBITRATION.....	41
PART XIII	DURATION AND TERMINATION OF YOUR POLICY AND OUR RIGHT TO MODIFY YOUR POLICY	43
PART XIV	NON-DUPLICATION OF ANTHEM BENEFITS.....	44
PART XV	DEFINITIONS.....	45
PART XVI	MONTHLY PREMIUMS	52

**Z126, Z127, Z128
INDIVIDUAL PPO \$1,500/70% Lumenos[®] HSA COMPATIBLE PLAN
A Prudent Buyer Plan**

Issued By
ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

INTRODUCTION

Coverage under this plan does not establish a Healthcare Savings Account (HSA). You must open an HSA with a financial institution qualified under applicable federal law and Internal Revenue Service rules. If you intend to purchase this plan to use with an HSA for tax purposes, you should seek professional guidance from an attorney, accountant or other qualified advisor.

The Policy contains the exact terms and conditions of coverage. Please read the Policy completely and carefully. Individuals with special health care needs should carefully read those sections that apply to them.

YOU HAVE THE RIGHT TO VIEW THE POLICY PRIOR TO ENROLLMENT.

You also have the right to receive a copy of the Notice of Privacy Practices. You may obtain a copy by calling our customer service department at 1-888-224-4911 or by accessing our web site at www.anthem.com/ca.

This is a Preferred Provider Organization (PPO) Plan. We provide access to a network of Hospitals and Physicians who contract with Anthem Blue Cross Life and Health Insurance Company (Anthem Blue Cross Life and Health) (Anthem) to facilitate services to our Insureds and who provide services at pre-negotiated discounted fees. Covered Expenses for Participating Providers are based on the Negotiated Fee Rate. Participating Providers have a Prudent Buyer Participating Provider Agreement in effect with us and have agreed to accept the Negotiated Fee Rate as payment in full. Non-Participating Providers do not have a Prudent Buyer Participating Provider Agreement with Anthem. Your personal financial costs when using Non-Participating Providers may be considerably higher than when you use Participating Providers. You will be responsible for any balance of a provider's bill which is above the allowed amount payable under this Policy for Non-Participating Providers. Please read the benefit sections carefully to determine those differences. For a directory of Participating Providers or additional information, you may contact our customer service department at 1-888-224-4911.

Some Hospitals and other providers do not provide one or more of the following services that may be covered under your Policy and that you or your family member might need.

- Family planning
- Contraceptive services, including emergency contraception
- Sterilization, including tubal ligation at the time of labor and delivery
- Infertility treatments
- Abortion

You should obtain more information before you become a Policyholder or select a network provider. Call your prospective doctor or clinic or call customer service toll free at 1-888-224-4911 to ensure that you can obtain the health care services that you need.

Note: Some of the above reproductive services may not be covered by this Policy.

If your provider has been terminated and you feel you qualify for continuation of services, you must request that services be continued. This can be done by calling 1-888-224-4911.

In this Policy, "we," "us" and "our" mean Anthem Blue Cross Life and Health Insurance Company (Anthem Blue Cross Life and Health) (Anthem). You are the eligible Policyholder whose individual enrollment application has been accepted by us. "You" and "your" also mean any eligible Dependents who were listed on your individual enrollment application and accepted by us for coverage under this Policy. When we use the word "Insured" in this Policy, we mean you and any eligible Dependents who are covered under this Policy.

THE BENEFITS OF THIS POLICY ARE PROVIDED ONLY FOR SERVICES THAT ARE CONSIDERED MEDICALLY NECESSARY. THE FACT THAT A PHYSICIAN PRESCRIBES OR ORDERS THE SERVICE DOES NOT, IN ITSELF, MAKE IT MEDICALLY NECESSARY OR A COVERED SERVICE.

The benefits of this Policy are intended for use in the state of California. Any benefits received for services performed outside of the state of California may be significantly lower and result in a greater out-of-pocket expense for the Insured.

Anthem Blue Cross Life and Health Insurance Company enters into this Policy with you based upon the answers submitted by you and your Dependents on the signed individual enrollment application. In consideration for the payment of the premiums stated in this Policy, we will provide the services and benefits listed in this Policy to you and your eligible Dependents.

IF, WITHIN TWO (2) YEARS AFTER THE EFFECTIVE DATE OF THIS POLICY, WE DISCOVER ANY MATERIAL FACTS THAT WERE OMITTED OR THAT YOU OR YOUR INSURED FAMILY MEMBERS KNEW, BUT DID NOT DISCLOSE ON YOUR APPLICATION, WE MAY RESCIND THIS POLICY AS OF THE ORIGINAL EFFECTIVE DATE. ADDITIONALLY, IF WITHIN TWO (2) YEARS AFTER ADDING ADDITIONAL FAMILY MEMBERS (EXCLUDING NEWBORN CHILDREN OF THE INSURED ADDED WITHIN 31 DAYS AFTER BIRTH), WE DISCOVER ANY MATERIAL FACTS THAT WERE OMITTED OR THAT YOU OR YOUR INSURED FAMILY MEMBERS KNEW, BUT DID NOT DISCLOSE IN YOUR APPLICATION, WE MAY RESCIND COVERAGE FOR THE ADDITIONAL FAMILY MEMBER AS OF THE DATE HE OR SHE ORIGINALLY BECAME EFFECTIVE.

YOU HAVE TEN (10) DAYS FROM THE DATE OF DELIVERY TO EXAMINE THIS POLICY. IF YOU ARE NOT SATISFIED, FOR ANY REASON WITH THE TERMS OF THIS POLICY, YOU MAY RETURN THE POLICY TO US WITHIN THOSE TEN (10) DAYS. YOU WILL THEN BE ENTITLED TO RECEIVE A FULL REFUND OF ANY PREMIUMS PAID. THIS POLICY WILL THEN BE NULL AND VOID.

CHOICE OF CONTRACTING HOSPITAL, SKILLED NURSING FACILITY AND ATTENDING PHYSICIAN

Nothing contained in this Policy restricts or interferes with your right to select the Contracting Hospital, Skilled Nursing Facility or attending Physician of your choice.

Payments of benefits under this Policy do not regulate the amounts charged by providers of medical care or attempt to evaluate those services.

Throughout this Policy, you will find key terms which will appear with the first letter of each word capitalized. When you see these capitalized words you should refer to the PART entitled DEFINITIONS of this Policy where the meanings of these terms or words are defined. Some key terms may be defined within a specific benefit description.

BECAUSE WE CARE ABOUT THE QUALITY OF THE SERVICE PROVIDED TO OUR CUSTOMERS, YOUR TELEPHONE CALL TO US MAY BE RANDOMLY OBSERVED OR RECORDED TO ENSURE THAT WE ARE ACHIEVING THAT GOAL.

THE ENTIRE POLICY SETS FORTH, IN DETAIL, THE RIGHTS AND OBLIGATIONS OF BOTH YOU AND ANTHEM. IT IS, THEREFORE, IMPORTANT THAT YOU READ YOUR ENTIRE POLICY CAREFULLY. PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

IMPORTANT!

This is not an annual Policy. The duration of your coverage depends on the method of payment you chose under Paragraph B. under the Part entitled **DURATION AND TERMINATION OF YOUR POLICY AND OUR RIGHT TO MODIFY YOUR POLICY**, and is not affected by any provisions defining your Deductible or other cost sharing obligations. Your Policy expires at the end of each billing cycle but will automatically renew upon timely payment of your next premium charge, subject to our right to terminate, cancel or non-renew as described in the Part entitled **DURATION AND TERMINATION OF YOUR POLICY AND OUR RIGHT TO MODIFY YOUR POLICY**, Paragraph D. Also, premiums, benefits, terms and conditions may be modified at any time during the Year following thirty (30) days written notice pursuant to the Part entitled **DURATION AND TERMINATION OF YOUR POLICY AND OUR RIGHT TO MODIFY YOUR POLICY**, Paragraph E. Please read the Part entitled **DURATION AND TERMINATION OF YOUR POLICY AND OUR RIGHT TO MODIFY YOUR POLICY** carefully and in its entirety to make sure you fully understand the duration of your coverage and the conditions under which we can change, terminate, cancel or decline to renew your Policy.

PART I ELIGIBILITY

Who is Eligible for Coverage

A resident of the state of California who has properly applied for coverage and who is insurable according to our applicable underwriting requirements.

Dependents: Any of the following persons listed on the individual enrollment application completed by the Policyholder and who is insurable according to our applicable underwriting requirements.

- The Policyholder's lawful spouse of the opposite sex.
- The Policyholder's Domestic Partner, subject to the following:
- The Policyholder and Domestic Partner have completed and filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code, have provided Anthem with a copy of the Declaration of Domestic Partnership, and the Domestic Partnership has not terminated. The Domestic Partner does not include any person who is covered as a Policyholder or Spouse.
- Any children of the Policyholder, the Policyholder's enrolled spouse or enrolled Domestic Partner who are under age 19, and
- Any unmarried children of the Policyholder, the Policyholder's enrolled spouse or enrolled Domestic Partner who are between their 19th and 23rd birthday, provided they are dependent upon them for at least half of their support. If your Dependent does not continue to meet the qualifications to remain as a Dependent on your Policy, but is a resident of California, Anthem will automatically offer your Dependent, the same Policy under his/her own identification number.

Overage Dependents and Dependents Enrolled as a Full-time Student

- Any of the Policyholder's, the Policyholder's enrolled spouse's or enrolled Domestic Partner's children who continue to be both incapable of self-sustaining employment due to a continued physically or mentally disabling injury, illness, or condition and who are dependent upon the Policyholder, enrolled spouse or enrolled Domestic Partner for support.
OR
- Taking a medical leave of absence from school.
- For Disabled Overage Dependents
 - Ninety (90) days before the dependent child reaches the limiting age, Anthem Blue Cross Life and Health will issue a request for proof that the child continues to meet the criteria for continued coverage.
 - The Policyholder must submit written proof of such dependency within sixty (60) days of receiving the request.
 - Before the date the child reaches the limiting age, Anthem Blue Cross Life and Health will determine whether the child meets the criteria for continued coverage.
 - Two (2) years after receipt of the initial proof, we may require no more than annual proof of the continuing handicap and dependency.
 - Anthem Blue Cross Life and Health may request a new Policyholder to provide information regarding a dependent child with a continued physically or mentally disabling injury, illness or condition at the time of enrollment and not more than annually thereafter for proof that the child meets the criteria for continued coverage. The Policyholder must submit written proof of such dependency within sixty (60) days of receiving the request.
- **For Dependents on Medical Leave of Absence from School**
 - The dependent child's coverage shall not terminate for a period not to exceed 12 months or until the date on which the coverage is scheduled to terminate as indicated in this Policy, whichever comes first.
 - The period of coverage under this paragraph shall commence on the first day of the medical leave of absence from school or on the date the physician determines the illness prevented the dependent child from attending school, whichever comes first.
 - Any break in the school calendar shall not disqualify the dependent child from coverage under this paragraph.

- Documentation or certification of the medical necessity for a leave of absence from school shall be submitted to Anthem Blue Cross Life and Health at least 30 days prior to the medical leave of absence from school, if the medical reason for the absence and the absence are foreseeable, or 30 days after the start date of the medical leave of absence from school and shall be considered evidence of entitlement to coverage under this paragraph.

Newborns and Adopted Children

- Newborns of the Policyholder, the Policyholder's enrolled spouse or enrolled Domestic Partner for the first thirty-one (31) days of life. TO CONTINUE COVERAGE, THE NEWBORN MUST BE ENROLLED AS A DEPENDENT BY NOTIFYING US IN WRITING WITHIN SIXTY (60) 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 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, THE ADOPTED CHILD MUST BE ENROLLED AS A DEPENDENT BY NOTIFYING US IN WRITING WITHIN SIXTY (60) 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.

Transferring to Another Individual Plan

If you and your dependents have been covered under this individual plan for at least 18 months, you and any applicable dependents, have the right to transfer at least once each year without medical underwriting, to any other individual plan that we offer that provides equal or lesser benefits, as determined by us. "Without medical underwriting," means that we will not deny you coverage or impose any pre-existing condition period on you or any applicable dependents when you transfer to another individual plan with equal or lesser benefits. We will notify you in writing of your right to transfer, whenever your premium rates for your present plan coverage are changed. The notice will provide information on other individual contracts available to you and how to apply for a transfer. You may also contact the Plan at anytime for further information as to how to transfer to another individual plan after you have been enrolled in the plan for at least 18 months.

At any time after you are enrolled in this individual plan, you may also apply to transfer to another individual plan with greater benefits. However, you and your dependents may need to pass medical underwriting requirements.

For further information, please contact customer service toll free at 1-800-333-0912.

Eligibility following Rescission

For individual Policies that have been rescinded, eligible Insureds on such Policies may continue coverage, without medical underwriting, in one of the following ways:

- enroll in a new individual Policy that provides equal benefits, or
- remain covered under the individual Policy that was rescinded.

In either instance, premium rates may be revised to reflect the number of persons on the Policy.

We will notify in writing all Insureds of the right to coverage under an individual Policy, at a minimum, when we rescind the individual Policy.

Eligible Insureds who continue coverage as a result of a rescinded Policy may be subject to completing the pre-existing condition exclusion period that was not fulfilled on the rescinded Policy. This means that we will credit any time that the eligible Insured was covered under the rescinded Policy. The time period in the new Policy for the pre-existing condition exclusion period will not be longer than the one in the Policy that was rescinded.

We will provide 60 days for enrollees to accept the offered new individual Policy and this contract shall be effective as of the effective date of the original Policy and there shall be no lapse in coverage.

PART II WHEN AN INSURED BECOMES INELIGIBLE

An Insured becomes ineligible for coverage under this 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. If a Domestic Partnership terminates, the Policyholder must send Anthem written notification that the Domestic Partnership has been terminated within sixty (60) days of the termination.
- The child fails to meet the eligibility rules listed in the PART entitled ELIGIBILITY.
- The Insured becomes enrolled under any other Anthem non-group Policy.

Notice of Change in Eligibility

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**.

Options in the Event of Changed Circumstances

Insureds who are 65 years of age or older may apply for an Anthem Blue Cross Plan which supplements Medicare benefits.

Dependents who lose eligibility for coverage under this Policy may apply for their own coverage.

If your Dependent does not meet the qualifications to remain as a Dependent on your Policy Anthem will automatically enroll your Dependent, if a resident of California, on the same Policy under his/her own identification number.

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.

SERVICES, BENEFITS AND PREMIUMS UNDER A MEDICARE SUPPLEMENT WILL NOT BE THE SAME AS THOSE PROVIDED UNDER THIS POLICY.

PART III MAXIMUM COMPREHENSIVE BENEFITS

LIFETIME MAXIMUM

The combined total for all medical and Prescription Drug benefits is limited to a maximum amount of \$7,000,000 per Insured during the Insured's lifetime, so long as this Policy remains in effect.

If, within the same calendar Year, an Insured replaces any Anthem individual medical Policy with another Anthem individual medical Policy, any benefits applied toward the Deductible, Participating or Non-Participating Provider Out-of-Pocket Maximum or any benefit maximums of that prior Policy, will be applied toward the Deductible, Participating or Non-Participating provider Out-of-Pocket Maximum or any benefit maximums of this Policy.

DEDUCTIBLE

Each Year, you must satisfy your annual Deductible before we will pay for medical or Prescription Drug benefits. Your Deductible amount is determined by the number of Insureds enrolled in this Policy, as follows:

- **\$1,500** per Year for a single Insured in a Policyholder only contract. Once your Deductible has been satisfied, no further Deductible will be required for the remainder of that Year.
- **\$3,000** combined per Year for a Family Contract. Once one or more Insureds in a Family Contract have satisfied an aggregate Deductible of **\$3,000**, no further Deductible will be required for all enrolled Insureds for the remainder of that Year.

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

If you submit a claim for services rendered by a Non-Participating Provider which have a maximum payment limit (e.g., Physical and/or Occupational Therapy and Chiropractic Care, or Mental or Nervous Disorders and Substance Abuse, not including the treatment of Severe Mental Illnesses and Serious Emotional Disturbances of a Child) and your Deductible is not satisfied, we will apply only the allowed per visit or per day amount, whichever applies, toward your Deductible.

Amounts applied to your Yearly Deductible for certain Covered Services rendered by Non-Participating Providers **will not** apply toward your Non-Participating Provider Out of Pocket Maximum (please see the "Exception" paragraph below in the section entitled Non-Participating Provider Out of Pocket Maximum).

No Deductible is required for benefits described under Preventive Care when received from Participating Providers.

You have one deductible for Participating and Non-Participating Providers. The full Deductible amount is included in both Your Participating Provider Out of Pocket Maximum and Non-Participating Provider Out of Pocket Maximum, regardless of where the claim is incurred, as explained below under COINSURANCE and ANNUAL OUT OF POCKET MAXIMUMS.

Once the Deductible is met, charges for Covered Services from a Participating Provider apply only to the Participating Provider Out of Pocket Maximum, and charges for Covered Services from a Non-Participating Provider apply only to the Non-Participating Provider Out of Pocket Maximum.

COINSURANCE

After your Deductible has been satisfied, you will be required to pay Coinsurance for services received while you are covered under this Certificate. Coinsurance is the percentage amount you are responsible for as stated in the Coinsurance list.

ANNUAL OUT OF POCKET MAXIMUMS

Out of pocket maximum amounts for Participating Providers and Non-Participating Providers are applied separately each Year, as follows:

Participating Provider Out of Pocket Maximum

Benefits for Prescription Drugs purchased from Participating Pharmacies and PrecisionRx mail service are subject to the same Out of Pocket Maximums for Participating Providers.

- **\$5,000** per Year for a single Insured in a Policyholder only contract: Once you have satisfied your Participating Provider Out of Pocket Maximum, no further Coinsurance will be required for Participating Providers for the remainder of that Year.
- **\$10,000** combined per Year for a Family Contract. Once one or more Insureds in a Family Contract have satisfied an aggregate Participating Provider Out of Pocket Maximum of **\$10,000**, no further Coinsurance will be required for Participating Providers for the remainder of that Year.

Non-Participating Provider Out of Pocket Maximum

Benefits for Prescription Drugs purchased from Non-Participating Pharmacies are subject to the same Out of Pocket Maximums for Non-Participating Providers.

- **\$10,000** per Year for a single Insured in a Policyholder only contract: Once you have satisfied your Non- Participating Provider Out-of-Pocket Maximum, no further Coinsurance, except as specified in the "Exception" paragraph below, will be required for the remainder of that Year.
- **\$20,000** combined per Year for a Family Contract. Once one or more Insureds in a Family Contract have satisfied an aggregate Non-Participating Provider Out-of-Pocket Maximum of **\$20,000**, no further Coinsurance, except as specified in the "Exception" paragraph below, will be required for the remainder of that Year.

EXCEPTION: AMOUNTS YOU PAY FOR CERTAIN COVERED SERVICES RENDERED BY NON-PARTICIPATING PROVIDERS WILL **NOT** ACCUMULATE TOWARD SATISFYING YOUR NON-PARTICIPATING PROVIDER OUT OF POCKET MAXIMUM. IN ADDITION, FOR THESE CERTAIN COVERED SERVICES, WHICH ARE DESCRIBED BELOW, YOU WILL CONTINUE TO BE REQUIRED TO PAY COINSURANCE AND ANY APPLICABLE CHARGES (E.G. CHARGES IN EXCESS OF WHAT WE ALLOW) EVEN AFTER YOUR NON-PARTICIPATING PROVIDER OUT OF POCKET MAXIMUM AND DEDUCTIBLE HAVE BEEN SATISFIED.

- **For Non-Participating Providers and/or Non-Contracting Providers the following services do not accumulate toward satisfying your Yearly Copayment/Coinsurance Maximum:**
 - Services listed under the benefit entitled Mental or Nervous Disorders and Substance Abuse (other than Severe Mental Illnesses and Serious Emotional Disturbances of a Child)
 - Acupuncture and Acupressure
 - Physical Therapy
 - Occupational Therapy
 - Chiropractic Care
 - Charges over what Anthem allows as Covered Expense
- **For Non-Contracting Hospitals the following services do not accumulate toward satisfying your Yearly Copayment/Coinsurance Maximum:**
 - Charges over what Anthem allows as Covered Expense for Medical Emergencies within California

You will always have to continue to pay any charges over what we allow as Covered Expense for all services rendered by Non-Participating Providers, even after your out of pocket maximum and Deductible have been reached.

Participating Provider and Non-Participating Provider Out-of-Pocket Maximums:

The Deductible amount is included in both the Participating Provider Out of Pocket Maximum and the Non-Participating Provider Out of Pocket Maximum, regardless of where the claim is incurred.

Once the Deductible has been met, charges for Covered Services from a Participating Provider apply only to the Participating Provider Out of Pocket Maximum, and charges for Covered Services from a Non-Participating Provider apply only to the Non-Participating Provider Out of Pocket Maximum.

For additional details, please refer to the specific benefit in the PART entitled BENEFIT COINSURANCE LIST.

PART IV BENEFIT COINSURANCE LIST

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

DETERMINATION OF COVERED EXPENSE

- Covered Expense is the expense incurred, up to the maximum described in the next bullet, for a Covered Service or supply. Expense is incurred on the date the Insured receives the service or supply for which the charge is made. **Please review the specific benefit under this PART for any per day, visit or Year limitation and review the PART entitled MAXIMUM COMPREHENSIVE BENEFITS for your lifetime maximum, which may be applied to a particular benefit.**
- In no event will Covered Expenses exceed:
 - Any charge for services of a Participating Hospital, Participating Physician, Participating Skilled Nursing Facility, Participating Hospice, Participating Ambulatory Surgical Center, Participating Home Health Care Provider or Participating Infusion Therapy Provider in excess of the Negotiated Fee Rate.
 - Any charge for services of a Non-Participating Physician in excess of the Negotiated Fee Rate except if Special Circumstances apply, in which case Covered Expense will not exceed the Customary and Reasonable Charge.*
 - Any charge for services of a Non-Participating Hospital in excess of a Reasonable Charge.*
 - Any charge for services of a Non-Participating Ambulatory Surgical Center, Hospice, Skilled Nursing Facility or Home Health Care Provider in excess of a Customary and Reasonable Charge.*
 - Any charge in excess of \$50 per day for administrative and professional services of a Non-Participating Infusion Therapy Provider; or any charge in excess of the Average Wholesale Price for Drugs provided by a Non-Participating Infusion Therapy Provider. **The combined maximum Covered Expense for a Non-Participating Infusion Therapy Provider will not exceed \$500 per day for all Drugs, professional and administrative services.**
 - Any charge in excess of a Reasonable Charge for all other covered providers, services and supplies for which Anthem does not enter into Prudent Buyer Plan Participating Provider agreements.

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

No benefits are provided for the few Non-Contracting Hospitals within California for inpatient Hospital services or outpatient surgical procedures except as specifically stated in the section entitled **Special Circumstances**.

*** See the Special Circumstances section under this PART for situations that may reduce your payment responsibility when utilizing Non-Participating Providers.**

SECOND OPINIONS

If you have a question about your condition or about a plan of treatment, which your Physician has recommended, you may receive a second medical opinion from another Physician. This second opinion visit would be provided according to the benefits, limitations and exclusions of this Policy. If you wish to receive a second medical opinion, remember that greater benefits are provided when you choose a Participating Provider. You may also ask your Physician to refer you to a Participating Provider to receive a second opinion.

AFTER YOU HAVE SATISFIED EITHER THE \$1,500 DEDUCTIBLE FOR A POLICYHOLDER ONLY CONTRACT OR THE \$3,000 AGGREGATE DEDUCTIBLE FOR A FAMILY CONTRACT FOR COVERED SERVICES INCURRED IN A YEAR, YOUR PAYMENT RESPONSIBILITY FOR THE REMAINDER OF THAT YEAR WILL BE AS FOLLOWS:

BENEFIT

YOUR PAYMENT RESPONSIBILITY

INPATIENT HOSPITAL

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

Participating Hospital

30% of the Negotiated Fee Rate.

Non-Participating Hospital

All charges in excess of \$650 per day for the remainder of that Year unless **Special Circumstances** apply.

A Center of Medical Excellence (CME) Network has been established for 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 MEDICAL EXCELLENCE (CME) FOR TRANSPLANTS AND BARIATRIC SURGERY under the PART entitled WHAT IS COVERED.

OUTPATIENT HOSPITAL, AMBULATORY SURGICAL CENTERS AND EMERGENCY ROOM

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

Participating Provider

30% of the Negotiated Fee Rate.

Non-Participating Provider

All charges in excess of \$380 per day for the remainder of that Year unless **Special Circumstances** apply.

PROFESSIONAL SERVICES

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

Participating Provider

30% of the Negotiated Fee Rate.

Non-Participating Provider

50% of Negotiated Fee Rate **plus** all charges in excess of Negotiated Fee Rate unless **Special Circumstances** apply.

PREVENTIVE CARE

No Deductible is required when utilizing a Participating Provider, however Preventive Care services received from Non-Participating Providers are subject to the Deductible.

Participating Providers

No Coinsurance required.

Non-Participating Providers

50% of Negotiated Fee Rate **plus** all charges in excess of Negotiated Fee Rate.

BENEFIT

YOUR PAYMENT RESPONSIBILITY

SKILLED NURSING FACILITY

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

Limited to 100 days per Year combined for Participating and Non-Participating Providers.

Participating Provider

30% of the Negotiated Fee Rate.

Non-Participating Provider
out-of-state provider

50% of Negotiated Fee Rate **plus** all and charges in excess of Negotiated Fee Rate.

AMBULANCE

Participating Provider

30% of the Negotiated Fee Rate.

Non-Participating Provider
For non-emergency services

50% of Negotiated Fee Rate **plus** all charges in excess of Negotiated Fee Rate unless **Special Circumstances** apply.

MEDICAL SUPPLIES AND EQUIPMENT

Participating Provider

30% of the Negotiated Fee Rate.

Non-Participating Provider

50% of Negotiated Fee Rate **plus** all charges in excess of Negotiated Fee Rate.

FOOTWEAR

Special Footwear, including orthotic devices and services related to the preparation and dispensing of custom orthotics, including Special Footwear prescribed to treat conditions of diabetes will be provided as Medically Necessary.

Footwear is limited to a maximum benefit of \$400 per Year for Participating and Non-Participating Providers combined.

Participating Provider

30% of the Negotiated Fee Rate.

Non-Participating Provider

50% of Negotiated Fee Rate **plus** all charges in excess of Negotiated Fee Rate.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND/OR CHIROPRACTIC CARE

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

Non-Participating Provider payments for these benefits will not be applied to the Insured's Non-Participating Provider Out-of-Pocket Maximum.

Participating Provider

30% of the Negotiated Fee Rate.

Non-Participating Provider

All charges in excess of \$25 per visit for the remainder of that Year

BENEFIT

YOUR PAYMENT RESPONSIBILITY

ACUPUNCTURE AND ACUPRESSURE

Limited to 24 visits per Year for Participating and Non-Participating Providers combined. Non-Participating Provider payments for this benefit will not be applied toward the Insured's Non-Participating Provider Out of Pocket Maximum.

Participating Provider	All of the Negotiated Fee Rate except \$30 per visit.
Non-Participating Provider	All charges in excess of \$30 per visit.

DENTAL INJURY

Participating Provider	30% of the Negotiated Fee Rate.
Non-Participating Provider	50% of the Negotiated Fee Rate plus all charges in excess of Negotiated Fee Rate unless Special Circumstances apply.

MENTAL OR NERVOUS DISORDERS AND SUBSTANCE ABUSE

This does not include the treatment for Severe Mental Illnesses and Serious Emotional Disturbances of a Child. Non Participating Provider payments for this benefit will not be applied toward the Insured's Non-Participating Provider Out of Pocket Maximum.

Inpatient Hospital and Day Treatment Program

Participating Provider	All of the Negotiated Fee Rate except \$175 per day. Limited to 30 days per Year. After 30 days, you pay all charges.
Non-Participating Provider	All charges except \$175 per day. Limited to 30 days per Year. After 30 days, you pay all charges.

Note: Inpatient Hospital and Day Treatment Program benefits are provided up to a maximum payment of \$5,250 per Year, thirty (30) days per Year, Participating Providers and Non-Participating Providers combined.

This does not include the treatment for Severe Mental Illnesses and Serious Emotional Disturbances of a Child. Non-Participating Provider payments for this benefit will not be applied toward the Insured's Non-Participating Provider Out of Pocket Maximum.

Professional Services

(Inpatient and Outpatient Physician Services)

Participating Provider	All of the Negotiated Fee Rate except \$25 per visit. Limited to 1 visit per day and 20 visits per Year. After 20 visits, you pay all charges.
Non-Participating Provider	All charges except \$25 per visit. Limited to 1 visit per day and 20 visits per Year. After 20 visits, you pay all charges.

Note: Inpatient Hospital and Day Treatment Program benefits are provided up to a maximum payment of \$5,250 per Year, thirty (30) days per Year, Participating Providers and Non-Participating Providers combined.

BENEFIT

YOUR PAYMENT RESPONSIBILITY

SEVERE MENTAL ILLNESSES AND SERIOUS EMOTIONAL DISTURBANCES OF A CHILD

Benefits provided as any other medical condition.

Participating Provider

30% of the Negotiated Fee Rate.

Non-Participating Provider

50% of the Negotiated Fee Rate **plus** all charges in excess of Negotiated Fee Rate.

FOREIGN COUNTRY PROVIDERS

For initial treatment of a Medical Emergency only.

All providers

30% of Customary and Reasonable Charges plus all charges in excess of the Customary and Reasonable Charges.

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

OTHER ELIGIBLE PROVIDERS

The following class of providers do not enter into participating agreements with us and your payment responsibility for these providers is as indicated below: a blood bank, a dentist (D.D.S.), a dispensing optician, a speech pathologist, a speech therapist, an audiologist, a respiratory therapist.

All providers listed above

All charges in excess of Customary and Reasonable Charges.

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

INFUSION THERAPY

Participating Provider

30% of the Negotiated Fee Rate.

Non-Participating Provider

Administrative and Professional Services:

All charges in excess of \$50 per day.

Drugs:

All charges in excess of the Average Wholesale Price of the Drug.

Note: The combined maximum payment we will make for all Infusion Therapy services (administrative, professional and Drugs) received by Non-Participating Providers will not exceed \$500 per day.

HOME HEALTH CARE

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

Participating Provider

30% of the Negotiated Fee Rate.

Non-Participating Provider

All charges in excess of \$75 per visit.

BENEFIT

YOUR PAYMENT RESPONSIBILITY

HOSPICE

Participating Provider

30% of the Negotiated Fee Rate.

Non-Participating Provider

50% of Negotiated Fee Rate plus all charges in excess of the Negotiated Fee Rate. unless Special Circumstances* apply. If Anthem does not have a Negotiated Fee Rate with your Hospice provider, you pay 50% of the Hospice rates set by Centers for Medicare and Medicaid Services (CMS – formerly HCFA) **plus** any excess charges unless Special Circumstances* apply.

SPECIAL CIRCUMSTANCES

Authorized Referral

Non-Participating Hospital,
Physician, Ambulatory Surgical Center

30% of Customary and Reasonable Charges plus all charges in excess of Customary and Reasonable Charges.

For Medical Emergencies Within California

Non-Participating Provider

Professional Services:

30% of Customary and Reasonable **plus** all charges in excess of Customary and Reasonable Charges.

Hospitals and Non-Contracting Hospitals:

30% of Customary and Reasonable Charges **plus** all charges in excess of Customary and Reasonable Charges for the first 48 hours. After 48 hours, all charges in excess of \$650 per day.*

Ambulatory Surgical Centers:

30% of Customary and Reasonable Charges **plus** all charges in excess of Customary and Reasonable Charges.

Ambulance:

30% of Customary and Reasonable Charges **plus** all charges in excess of Customary and Reasonable Charges.

* 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 Customary and Reasonable Charges plus all charges in excess of Customary and Reasonable Charges, until his/her condition permits transfer to a Participating facility.

BLUECARD PROGRAM

For Medical Services Outside California

The Blue Cross and Blue Shield Association, of which we are a member/Independent Licensee, administers a program called **BlueCard Program**, in which we participate, which allows our Insureds to have the reciprocal use of Participating Providers that contract with other Blue Cross and/or Blue Shield Plans. Providers available to you through the BlueCard Program have not entered into contracts with Anthem Blue Cross Life and Health Insurance Company. If you have any questions or complaints about the BlueCard Program, please call us at 1-888-224-4911.

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

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

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

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

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

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

BlueCard Provider Types

PPO Providers

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

Traditional Providers

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

Non-Participating Providers

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

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

BENEFIT

Medical Non-Emergencies Outside California

Physician

PPO Provider

Traditional Provider*

Non-Participating Provider

Hospital or Ambulatory Surgical Center

PPO Provider

Traditional Provider*

Non-Participating Provider

YOUR PAYMENT RESPONSIBILITY

30% of the BlueCard provider's Negotiated Price.

50% of the BlueCard provider's Negotiated Price.

50% of the BlueCard provider's Negotiated Price **plus** all charges in excess of the BlueCard provider's Negotiated Price.

30% of the BlueCard provider's Negotiated Price.

50% of the BlueCard provider's Negotiated Price.

Inpatient Hospital:

All charges in excess of \$650 per day.

Outpatient Hospital and/or Ambulatory Surgical Centers:

All charges in excess of \$380 per day.

* If there are no BlueCard PPO providers in the area, your payment responsibility will be 30% of the BlueCard provider's Negotiated Price.

Medical Emergencies Outside California

Your payment responsibility for Covered Services received from non-participating providers, including ambulance, will be at the PPO provider percentage for emergency services as described below.

Physician

PPO Provider

Traditional Provider

Non-Participating Provider

30% of the BlueCard provider's Negotiated Price.

30% of the BlueCard provider's Negotiated Price.

30% of the Customary and Reasonable Charge **plus** all charges in excess of the Customary and Reasonable Charges.

Your payment responsibility for Covered Services received from non-participating providers, including ambulance, will be at the PPO provider percentage for emergency services as described below.

Hospital or Ambulatory Surgical Center

PPO Provider

Traditional Provider

Non-Participating Provider

30% of the BlueCard provider's Negotiated Price.

30% of the BlueCard provider's Negotiated Price.

Hospital:

30% of the Customary and Reasonable Charge **plus** all charges in excess of the Customary and Reasonable Charges for the first 48 hours. After 48 hours, all charges in excess of \$650 per day.**

Ambulatory Surgical Centers:

30% of the Customary and Reasonable Charge plus all charges in excess of the Customary and Reasonable Charge.

**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 the Customary and Reasonable Charge, until his/her medical condition permits transfer to a PPO or Traditional facility.

PART V WHAT IS COVERED

COVERED SERVICES

All Covered Services are subject to the Yearly Deductible including limited benefits such as Non-Participating Physical Therapy, Occupational Therapy and/or Chiropractic Care, Acupuncture and Acupressure, Mental or Nervous Disorders and Substance Abuse except as specifically indicated in this Policy.

The medical Deductible is described in the section Deductible under the PART entitled BENEFIT COINSURANCE LIST.

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

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

HOSPITAL

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

- A Hospital room with two or more beds. If a private room is used, we will only allow up to the prevailing two-bed room rate.
- Services in special care units.
- Operating rooms, delivery rooms and special treatment rooms.
- Supplies and ancillary services including laboratory, cardiology, pathology and radiology rendered while in the facility.
- Drugs and medicines approved by the Food and Drug Administration, including oxygen given to you during your stay, which are supplied by the Hospital for the illness, injury or condition for which the Insured is hospitalized, including take home Drugs billed on the Insured's Inpatient Hospital bill and dispensed by the Hospital's Pharmacy at the time of the Insured's discharge from the Hospital.
- Use of the emergency room.
- Outpatient services and supplies, including those in connection with outpatient surgery performed at an Ambulatory Surgical Center.
- Outpatient Day Treatment Program services when rendered at a psychiatric facility.

PROFESSIONAL SERVICES

- Services of a Physician, including surgeons and specialists.
- Services of an anesthesiologist or anesthetist.
- Outpatient diagnostic radiology and laboratory services.

Note: The following procedures require Preservice Review:

- Computerized Tomography (CT) scan
- Positron Emission Tomography (PET) scan
- Magnetic Resonance Imaging (MRI) scan
- Magnetic Resonance Spectroscopy (MRS) scan
- Nuclear Cardiology (NC) scan.
- Radiation therapy and hemodialysis treatment.
- Surgical implants.
- Artificial limbs or eyes.
- Prosthetic devices to achieve symmetry after mastectomy.
- The first pair of contact lenses or eyeglasses, when required as a result of covered eye surgery.
- Blood transfusions, including blood processing and the cost of un-replaced blood and blood products. Autologous blood donations will be covered only when the blood is transfused back into the patient.

- Injectable contraceptives, except Norplant, when administered in a Physician's office.
- FDA approved medications that may only be dispensed by a Physician.
- Reconstructive Surgery is defined as Medically Necessary and appropriate surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or create a normal appearance to the extent possible.
- Services of a Physician for diabetes education services.
- Services of a Physician or dentist treating an Accidental Injury to your natural teeth when you receive treatment within one (1) year following the injury. Damage to your teeth due to chewing or biting is not an Accidental Injury.

LIMITED PROFESSIONAL SERVICES

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

PREVENTIVE CARE

No Deductible is required for preventive care services received from Participating Providers; however preventive care services received from Non-Participating Providers are subject to the Deductible.

Preventive care services include Office Visits and physical exams. Also included are medically appropriate laboratory tests and X-ray services associated with preventive care benefits when ordered by your Physician.

Well Baby and Well Child Care (birth through 18 years)

- Childhood immunizations, including vaccinations as recommended by the American Academy of Pediatrics, and the routine physical examination associated with the immunization.
- Medically appropriate laboratory tests and procedures and radiology services in connection with the examination, including screening of blood lead levels for Children at risk for lead poisoning.
- Physical assessment with a health history.
- Routine hearing and vision tests.
- Screening for blood lead levels in Children, when the screening is prescribed by your Physician.
- Routine pelvic, PAP test and contraceptive management for female Children.

Adult Preventive Services (age 19 and above)

- FDA-approved cancer screenings including an annual pap examination, breast exams, mammography testing, appropriate screening for breast cancer, cervical and ovarian cancer screening tests, including the human papilloma virus (HPV) test for cervical cancer, prostate cancer screenings including prostate specific antigen (PSA) testing and digital examination.
- Human Immunodeficiency Virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.
- Medically appropriate immunizations.
- Physical exams.
- Screenings for Type II Diabetes, osteoporosis (bone density), cholesterol, lipid.

SKILLED NURSING FACILITIES

Limited to one hundred 100 days per Year for Participating and Non-Participating Providers combined. You must be under the active supervision of a Physician treating your illness or injury.

- A room with two or more beds. If a private room is used, we will only allow up to the prevailing two-bed room rate.
- Special treatment rooms.
- Laboratory tests.
- Physical, occupational and speech therapy. Oxygen and other respiratory therapy.
- Drugs and medicines approved for general use by the Food and Drug Administration which are used in the facility.

AMBULANCE

- Base charge and mileage to transport you to, or from, a Hospital or Skilled Nursing Facility when Medically Necessary.
- Non-reusable supplies.
- Monitoring, electrocardiograms (EKG or ECG), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with the ambulance service. An appropriately licensed person must render the services.
- Payment of benefits for ambulance services will be made directly to the provider of service unless proof of payment is received by us prior to the benefits being paid.
- If requested through a 911 call, ambulance charges are covered if it is reasonably believed that a Medical Emergency existed even if you are not transported to a Hospital.

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

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

TREATMENT FOR DIABETES

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

Diabetes Equipment and Supplies

- Blood glucose monitors, including monitors designed to assist the visually impaired and blood glucose testing strips
- Insulin Pumps
- Pen delivery systems for insulin administration
- Podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes related complications
- Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin

These covered equipment and supplies are covered under your Policy's benefits for durable medical equipment. See the section MEDICAL SUPPLIES AND EQUIPMENT under this PART.

Diabetes Outpatient Self-Management Training Program

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

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

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

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

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

MEDICAL SUPPLIES AND EQUIPMENT

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

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

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

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

FOOTWEAR

Footwear services in relation to preparation and dispensing of custom footwear necessary to treat an injury or illness. Limited to a maximum benefit of \$400 per Year combined for Participating and Non-Participating Providers. Covered Medically Necessary Special Footwear prescribed to treat conditions of diabetes will be charged against the maximum benefit of \$400 per Year; however, such benefits will be provided as Medically Necessary and the amount of benefits will not be subject to the maximum dollar limitation.

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

WIGS

We will pay up to \$400 per Insured per Year with a Physician's Prescription.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND/OR CHIROPRACTIC CARE

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

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

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

DENTAL

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

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 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.

TREATMENT FOR SEVERE MENTAL ILLNESSES 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.

PHENYLKETONURIA (PKU)

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

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

"Special food product" means a food product that is all of the following:

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

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

INFUSION THERAPY

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

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

Covered Services include:

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

- Blood transfusions, including blood processing and the cost of un-replaced blood and blood products.

Infusion Therapy benefits will not be provided for:

- Compounding fees, such as charges for mixing or diluting Drugs, medicines or solutions, or incidental supplies, including disposable items, such as cotton swabs, tubing, syringes and needles for Drugs, adhesive bandages and intravenous starter kits.
- Drugs and medicines not requiring a Prescription.
- Drugs labeled “Caution, limited by federal law to investigational use” or drugs prescribed for experimental use.
- Drugs or other substances obtained outside the United States.
- Non-FDA approved homeopathic medications or other herbal medications.
- Charges by a Non-Participating Provider exceeding the Average Wholesale Price of a Drug as determined by the manufacturer. The Average Wholesale Price includes the preparation of the finished product.

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

CANCER CLINICAL TRIALS

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

The treatment provided in a clinical trial must either:

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

Covered Services include:

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

Covered Services will not include the following:

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

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

Anthem has established a network of Hospital facilities (called Centers of Medical Excellence) to provide services for specified organ and tissue transplants and bariatric surgical procedures.

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 1-888-224-4911.**

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 by a Participating Provider at an approved 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.**

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

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 (1) pre-surgical visit, the initial surgery and one (1) 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 (1) 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. Tobacco, alcohol and drug expenses are excluded from coverage.

Organ and Tissue Transplants (requires Preservice Review):

You or your Physician must obtain Preservice Review for all services related to specified organ and tissue transplants (heart, liver, lung, heart/lung, pancreas, kidney, simultaneous pancreas/kidney, bone marrow harvest and transplant, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures). **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 approved by Anthem and performed at an Anthem approved CME.**

The following services are provided to you in connection with a covered 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.

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.

Organ and Tissue Transplants

Travel expenses will be provided for the recipient and one companion per transplant (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 twenty-one (21) days per trip and is 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 (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 seven (7) 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.

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.

HOME HEALTH CARE

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

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

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

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

HOSPICE

Anthem provides, for the terminally ill, Hospice care benefits that emphasize supportive services such as home care and pain control.

Insureds who have a terminal illness and a life expectancy of one year or less have the option of electing Hospice benefits, which include professional services of an attending Physician. An attending Physician is a Physician who is identified by the Insured, at the time he or she elects Hospice coverage, as having the most significant role in the determination and delivery of their medical care. If the Insured elects to receive Hospice care, he or she must file an election statement with the Hospice. The Insured may revoke the election at any time. Election and revocation statements are available through the Hospice.

Hospice care will be considered only after the Insured's attending Physician and the medical director of the Hospice each certifies in writing that the Insured is terminally ill. Anthem has the right to review any and all medical records or attending Physician's notes to verify that such certification is appropriate.

Covered Services include:

- Interdisciplinary team care with the development and maintenance of an appropriate plan of care. An interdisciplinary team is a Hospice care team provided by the Hospice program providing care that includes the patient, the patient's family, a Physician, a registered nurse, and a social worker, and may include a volunteer and a spiritual care giver. A plan of care is a written plan that addresses the patient's needs and the needs of the family admitted to the Hospice program.
- Short-term inpatient care arrangements.
- Skilled nursing services provided by or under the supervision of a registered nurse. Certified home health aide services and homemaker services provided under the supervision of a registered nurse.
- Social services and counseling services provided by a qualified social worker.
- Dietary and nutritional guidance. Nutritional support such as intravenous feeding or hyperalimentation.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy provided by a licensed therapist.
- Volunteer services provided by trained Hospice volunteers under the direction of a Hospice staff member.
- Pharmaceuticals, medical equipment, and supplies necessary for the management of your condition. Oxygen and related respiratory therapy supplies.
- Bereavement services, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following your death. Bereavement services are available to surviving members of the immediate family for a period of one year after your death. Immediate family members are Spouses, Domestic Partners, children, stepchildren, parents, stepparents, siblings, stepsiblings, and legal guardians.
- Palliative care (care which controls pain and relieves symptoms, but does not cure) which is appropriate for the illness.

A period of crisis is a period in which a patient requires continuous care to achieve palliation or management of acute medical symptoms. During a period of crisis, Anthem will:

- Make nursing care available on a continuous basis for as much as twenty-four (24) hours a day during periods of crisis as necessary to maintain the patient at home.
- Cover short-term inpatient care arrangements when the interdisciplinary team decides inpatient skilled nursing care is required that cannot be provided at home.
- Cover homemaker or home health aide services or both on a 24-hour continuous basis during periods of crisis, but the care provided during these periods must be predominantly nursing care.

Anthem also will make respite care available based on need. This means short-term inpatient care provided only when necessary to relieve the family members or other persons caring for the patient.

Note: For services of a Non-Participating Hospice, unless Special Circumstances apply, the maximum Anthem allowed Covered Expense for all Hospice benefits will be any annual or per diem maximums as determined by Centers for Medicare and Medicaid Services (CMS – formerly HCFA).

Note: Your Physician must consent to your care provided by the Hospice and must be consulted in the development of your treatment plan. The Hospice must submit a written treatment plan to us.

PART VI EXCLUSIONS AND LIMITATIONS

We will not furnish benefits for:

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

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

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

Diagnostic Admissions: Inpatient room and board charges in connection with a Hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

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

Educational Services and Nutritional Counseling, except as specifically provided or arranged by us under the Diabetes Outpatient Self-Management Training Program and PKU provisions in the PART entitled WHAT IS COVERED.

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

Experimental or Investigative: Medical, surgical and/or other procedures, services, products, drugs or devices (including implants) except as specifically stated under Cancer Clinical Trials in the PART entitled WHAT IS COVERED, which are either:

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

Food and/or Dietary Supplements, except for formulas and special food products as specifically stated under Phenylketonuria (PKU) under the PART entitled 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, except as specifically stated in the PART entitled WHAT IS COVERED.

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

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

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

Non-Contracting Hospital: No benefits are provided for care or treatment furnished in a Non-Contracting Hospital, **except for** a Medical Emergency as defined in the PART entitled DEFINITIONS of this Policy. This exclusion applies **only** in California.

Non-Duplication of Medicare: We will not provide benefits that duplicate any benefits you would be entitled to receive under Medicare. This exclusion applies to all parts of Medicare in which you can enroll without paying additional premium. However, if you have to pay an 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).

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

Not Medically Necessary: Any services or supplies that are:

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

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

Outdoor Treatment Programs

Outpatient Drugs and Medications: Any Drugs, medications or other substances dispensed or administered in any outpatient setting, except as specifically stated under the PART entitled YOUR 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. This limitation does not apply to a child born to or newly adopted by a Policyholder, enrolled spouse or enrolled Domestic Partner. However, we may apply Creditable Coverage to satisfy or partially satisfy the six (6) month period if the length of time between the ending date of your prior coverage and your Effective Date under this Policy did not exceed sixty-two (62) days.

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

Routine Physical Exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority.

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

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

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.

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

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

PART VII YOUR PRESCRIPTION DRUG BENEFITS

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

If you have a question regarding your Prescription Drug benefits, please call Anthem Prescription Drug Plan toll free 1-888-224-4911.

Some medications may require prior authorization from Anthem. Please call Anthem Prescription Drug Plan toll free 1-800-338-6180 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.

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 WHEN YOU GO TO A NON-PARTICIPATING PHARMACY for information on the percentage 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. To identify a Participating Pharmacy, call your local Pharmacy directly or call Anthem Prescription Drug Plan toll free 1-888-224-4911. 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.

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.

PRESCRIPTION DRUG DEDUCTIBLE

Prescription Drugs are subject to the same **Deductible** as indicated in the PART entitled MAXIMUM COMPREHENSIVE BENEFITS.

PRESCRIPTION DRUG OUT OF POCKET MAXIMUMS

Prescription Drugs purchased from Participating Pharmacies and WellPoint NextRx mail service are subject to the same **Out of Pocket Maximum** as indicated for Participating Providers in the Part entitled MAXIMUM COMPREHENSIVE BENEFITS.

Prescription Drugs purchased from Non-Participating Pharmacies are subject to the same **Out of Pocket Maximum** as indicated for Non-Participating Providers in the Part entitled MAXIMUM COMPREHENSIVE BENEFITS.

WHAT IS COVERED

- Outpatient Drugs and medications which federal and/or state of California law restrict to sale by Prescription only.
- Insulin and Insulin syringes prescribed and dispensed for use with Insulin. Lancets and test strips for use in monitoring diabetes.
- All non-infused compound 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 Anthem and are limited to eight (8) tablets/units per thirty (30) day period. **(Not covered under the mail service prescription drug program.)**
- Oral contraceptive Drugs prescribed for birth control. If your Physician determines that oral contraceptive Drugs are not medically appropriate, coverage for another FDA approved Prescription contraceptive method will be provided.
- Phenylketonuria (PKU) formulas and food products. These formulas are subject to the Coinsurance for Brand Name Drugs and the Deductible.

CONDITIONS OF SERVICE

The Drug or medicine must:

- Be prescribed in writing by a Physician and be dispensed 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 service prescription drug program.
- Not be used while the Insured is an inpatient in any facility.

Note: The Prescription must not exceed a thirty (30) day supply (unless ordered by mail through the mail service prescription drug program, in which case the limit is a ninety (90) day supply).

WHEN YOU GO TO A PARTICIPATING PHARMACY

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

You will pay 100% of the Negotiated Fee per Insured per Year until the Deductible has been satisfied. After the Deductible has been satisfied, you will have the applicable Coinsurance for each covered Prescription and/or refill listed below until your Participating Provider Out-of-Pocket Maximum has been satisfied. Once your Participating Provider Out-of-Pocket Maximum has been satisfied, Anthem will provide benefits at 100% of the Negotiated Fee for Prescription Drugs incurred by the Insured for the remainder of the Year.

Prescription Drugs including Self-Administered Injectable Drugs: 30% of the Negotiated Fee Rate.

Note: Self-Administered Injectable Drugs include any combination kit or package containing both oral and Self-Administered Injectable Drugs, except for Insulin.

WHEN YOU GO TO A NON-PARTICIPATING PHARMACY

You will pay 100% of the cost of the Drug per Insured per Year until the Deductible has been satisfied. After the Deductible has been satisfied, you will have the applicable Coinsurance for each covered Prescription and/or refill listed below until your Non-Participating Provider Out-of-Pocket Maximum has been satisfied. Once your Non-Participating Provider Out-of-Pocket Maximum has been satisfied, Anthem will provide benefits at 100% of the Drug Limited Fee Schedule for Prescription Drugs for the remainder of the Year.

Remember you will always have to continue to pay any charges over the Drug Limited Fee Schedule for all Prescription Drugs received from Non-Participating Pharmacies, even after your Out of Pocket Maximum has been reached.

If you purchase a Prescription Drug from a Non-Participating Pharmacy, you will have to pay for the full cost of the Drug.

Prescription Drugs Reimbursement is 50% of the Drug Limited Fee Schedule.

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

Anthem Prescription Drug Plan
P.O. Box 145433
Cincinnati, OH 45250-4880

Claim forms and customer service are available by calling 1-888-224-4911. 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.

Many Prescription Drugs are available in Generic form, which is more cost-effective for you. It makes good sense to ask your Physician to prescribe, and your pharmacist to dispense, Generic Drugs whenever possible.

WHEN YOU ORDER BY MAIL

Your mail service prescription drug program is administered by WellPoint NextRx. Your mail service 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. You will pay 100% of the Negotiated Fee per Insured per Year until the Deductible has been satisfied. After the Deductible has been satisfied you will pay the applicable Coinsurance amount, as listed below, for each covered Prescription and/or refill. Once your Participating Provider Out of Pocket Maximum has been satisfied, Anthem will provide benefits at 100% of the Negotiated Fee for Prescription Drugs for the remainder of the Year.

Generic and Brand Name Drugs: 30% of the Negotiated Fee Rate.

Note: The Prescription must not exceed a ninety (90) day supply.

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

The first mail service 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 Coinsurance to be enclosed.

You must authorize the pharmacist to release information needed in connection with the filling of a Prescription to the mail service prescription drug program.

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail service prescription drug program including, but not limited to, antibiotics, Drugs and medications to treat Infertility, impotence and/or sexual dysfunction, injectables, including Self-Administered Injectables except Insulin. Please check with WellPoint NextRx customer service department at 1-866-595-9844 for availability of the Drug or medication.

Specialty Drug Fulfillment

PrecisionRx Specialty Solutions will be the sole specialty pharmacy available in our network. Specialty drugs will be covered only when obtained through PrecisionRx Specialty Solutions. Specialty drugs are defined as high-cost, injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of the patient's drug therapy. These drugs often require special handling such as temperature controlled packaging and overnight delivery and are often unavailable at retail stores. PrecisionRx Specialty Solutions is currently available to provide specialty drugs to Members. PrecisionRx Specialty Solutions network will fill a thirty (30) day supply of specialty drugs at your retail Coinsurance.

You or your doctor can order your specialty medication direct from PrecisionRx Specialty Solutions by simply calling 1-800-870-6419.

You may obtain a list of specialty drugs available through the PrecisionRx Specialty Solutions network by contacting Member Services by calling toll free 1-800-870-6419 or online at www.precisionrxspecialtysolutions.com.

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 Physician's 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.
- 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, whichever 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 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 the PARTS entitled BENEFIT COINSURANCE LIST and WHAT IS COVERED.
- 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 Prescription Drug 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 the mail service prescription drug program).
- A Prescription dispensed in excess of a thirty (30) day supply (unless ordered by mail through the mail service prescription drug program, in which case the limit is a ninety (90) day supply).
- Prescription Drugs with a non-Prescription (over-the-counter) chemical and dose equivalent.

CLAIMS AND CUSTOMER SERVICE

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

Anthem Prescription Drug Plan
P.O. Box 145433
Cincinnati, OH 45250-4880
or call the toll free customer service phone number at 1-888-224-4911

For **mail service prescription drug program** information, please write to:

Anthem Blue Cross Mail Service Prescription Drug Program
c/o PrecisionRx
P.O. Box 961025
Fort Worth, TX 76161-9863
or call the toll free customer service phone number at 1-866-595-9844

web site: www.precisionrx.com

PART VIII UTILIZATION MANAGEMENT AND PRESERVICE REVIEW

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

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

Preservice Review. You are always responsible for initiating Preservice Review. Anthem will determine **in advance** whether certain procedures and admissions are Medically Necessary and are the appropriate length of stay, if applicable.

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

Preservice Review is required for, but not limited to:

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

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

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

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

For a copy of the Medical Necessity Review Process, please contact our customer service department toll free at 1-888-224-4911.

PART IX ALTERNATIVE BENEFITS

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

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

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

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

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

Alternative benefits paid are accumulated toward any annual or lifetime maximums under the Policy.

PART X GENERAL PROVISIONS

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

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

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

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

- The Insured must be under the care of the Participating Provider at the time of our termination of the provider's participation. The terminated provider must agree in writing to provide services to the Insured in accordance with the terms and conditions of his/her agreement with Anthem prior to termination. The provider must also agree in writing to accept the terms and reimbursement rates under his/her agreement with Anthem prior to termination. If the provider does not agree with these contractual terms and conditions, we are not required to continue the provider's services beyond the contract termination date.
- Anthem will furnish such benefits for the continuation of services by a terminated provider only for any of the following conditions:
 - An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services shall be provided for the duration of the acute condition.
 - A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Anthem in consultation with the Insured and the terminated provider and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the provider's contract termination date.
 - A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Services shall be provided for the duration of the pregnancy.
 - A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of Covered Services shall be provided for the duration of the terminal illness.
 - The care of a newborn child between birth and age thirty-six (36) months. Completion of Covered Services shall not exceed twelve (12) months from the provider's contract termination date.
 - Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the provider's contract termination date.
- Such benefits will not apply to providers who voluntarily leave their provider group network, providers who choose not to renew their agreement, or providers who have been terminated due to medical disciplinary cause or reason, fraud or other criminal activity.
- Please contact customer service toll free at 1-888-224-4911 to request continuation of care or to obtain a copy of the written policy. Eligibility is based on the Insured's clinical condition; it is not determined by diagnostic classifications. Continuation of care does not provide coverage for services not otherwise covered under the Policy.

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

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

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

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

Out of California Providers: The Blue Cross and Blue Shield Association, of which we are a member/Independent Licensee, administers a program called the BlueCard Program, in which we participate, which allows our Insureds to have the reciprocal use of participating providers that contract with other Blue Cross and/or Blue Shield Plans. Providers available to you through the BlueCard Program have not entered into contracts with Anthem. If you have any questions or complaints about the BlueCard Program, please call us at 1-888-224-4911. If you are outside of California and require medical care or treatment, you may use a local Blue Cross and/or Blue Shield participating provider. If you use one of these providers, your out-of-pocket expenses may be lower than those incurred when using a provider that does not participate with a local Blue Cross and/or Blue Shield Plan. In order for you to receive access to whatever reductions in out-of-pocket expenses may be available, we must abide by the BlueCard Program rules, as set by the Blue Cross and Blue Shield Association.

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

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

Often, this "Negotiated Price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The Negotiated Price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The Negotiated Price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price. Statutes in a small number of states may require the Host Blue to use a basis for calculating Policyholder liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state mandate Policyholder liability calculation methods that differ from the usual BlueCard method noted above in the preceding paragraph of this item or require a surcharge, we would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

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

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

If you or one of your Dependents receives services from a Non-Participating Provider or Non-Contracting Hospital, payment will be made directly to the Policyholder, and you will be responsible for payment to that provider. Any assignment of benefits, even if assignment includes provider's right to receive payment, is void unless an Authorized Referral has been approved by Anthem.

If you or one of your Dependents receives services from a Non-Participating Provider or Non-Contracting Hospital, payment may be made directly to the Policyholder, and in that situation, you will be responsible for payment to that provider. An assignment of benefits, even if assignment includes the provider's right to receive payment, may be void unless an Authorized Referral has been approved by Anthem.

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

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

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

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. Contact our customer service department at 1-888-224-4911 for a copy.

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

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

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

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

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

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

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

Terms of Coverage:

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

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

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

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

PART XI INDEPENDENT MEDICAL REVIEW OF GRIEVANCES

If an Insured has had any Covered Service denied, modified or delayed or has had coverage denied because proposed treatment is determined by us to be investigational or experimental, or not Medically Necessary, the Insured may ask for review of that denial, modification or delay by an external, independent medical review organization. To request a review, please call 1-888-224-4911 or write to us at Anthem Blue Cross Life and Health Insurance Company, P.O. Box 9086, Oxnard, California 93031-9086. To request an Independent Medical Review (IMR) from the California Department of Insurance (DOI), all of the following conditions must be satisfied:

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

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

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

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

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

“Acceptable scientific support” is the following sources:

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

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

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

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

The disputed health care service has been denied, modified or delayed by us based in whole or in part on a decision that the health care service is not Medically Necessary

AND

You have filed a grievance with us and the disputed decision is upheld or the grievance remains unresolved after thirty (30) days. If your grievance requires expedited review you may bring it immediately to the DOI’s attention. The DOI may waive the requirement that you follow our grievance process in extraordinary and compelling cases.

GENERAL

If your case is eligible for IMR, the dispute will be submitted to a medical specialist who will make an independent determination of whether or not the care is not experimental or investigational, or is Medically Necessary. You will receive a copy of the assessment made in your case. If the IMR determines the service is not experimental or investigational or is Medically Necessary, we will provide available benefits for the health care service.

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

For non-urgent cases, the IMR organization designated by the DOI must provide its determination within thirty (30) days of receipt of your application and supporting documents. For urgent cases involving an imminent and serious threat to your health, including but not limited to, serious pain, the potential loss of life, limb or major bodily function or the immediate and serious deterioration of your health, the IMR organization must provide its determination within three (3) business days.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. We must provide you with an IMR application form with any grievance disposition letter that denies, modifies or delays health care services. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against us regarding the disputed health care service.

For more information regarding the IMR process or to request an application form please call 1-888-224-4911.

PART XII 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.

Please send all Binding Arbitration demands in writing to:

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

COMPLAINTS

If you have a complaint about services from Anthem or your health care provider, including your ability to access needed health care in a timely manner please call Anthem first at our customer service number toll free 1-888-224-4911. You may write to us at:

Anthem Blue Cross Life and Health Insurance Company
P.O. Box 60007
Los Angeles, CA 90060-0007

If you have any questions regarding your eligibility or membership, please contact our customer service department toll free at 1-888-224-4911, or you may write to us at:

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

DEPARTMENT OF INSURANCE

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

Department of Insurance, Consumer Services Division
300 South Spring St., South Tower
Los Angeles, CA 90013

Toll-free phone number 1-800-927-HELP (4357)

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

- A. The Effective Date of your coverage is printed on your Anthem identification card which is issued together with this Policy and is a part of this Policy.
- B. The duration of your coverage under this Policy depends on how your premiums are billed, and is equal to the length of time between billing cycles. For example, if we bill premiums on a bi-monthly basis, your coverage is for a two-month duration. If we bill premiums on a quarterly basis, your coverage is for a three-month duration. If you have chosen Anthem's monthly checking account deduction program, or are a member of a list bill program, or if we otherwise bill premiums on a monthly basis, your coverage is for a one-month duration. The duration of the Policy is determined by how you pay your premiums (measured from the effective date of coverage) and is unrelated to, and is not affected by, the use of other periods of time to measure or determine your rights or benefits, such as, for example, the use of a calendar year or other Deductibles.
- C. Although your Policy expires at the end of each billing cycle, it will, upon timely payment of the billed premiums, automatically renew under the same terms and conditions unless (1) Anthem has terminated, canceled, or declined to renew the Policy pursuant to Paragraph D. below; or (2) Anthem has modified the Policy pursuant to Paragraph E. below. In the case of a modification under Paragraph E., the Policy will renew for the term specified in Paragraph B. above under the modified terms and conditions.
- D. Anthem may, at any time, terminate, cancel or decline to renew this Policy in the event of any of the following:
1. When your premium is not paid within the grace period. The grace period for payment of future premiums is thirty-one (31) days. If you fail to pay premiums as they become due, Anthem may terminate this Policy as of the last day of the grace period described above. Nevertheless, Anthem will terminate this Policy only upon first giving you a written Notice of Cancellation at least fifteen (15) days prior to that termination. The Notice of Cancellation shall state that this Policy shall not be terminated if you make appropriate payment in full within fifteen (15) days after Anthem issues the Notice of Cancellation. You are not entitled to a grace period until you have made your first payment to us. If you need covered benefits during the grace period, coverage will be provided. However, we will deduct the premiums due for coverage continued during the grace period from any benefits we pay.

The Notice of Cancellation also shall inform you that, if this Policy is terminated for non-payment of premiums, you may apply for reinstatement by submitting a new application and any premiums that are owed. See the section Reinstatement under the PART entitled GENERAL PROVISIONS for information on our reinstatement provision.
 2. On the first of the month following our receipt of your written notice to cancel.
 3. For fraud or misrepresentation in certain situations. Misrepresentation or omissions on the application may result in termination or rescission of this Policy. This Policy may also be terminated if you knowingly participated in or permitted fraud or deception by any provider, vendor or any other person associated with this Policy. Termination for fraud or misrepresentation will be effective as of the Effective Date of coverage in the case of rescission. Please see the PART entitled ELIGIBILITY for information on continuing coverage for eligible Insureds on rescinded Policies.
 4. For fraud or deception in the submission of claims or use of services or facilities or if you knowingly permit such fraud or deception by another. Termination is effective on the date of mailing the written notice.
 5. Upon becoming ineligible for this coverage. See the PART entitled WHEN AN INSURED BECOMES INELIGIBLE.
- E. Notice to Cancel or Cease Coverage
1. Before we will cease to provide any new or existing individual health benefit Policy:
 - a. We will give you at least 180 days written notice prior to cessation of this Policy, and
 - b. Those individual health benefit Policies that are in effect shall not be canceled for 180 days, after the day of notification to cease coverage, except for specific non-compliance previously stated under B. of this PART.
 2. We will give you ninety (90) days written notice before we withdraw this individual health benefit Policy from the health care market.

3. In addition to the right to terminate, cancel or decline to renew the Policy set forth in Paragraph D., Anthem has the right upon renewal, or at any time during the duration of your Policy, to modify or otherwise change the terms and conditions of your Policy, **including premiums**, provided that Anthem gives you thirty (30) days written notice of such modifications or changes. Such modifications or changes may alter any term or benefit of this Policy, including without limitation, premiums, covered benefits, Deductibles, copayments or Coinsurance. Anthem can modify or change the terms and conditions of your Policy at any time during the Year on thirty (30) days written notice, regardless of whether your Deductible or other cost sharing provisions are calculated on an annual or calendar-year basis.
 - a. In addition to the thirty (30) days written notice provision set forth above, Anthem's right to modify this Policy under Paragraph E. 3. is subject to the following conditions:
 - i. We will not cancel or modify this Policy under this paragraph E., 3. on an individual basis but only for all Insureds in the same class and covered under the same Policy as you, except:
 - (a) if we discover any fraud or intentional misrepresentation of material fact under the terms of the coverage by an individual.
 - (b) if we find out about any fraud or deception in the use of the benefits of this Policy by you, your enrolled family or anyone else if you or any Insured of your family knows about it.
 - ii. The modifications or changes will take effect upon the next applicable renewal date occurring (determined as provided in Paragraph A. above) on or after the 30th day following the date of the above notice.
 4. If, on the date we cancel your coverage on written notice (except for the reasons described in E., 1. a. and b.), you are suffering from either an injury sustained or an illness arising while your coverage under this Policy was in effect, benefits will continue, but limited by and subject to all of the following:
 - a. These continued benefits cover only treatment of an injury sustained or an illness arising while your coverage under this Policy was in effect. When we refer to an injury sustained while your coverage under this Policy was in effect, we mean that the incident or accident directly causing the injury must have occurred while your coverage under this Policy was in effect. When we refer to an illness arising while your coverage under this Policy was in effect, we mean that either the illness was first diagnosed while your coverage under this Policy was in effect or your illness first manifested itself by signs or symptoms by which a Physician could have diagnosed the illness while your coverage under this Policy was in effect.
 - b. These benefits will be provided only for treatment actually received during the ninety (90) day period following cancellation of your coverage under this Policy. If you are in a Hospital or Skilled Nursing Facility on the last day of that ninety (90) day period for treatment of a condition covered under these continued benefits, benefits will continue until the first of the following occurs:
 - (i) the date of discharge from the Hospital or Skilled Nursing Facility, or
 - (ii) care or treatment is no longer Medically Necessary.
 - c. All conditions, reductions, limitations and exclusions of this Policy, including any benefit maximums, will apply to these continued benefits. In no event will benefits in excess of any maximum benefits be provided.
- F. Any written notice will be officially given by us when it is mailed to your address as it appears on our records.
- G. You should address any written notice to us at Anthem Blue Cross Life and Health Insurance Company, P.O. Box 9051, Oxnard, California 93031-9051.

PART XIV NON-DUPLICATION OF ANTHEM BENEFITS

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

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

PART XV DEFINITIONS

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

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

Ambulatory Surgical Center is a freestanding outpatient surgical facility. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services. It must also meet accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations or the Accreditation Association of Ambulatory Health Care.

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

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

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

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

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

Contracting Hospital is a Hospital which has a contract with us to provide care to our Insureds. A Contracting Hospital is not necessarily a Participating Hospital. To determine whether a Hospital contracts with Anthem, you may contact the Hospital directly or call 1-888-224-4911 which is the telephone number printed on the back of your identification card, and a list of Contracting Hospitals will be sent to you on request.

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.

Note: Cosmetic Surgery does not become Reconstructive Surgery because of psychological or psychiatric reasons.

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

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

Creditable Coverage

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

Custodial Care is care provided primarily to meet your personal needs. This includes help in walking, bathing or dressing. It also includes preparing food or special diets, feeding, administration of medicine which is usually self-administered or any other care which does not require continuing services of a medical professional.

Customary and Reasonable Charge, as determined annually by 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.

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

Deductible means the amount of charges you must pay in a Year for any Covered Services and Prescription Drugs before any benefits are available to you under this Policy. Your Deductible is stated in the PART entitled MAXIMUM COMPREHENSIVE BENEFITS.

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

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

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

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

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

Domestic Partner meets the plan's eligibility requirements for Domestic Partners outlined in the section Who is Eligible for Coverage under the PART entitled ELIGIBILITY.

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

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

Family Contract is a contract consisting of two (2) or more enrolled Insureds.

Home Health Agencies and Visiting Nurse Associations are home health care providers which are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in your home or they must be approved as home health care providers under Medicare and the Joint Commission on Accreditation of Healthcare Organizations.

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

Hospital is a facility which provides diagnosis, treatment and care of persons who need acute inpatient Hospital care under the supervision of Physicians. It must be licensed as a general acute care Hospital according to state and local laws. It must also be registered as a general Hospital by the American Hospital Association and meet accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations.

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

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

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

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

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

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

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

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

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

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

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

Mental or Nervous Disorders and Substance Abuse are conditions that affect thinking and the ability to figure things out, perception, mood and behavior. A Mental or Nervous Disorder is recognized primarily by symptoms or signs that appear as distortions of normal thinking, distortions of the way things are perceived (for example, seeing or hearing things that are not there), moodiness, sudden and/or extreme changes in mood, depression, and/or unusual behavior such as depressed behavior or highly agitated or manic behavior. Some Mental or Nervous Disorders are: schizophrenia, manic depressive and other conditions usually classified in the medical community as psychosis; drug, alcohol or other substance addiction or abuse; depressive phobic, manic and anxiety conditions (including panic disorders); bipolar affective disorders including mania and depression; obsessive compulsive disorders; hypochondria; personality disorders (including paranoid, schizoid, dependent, anti-social and borderline); dementia and delirious

states; post traumatic stress disorder; hyperkinetic syndromes (including attention deficit disorders); adjustment reactions; reactions to stress; anorexia nervosa and bulimia. Any condition meeting this definition is a Mental or Nervous Disorder no matter what the cause. One or more of these conditions may be specifically excluded in this Policy. **However, medical services provided to treat medical conditions that are caused by behavior of the Insured that may be associated with these mental conditions (for example, self-inflicted injuries) and treatment for Severe Mental Illnesses and Serious Emotional Disturbances of a Child are not subject to these limitations.**

Negotiated Fee Rate is the rate of payment that Anthem has negotiated with the Participating Provider under a Prudent Buyer Participating Provider Agreement for Covered Services furnished to persons insured under a Prudent Buyer Policy.

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

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

Non-Contracting Hospital is a Hospital which has neither a standard contract or a Prudent Buyer Participating Hospital Agreement with Anthem. **No benefits are available for care furnished in Non-Contracting Hospitals in California** except for Medical Emergencies.

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

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

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

Office Visit is when you go to a Physician's office and have one or more of **ONLY** the following three services provided:

- History (gathering of information on an illness or injury)
- Examination
- Medical Decision Making (the Physician's actual diagnosis and treatment plan)

For purposes of this definition, 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.

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

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

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

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

Physician means:

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

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

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

Policy Anniversary Date is the date the 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 and/or

adding or deleting dependent(s) will be effective on the next billing date following written notification of the change of residence or addition/deletion of a family member.

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

Pre-existing Condition means an illness, injury, disease or physical condition for which medical advice, diagnosis, care or treatment, including the use of Prescription Drugs was recommended or received from a licensed health care provider during the six (6) months immediately preceding the Insured's Effective Date of coverage.

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

Reasonable Charge is a charge we've determined is not excessive based on the circumstances of the care provided. Such circumstances include level of skill or experience required, the prevailing or common cost of similar services or supplies and any other factors which determine value.

Serious Emotional Disturbances of a Child is defined by the presence of one or more mental disorders as identified in the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. The child must also meet one or more of the following criteria:

- As a result of the mental disorder, the child has substantial impairment in at least two (2) of the following areas:
 - Self-care
 - School functioning
 - Family relationships
 - The ability to function in the community and is at risk of being removed from the home or has already been removed from the home or the mental disorder has been present for more than six (6) months or is likely to continue for more than one (1) year without treatment.
- The child is psychotic, suicidal or potentially violent.
- The child meets special education eligibility requirements under California law.

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

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

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

Skilled Nursing Facility is a facility that provides continuous nursing services. It must be licensed according to state and local laws and be recognized as a Skilled Nursing Facility under Medicare. For purposes of Severe Mental Illnesses and Serious Emotional Disturbances of a Child only, a Skilled Nursing Facility will also include a residential treatment center which is an inpatient treatment facility where the Insured resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation as the result of a mental disorder or substance abuse. The facility must be licensed to provide psychiatric treatment of mental disorders or rehabilitative treatment of substance abuse according to state and local laws.

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

PART XVI MONTHLY PREMIUMS

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

There are different billing options available:

Paper Bill:

- Quarterly (3 months)
- Bi-Monthly (2 months)

Checking Account Deduction Program/Credit Card

- Monthly (1 month)

An administrative billing fee of \$2 may be added for a paper bill or credit card. 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.

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

Important: If you are enrolled in the checking account deduction program, you must give us thirty (30) days advance written notice to:

- change banks
- change account numbers
- change account names
- stop deduction, or
- re-start eligible deductions.

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

Premiums are the monthly charges the member must pay Anthem to establish and maintain coverage. Anthem determines and establishes the required premiums based on the member's age and the specific regional area in which the member resides. If the member changes residence, he or she may be subject to a change in premiums, 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.

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

Please be sure to read the PART entitled TERMS OF YOUR POLICY for additional terms and conditions.

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